



The Case of the Discriminatory Patient

Case by Arden Azim, BScN, MD (Candidate)

Case

Arden Azim

Objectives / Questions:

Dr. Teresa Chan

Expert Commentaries

Dr. John Neary

Dr. Teresa Y. Smith

Dr. Brenda O Oiyemhonlan

Curated Community Commentary

Dr. John Eicken

MEiC Project Lead

Dr. Tamara McColl

Dr. Teresa Chan

ALiEM Editor-in-Chief

Dr. Michelle Lin

It was a busy night in the emergency department (ED), and Dr. Young is working with an EM PGY-1, Natasha, and an off-service PGY-1, Steven. Natasha was born in India but immigrated at the age of 2, and subsequently grew up and completed all of her schooling (including medical school) in Toronto, ON, Canada. Dr. Young has worked with her before, and was already impressed with her competency and bedside manner.

Several hours into the shift, Natasha checked in with Dr. Young, who said, "Why don't you go see Mrs. Richardson? You want to see more ortho patients, and she might have a fracture you could reduce."

Mrs. Richardson, an older white woman, has been waiting for hours and was clearly uncomfortable, cradling her wrist. Natasha began the interview but Mrs. Richardson became very dismissive and asked Natasha to repeat herself several times. Natasha assumed this is due to pain and frustration, and so she reoriented herself, empathizing with her pain, and explaining that once she answered a few more questions she could go write some pain control orders. However, Mrs. Richardson interrupted, "Sorry but I just can't understand what you're saying. Not to be rude, but can I get a Canadian doctor?"

Caught off guard, Natasha stumbled over her words, "Um...I am Canadian, I'm went to school here. I'm sorry you're having trouble understanding me, what can I do to help?"

Mrs. Richardson huffed exasperated.

"No, I don't want to talk to you. I want a Canadian doctor - you know, a white one. One that

preferably speaks English. Surely there's at least one here." Stunned, Natasha stood stricken for a few seconds before telling Mrs. Richardson that she would let her attending physician know. Natasha walked out of the room slowly, shaken.

Dr. Young was busy, but tried to sympathize, "I'll try to talk to her later. In the meantime, Steven, you see her so Natasha doesn't have to go in there again."

Natasha still seemed upset, so Dr. Young reassured her, "You know how some older patients are. It's a shame, but don't take it personally."

Steven was, of course, exactly everything that Mrs. Richardson was expecting in a doctor: Tall, handsome, male... and Caucasian. Within seconds, Natasha and Dr. Young could see that he had easily won her over. With him in the room, she seemed pleasant and agreeable. Later, Natasha checked in with him and he reassured her that she did not make any other racist or discriminatory comments during the encounter, nor scoff at him when he reduced her displaced distal radius fracture under a hematoma block.

Natasha continued on with her shift, seeing other patients... but her encounter with Mrs. Richardson continued to weigh on her mind. She wondered whether she could have responded differently, and felt a bit frustrated and a bit disappointed that Steven got to perform the procedure.

Nearing the end of the shift, Dr. Young noted that Natasha appeared more withdrawn, and began to doubt how he handled the situation. He wonders whether it would be worth it for him to say something to Mrs. Richardson, and if so, what he

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Questions for Discussion

1. How should Dr. Young have responded when Mrs. Richardson refused care from a learner on a discriminatory basis?
2. Should Dr. Young have allowed another learner to see the patient in Natasha's place?
3. Should Steven have advocated for his fellow trainee? If so, how?
4. If Dr. Young belonged to the group(s) being discriminated against (e.g. female, a person of color), how would this change the response?
5. How should physicians respond when patients refuse care on a discriminatory basis in urgent situations or when no other providers are available?

Competencies

ACGME	CanMEDS
Professional Values (PROF1) Accountability (PROF2) Patient Centered Communication (ICS1)	Professional Communicator Collaborator

Intended Objectives of Case

1. Discuss the role of an attending in a case where a patient refuses the care of a delegate or trainee based on race, gender, or other unchangeable attribute.
2. Describe an approach to handling patients who make demands based on race (or gender).

Discrimination is a problem for everyone

by John Neary MD, FRCPC

"The Case of the Discriminatory Patient" illustrates the complexities of responding to a patient (Mrs. Richardson) who behaves in an overtly discriminatory manner towards a medical trainee (Natasha) whose role is both educational and clinical. The patient's behavior is related not to the resident's level of training or demonstrated competence, but rather to the patient's perceptions of the resident's ethnicity, national origin, and fluency in English.

The dual educational and clinical role of the resident (and the attending physician) and the acuity of the clinical presentation are the crux of this case. Were Natasha the attending physician, then she would owe a duty of care to the patient that would not, on its own, be waived by the patient's discriminatory behavior. (In that case, Natasha might very well decide to tell Mrs. Richardson that her behavior is intolerable and that her care will be transferred to a different physician, but Natasha could not simply deny care without providing alternate options.) Conversely, were the interaction purely educational (e.g. if Mrs. Richardson were a standardized patient or a nonclinical instructor), then it would be entirely justifiable to simply terminate the encounter in the face of this behavior. Finally, if the presentation were less acute (e.g. a wrist sprain), then it might be justifiable for the attending physician (Dr. Young) to ask the patient to seek care elsewhere.¹ In the encounter as described, Dr. Young owes a duty of care to the patient, but the trainees Natasha and Steven do not. However, Dr. Young also owes a duty as an educator to his two trainees. His inability to separate his own clinical and educational roles is a crucial factor in the unsatisfactory outcome of the educational encounter.

As a white cis-gendered, heterosexual, native-English-speaking, Canadian-born male physician, my standing to comment on this case might be questioned. Indeed, I have never been the target of discriminatory behavior as described in this case. However, without detracting from Natasha's agency to advocate for her own clinical and educational role in this encounter, it is certainly the case that her supervisor and her co-trainee also have an important opportunity to advocate on her behalf. Barriers to advocacy may be lower for people who occupy positions of authority within the medical hierarchy and for people who do not belong to the group against which the patient's discriminatory behavior is directed. In many cases, and in part because of historical and current discrimination in medicine, these will be the same people.² Intersectionality and the professional identity of the trainees are also relevant here. As a woman, Natasha may have a justifiable concern about being labelled as a

"confrontational" or "difficult" learner if she directly calls out Mrs. Richardson's discriminatory behavior, whereas a man in the same situation might instead be framed as "assertive" or "confident".³ Moreover, as a resident in emergency medicine, Natasha has much more at stake with respect to her relationship with Dr. Young than the off-service resident Steven has. For these reasons, the onus in this case is on both Steven and Dr. Young to advocate for Natasha rather than to passively enable discrimination against her. In many real-life situations, the onus will similarly be on supervisors and colleagues to declare themselves as allies when a learner is targeted by discriminatory behavior.

In his role as an educator for Natasha, Dr. Young errs in at least three ways. Firstly, he does not stand up against Mrs. Richardson's discriminatory behavior or for Natasha's role in her care. ("I'll try to talk to her later" is likely a polite way of saying "I'm not going to do this, but I don't want to say so explicitly.") Proper advocacy for the trainee's role would require Dr. Young to inform Mrs. Richardson that her behavior is unacceptable, that Natasha is a skilled clinician, and that if Mrs. Richardson refuses to accept Natasha's participation in her care, then her care may be delayed. This is not with punitive intent, but simply because of very real resource limitations. Secondly, Dr. Young does not provide Natasha with any meaningful opportunity to debrief about this encounter. Finally, Dr. Young completely overlooks the educational inequity that results from Steven being assigned a desirable educational opportunity (reducing and splinting a fracture-dislocation) because of the patient's discrimination directed towards Natasha.

It is in this last regard that Steven also misses a key opportunity to advocate for his fellow trainee. His performing the bedside procedure creates an educational inequity that compounds Mrs. Richardson's initial discriminatory behavior towards Natasha. He may be unaware of this dimension, but that is nevertheless still the effect of his actions. As an off-service resident, he has less reason to be concerned about relationship-building with Dr. Young than Natasha has. He would do better to say to Dr. Young, "I do not think that it is right for me to see this patient and perform this procedure because this patient has discriminated against my colleague Natasha."

Returning to Dr. Young, it is possibly but not necessarily the case that he should remove Natasha from participation in Mrs. Richardson's care. This decision should be shared between Dr. Young and Natasha, but the circumstances matter greatly. Dr.

Expert Response

Young should only offer Natasha the option of continuing to participate in Mrs. Richardson's care if he is able to do so with absolute clarity that she will not be negatively judged if she opts out. This will be more likely if he has a strong pre-existing relationship with Natasha and perhaps if he also belongs to a group that is often the target of similar discrimination. If he is uncertain, then he should err on the side of removing not just Natasha but all learners from Mrs. Richardson's care. The duty of care is Dr. Young's alone; by designating Mrs. Richardson as a "non-teaching" patient, he can ensure educational equity between his learners. On the other hand, if Dr. Young can be very confident that Natasha will be able to opt out without coercion, then he should give her the choice.⁴ She might ask to continue with Mrs. Richardson for any of a number of reasons: finishing what she started, overcoming adversity, performing a procedure, or learning how to cope with discrimination that may regrettably recur once she is practicing independently.

Finally, the hospital and residency program have a duty to develop policies that create clear procedures for responding to discrimination in clinical and educational settings. In many cases, existing policies may be inadequate to guide the response to a case that has both clinical and educational dimensions. If discrimination is prevalent within the training sites, the residency program should provide curriculum and faculty development to help learners and faculty respond to such cases when they do occur.

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About the Expert

John Neary (@jddneary) is a general internist at St. Joseph's Healthcare Hamilton and deputy program director for the Core Internal Medicine Training Program at McMaster University.

He would like to develop an infrastructure for massively distributed point-of-care RCTs, but in real life he mostly lurks on ED/Geriatrics/Nephro Twitter discussions.

Racism and Discrimination in Medicine

by Teresa Y. Smith MD, MEd, FACEP

Though not frequently discussed, racism, sexism, and homophobia are common issues encountered by physicians. Encounters become particularly fraught when providers of minority backgrounds are faced with the moral dilemma of treating the patient versus protecting their own dignity.

There are a few considerations that providers should contemplate when confronted with these challenging situations:

First, how stable is the patient?

Patients who are unstable should be treated by the assigned physician. Paul-Emiline and colleagues suggested in an article in the *New England Journal of Medicine*, titled *Dealing with Racist Patients*, that providers approach scenarios on a case by case basis, using an algorithm that measures the patient's medical condition against the comfort of the assigned physician.¹ When the patient is unstable, preferences cannot be accommodated and should not supersede the immediate stabilizing care. The provider should attempt to explain this to the patient (and the patient's family).

Second, does the patient have capacity?

Presuming the patient is stable, the next question is whether the patient has the capacity to make his or her own decisions.¹

In the hospital setting, all patients with capacity to make decisions regarding their medical care should be granted that autonomy; autonomous decision-making should be respected, even if it means a refusal of medical care. If the patient lacks capacity, the decision to not reassign a physician based on the patient's discriminatory preferences is easy. Again, a reasonable discussion with the patient and their family, along with continued care by the provider is within best-practices.

It is the stable patient with capacity for decision making who requests a reassignment of a physician based on the physician's gender, race, sexual orientation, or religious or cultural background who presents the most difficult scenario. This is the situation reflected in this month's case.

Natasha is a trainee. As such, her rights as a training physician are likely to be protected by governmental bodies and organizations that vary by geographic location. In the United States, the ACGME Non-Discrimination Policy states, "...the ACGME is committed to the principle that

discrimination and harassment is unacceptable and must not be tolerated. The ACGME expects that participants in the greater graduate medical education community will be able to work and study in an atmosphere that discourages discrimination and harassment by colleagues, supervisors, teachers, peers, other staff members, and patients..."² Under this policy, Natasha should be protected to practice in an environment free of discrimination.

Most hospitals have local policies that reflect a similar goal of protecting employees from discriminatory practices. These policies should be publicized and available to employees and patients alike. Title VII of the United States Civil Rights Act of 1964 and the Canadian Human Rights Act of 1977, further protect the citizens of these countries from working in conditions of discrimination.^{3,4} Regardless if it is from the laws, governmental agencies or the accreditation bodies, Natasha should be protected, though how this is best executed in the clinical environment is not always straightforward.

Competing with the trainee's right to practice in an environment free of discrimination is the patient's right to culturally-appropriate medical care. There are situations where concordant gender, culture, or language between the provider and the patient is a reasonable expectation; for example, it may be reasonable for a stable Muslim female patient to request a female clinician. In these circumstances, reassignment of the provider may facilitate the development of rapport between physician and patient. It is Dr. Young's responsibility as the attending physician to investigate why the request is being made by Mrs. Richardson before deciding to reassign Natasha.

Ultimately, if the request is based simply on bigotry, Dr. Young should protect Natasha in whatever way he feels most appropriate. It is at the comfort of the assigned physician to determine if she would like to continue to care for the patient, or would like to accommodate this request of reassignment. Literature as shown that for the mental well-being of the provider being placed in this situation, the institution, and in this case the attending physician should be supportive in whatever decision Natasha makes about continuing to care for Mrs. Richardson. To force Natasha to be exposed to the patient who may be verbally abusive, is not appropriate; similarly, to force Natasha to be reassigned to another patient because of Mrs. Richardson's bigotry is also not the right answer.

Expert Response

Passive silence implies acceptance of the discriminatory behavior. In an article in BMJ, Selby describes an ethical dilemma wherein she, as a house-staff physician, encountered a patient who made anti-Semitic comments towards the treatment team and other patients.⁵ Dr. Selby regretted staying silent to maintain a professional environment and avoid engaging in a confrontational discourse with the patient. In staying silent, she questioned whether her other patients, who were a witness to his inappropriate behavior and commentary, thought that she shared or agreed with his views. In the commentary following the article, other physicians empowered Dr. Selby that at the very minimum she should express her discontent with his comments and ask that he not continue with this behavior as it is offending other patients and staff. In our case, Dr. Young should express to Mrs. Richardson in front of Natasha that discrimination is not accepted at this hospital, and that all providers and staff should be respected.

These conversations should be held in a professional manner and non-confrontational manner. Gathering patient relations officers and social workers to participate in these discussions may be helpful to ensure that escalation to an argument does not ensue.

In summary, Dr. Young should have had a discussion with the patient first to inquire with Mrs. Richardson as to why the request was made. He should have then discussed with Natasha what her comfort level was with continuing to care for the patient, and respected and supported the decision she made. Dr. Young should have told Mrs. Richardson that discrimination was not accepted at this hospital, and advised her of all of her options. If Dr. Young came from a minority background, this would even further limit the options that Mrs. Richardson would have to be cared for at this facility. Steven is not in the position to make a decision over his attending, but in an effort to not stay silent he could also express his discontent to both Dr. Young and the patient and tell the patient that discrimination is not tolerated or tolerable. Ultimately, the stability of the patient's medical condition is the priority. Any further decisions should be made to ensure comfort of the assigned physician and

appropriate medical care of the patient. As physicians, our duty to care for our patients does come with certain sacrifices but we should not have to tolerate abusive conditions, including racial, ethnic, gender or homophobic discrimination.

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About the Expert

Dr. Teresa Y. Smith (@docteresayvonne) is currently the Residency Program Director, Clinical Assistant Dean, and Education Fellowship Director at SUNY Downstate/Kings County Hospital in Brooklyn, New York, which heralds as the largest combined emergency medicine and internal medicine/emergency medicine training program in the country, but also one of the most diverse. Her interest include, promoting diversity and inclusion in medical education from medical school to GME training. She has worked on research projects that address the health care disparities in the community served by the hospitals in Brooklyn.

A Complex Situation

by Brenda O Oiyemhonlan MD, MHSA, MPH

This scenario is quite challenging and complex. Objectively, because of the nature of emergency medicine practice, we are mandated to provide a medical screening examination and stabilization to all patients who present for care. That being said, I am also mindful and cognizant of the working conditions and environment that I create for my residents, nurses, and ancillary staff members.

By allowing a patient to discriminate against a resident based on race and/or ethnic background, I would, first and foremost, be compromising her educational experience and limiting her ability to attain the same clinical experience as her peers; which she is entitled to. Secondly, failing to appropriately address and call out these underpinnings of racism and bigotry, exposes our trainees and staff members to biased and unreasonably difficult working conditions.

Based on the research emerging in the field of psychiatry around the impact of microaggression, these seemingly benign, minor acts of aggression, in their aggregate, have been shown to be detrimental to individuals. Notwithstanding, the degree or impact of these experiences have yet to be qualified or quantified.¹

Lastly, our current political and cultural climate, really compels individual providers and healthcare organizations to be clear, plain spoken and unequivocal in their response to patient racism and bigotry and it should not be tolerated or accepted. Are there circumstances where provider reassignment may be warranted? Certainly. I can think of several instances where I have been asked to assist a colleague with a patient care issue or times where I have requested support from a colleague regarding a particularly challenging circumstance however they have not been based on physician-patient racial discordance. In most cases, the requests were based on ethical or religious values. In those instances when a patient's request for physician reassignment was accommodated, it was only after a clear discussion with the patient, trainee, and all staff associated with a patient.

Reassignment based solely on racial/ethnic bigotry or intolerance should really be considered quite separate from the scenarios raised above. I would also contend that even in a scenario where refusal of a physician may be due to a negative personal experience with people of a particular race or ethnic group, we must again, consider the overall environment that we are creating if we allow for physician reassignment based solely on this factor.²

Most healthcare organizations, unfortunately, have been quite delayed in either developing and/or disseminating their organizational diversity and inclusion core values to patients. We have for many years operated under the mantra that the patient is king. While I am not suggesting that we completely abandon those sentiments, I would strongly advise that we consider our staff and trainees as our internal customers. We must demonstrate in our actions around this subject, that we not only embrace cultural and ethnic differences but that we actively pursue opportunities to better engage the community and patients in exhibiting those values each and every time they arrive to the doors of our emergency departments. The mechanism by which we accomplish this may be diverse but could be accomplished by working with your leadership and/or marketing division to create signage that publicly display your organization's values with respect to diversity and inclusion or your organization's expectation for patient and family conduct when interacting with staff at your emergency department. Whatever manner in which you choose to communicate, it should be clear and patients should recognize that your healthcare environment is a discrimination free space.

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2. Paul-Emile, K, Smith AK, Lo, B, and Fernandez, A. Dealing with Racist Patients, *The New England Journal of Medicine*, 2016 Feb:374(8):708-11.



About the Expert

Dr. Brenda Oiyemhonlan completed her graduate studies at the University of Michigan, School of Public Health in the area of Public Health and Health Services Administration. She then completed her medical training at the Keck School of Medicine at the University of Southern California, followed by her residency at SUNY Downstate/Kings County Hospital Center. Her interests include administration – observation medicine, quality improvement, process improvement, resource utilization, patient experience and ED flow. She also loves to travel with significant other Nosa and enjoys reading and spending time with family.

Curated Community Commentary

By John Eicken MD, Ed.M.

This month's case involves a resident trainee, Natasha, who experiences discrimination because of her appearance and accent from a patient in the Emergency Department. Despite Natasha being raised in Canada, having completed medical training in Canada, and speaking English to the patient, the patient demanded, "I want a Canadian doctor - you know, a white one. One that clearly speaks English in a way I can understand." The supervising attending, Dr. Young, approaches the situation by having one of Natasha's colleagues, Steven, who happens to be "tall, handsome, male, and Caucasian" see the patient and provide care to the patient while Dr. Young consoles Natasha by rationalizing the patient's behavior to her by saying, "You know how some older patient's are. It's a shame, but don't take it personally". Natasha's demeanor and engagement with her subsequent patients is negatively impacted by this patient encounter.

This month's community commentary focused on three overarching topics:

- How the case resonated with other providers who have experienced similar discrimination
- How the situation could have been more appropriately handled in the moment
- The importance of support at an institutional level to counteract discrimination in the Emergency Department

Drs. Swaminathan, Chan, and Kaul noted that either themselves or someone they directly work with have experienced discrimination from patients in the Emergency Department based upon their race, gender, and/or religion. Based upon their previous experiences they shared insight on how they have addressed discriminatory events.

Dr. Swaminathan determines whether the patient is stable or if he/she has a life-threatening condition and assesses whether the patient has altered mental status. If the patient is stable and not intoxicated or altered he informs the patient that "this is the physician who is most qualified to take care of them with me as the supervisor." If the patient continues to exhibit discriminatory behavior Dr. Swaminathan has institutional support to tell the patient they are free to seek care elsewhere and he/she may even be escorted out of the building.

Dr. Chan shared an experience involving a male trainee who was discriminated based upon his gender when a female patient requested a female provider perform the pelvic exam. She approached the situation by assessing whether the trainee was competent in performing a pelvic exam (he was) followed by empowering the trainee to offer the patient the choice of either waiting for a female provider to become available (which may take an hour due to other patient needs) or for the trainee to immediately perform the exam. Dr. Chan noted that once the

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

Teresa Chan
Viren Kaul
Christie Lech
Kaif Pardhan
David Strauss
Anand Swaminathan

patient was fully informed of the situation and empowered with a choice she elected for the trainee to perform the pelvic exam. Furthermore, the patient reported after the exam that her concerns about the trainee were not accurate.

Dr. Kaul shared a colleague's experience in which a stable patient refused to speak to the colleague because he was Indian and proceeded to call the physician names that are "best not repeated". This patient then proceeded to exhibit more profound discriminatory treatment to the attending physician who happened to be Sikh. The patient was removed from the room and ultimately assigned to another team. Dr. Kaul highlighted the significant impact this event had among the group of residents, particularly the sense of "disappointment and hurt" that was so strong it made the topic difficult to speak about. The incident acted as a shock wave that led to collateral damage within the physician population and ultimately may have acted as a catalyst for the creation of an institutional policy. Dr. Kaul also raised concern about the potential long-term negative impact these types of events can have on physician morale and questioned how physicians can best be supported over time following a discriminatory event.

Dr. Pardhan noted that despite being a member of a visible minority group he has been fortunate in that the majority of patient interactions that involve comments about his ethnicity are related to curiosity rather than hostility. He highlighted the dangers of empty comments like those used by Dr. Young in an attempt to console Natasha given that they do little to ease the pain of being discriminated upon because of one's appearance rather than judged upon one's qualifications. He shared Dr. Swaminathan's approach of determining the potential severity of the patient's presentation (i.e. stable, non-life threatening versus critical, time-sensitive, or life-threatening) and assessing the patient's capacity and/or presence of intoxication or altered mental status. Rather than have Steven replace Natasha as the patient's provider Dr. Pardhan suggested the following approaches based upon the patient's condition. If a non-life threatening illness is present he suggested that Dr. Young inform the patient that refusal to

Curated Community Commentary

see a member of the healthcare team will mean that she will have to wait until the next team arrives (appropriate analgesia should be administered in the interim). If a possible time-critical or life-threatening diagnosis may exist Dr. Pardhan suggested that Dr. Young make the patient a “non-teaching patient” and care for the patient independently without resident trainee involvement. Dr. Pardhan also supported the presence of institutional policies and protocols to help guide and support providers who encounter patients who are discriminating against providers.

Drs. Lech and Pardhan highlighted the importance of debriefing and discussing situations involving discrimination giving the potential downstream and lasting negative effects that can result from such encounters and to ensure providers have access to the support systems and resources needed to cope with discrimination.

Finally, Dr. Lech raised the interesting question of how the Civil Rights Act relates to the discrimination against providers by patients in the Emergency Department - the answer being that it is not entirely clear. There seem to be circumstances where the Civil Rights Act supports “race congruence” when a patient requests a physician of a certain race with the basis of the request being not to discriminate against the physician but rather to optimize care. Dr. Lech notes the important caveat that this principle “does not distinguish between patients who requests originate from a space of bigotry and racism (which we are talking about) as opposed to being rooted in being a member of a stigmatized/marginalized group.” Dr. Lech echoed the importance of institutional leadership support and engagement regarding provider discrimination and suggested the following statement, “We respect people of all ethnicities, races, gender, sexual orientation, age, religious beliefs, etc. We will support and protect all our staff and make every effort to

prevent and mitigate situations of intolerance and discrimination”.

About

The Medical Education In Cases (MEiC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

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