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# Discriminatory Patient Behavior Towards Minority Healthcare Providers: Prevalence, Consequences, and Coping Strategies

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**Abstract**

In recent years, waves of civil unrest precipitated a national reckoning on the topics of racial injustice, diversity, equity, inclusion, and belonging. Despite playing an essential role in society, minority healthcare personnel are not immune to experiencing discriminatory patient behavior in the clinical setting. As the U.S. healthcare workforce becomes more racially and ethnically diverse, the frequency of negative encounters between patients/families and healthcare providers of varying social identities will likely increase. For minority healthcare personnel, patients' discriminatory behavior can be emotionally challenging, painful, degrading, and could cause feelings of distress, potentially leading to burnout. Patients/families who demean healthcare providers based on their social identity pose multiple clinical obstacles and ethical dilemmas to care, which unfortunately can elicit a significant psychological toll on healthcare providers. A stable therapeutic bond between provider and patient is built on mutual trust, respect, and understanding. This is the basis of a mutually fulfilling physician-patient relationship and efficacious patient care. In contrast, an incongruous therapeutic alliance poses challenges to achieve optimal patient and provider outcomes.

We will discuss the prevalence of discriminatory patient behavior against minority health providers and explore the impact of these potentially distressing experiences. We will present coping strategies and resources for healthcare providers when directly facing negatively biased patient behavior. Finally, we will offer guidance and a framework that physicians, bystanders, and institutions that encounter racially motivated behavior from patients and/or their families can use to respond to these difficult situations.

**Key Concepts**

- Patients' racially discriminatory behavior towards minority healthcare providers is common, emotionally challenging, painful, and humiliating.
- When encountering inappropriate patient behavior, individuals and teams should approach patients/families with compassion and provoke self-affirmation in prejudiced patients to reduce bias.
- After the encounter, a team meeting can offer a supportive environment for affected individuals and team members. Furthermore, debriefing and reflection can facilitate discussion on future responses and improve morale.
- Institutions and bystanders play an essential role in protecting and intervening in racially prejudiced patients' behavior against minority physicians.
- Organizations and providers must aim to devise effective policies, develop mandatory anti-discrimination training for all healthcare team members, and cultivate a culture of safety and belonging in the work environment.

## Introduction

A constructive relationship between patient and physician is the cornerstone of healthcare. This relationship is built on mutual trust, respect, and understanding. However, this relationship is often strained in today's diverse society because of our many differences. This not only results in decreased quality of healthcare delivery but can also result in poor patient experience, increase the cost of healthcare, and harm both the patient and the healthcare provider. Over the last few decades, much time has been spent on evaluating the issues of physician bias against patients that are members of underrepresented minorities and how this affects outcomes. Additionally, discrimination against physicians of minority backgrounds by fellow physicians has also been reviewed. Yet little attention has been paid to healthcare providers of minority backgrounds that experience bias and/or abuse from patients and their families.

It has been found that minority physicians are significantly more likely to have left at least one job because of discrimination in the workplace (black, 29%; Asian, 24%; other race, 21%; Hispanic/Latino, 20%; White, 9%).[1] In multivariate models, individuals that experienced racial/ethnic discrimination at work were associated with higher job turnover than those who did not. Among physicians who experienced workplace discrimination, only 45% of physicians were satisfied with their careers.[1] Furthermore, increased physician turnover puts additional strain on our healthcare system. For example, the turnover of primary care physicians (PCP) results in approximately $979 million in excess healthcare expenditures for public and private payers annually, with $260 million attributable to PCP burnout-related turnover.[2] Increasing physician turnover due to racial discrimination would only further hinder the healthcare system.

Living with societal prejudice, in addition to experiencing micro and macroaggressions in the workplace, takes its toll. Ungrateful, or even openly hostile behavior from patients' families because of one's minority status can significantly impact healthcare provider well-being and fulfillment. In this article, we seek to explore this painful experience further, discuss its consequences to patient and provider outcomes, and provide suggestions as to how we can address, cope, and thrive in the face of discriminatory patient behavior.

## Prevalence

The turn of 21st-century medicine in the U.S. has seen explosive growth in the diversity of the healthcare workforce. Through recruitment initiatives, the U.S.

healthcare workforce has become increasingly racially and ethnically diverse: 28% of practicing physicians are foreign-born, 51% are nonwhite, and 10% are from minority groups underrepresented in medicine.[3] Consequently, patients are more likely to encounter physicians whose identity or appearance is different than their own.

In a retrospective survey study of three academic medical centers, 98% of residents reported experiencing or witnessing biased behaviors at least once in the past year.[4] A total of 14% of residents experienced belittling comments at least once a week, and 11% experienced questioning of credentials or abilities at least once a week.[4] Furthermore, 33% of residents reported experiencing negative patient bias at least once per month. These included: belittling comments (38%), assertive inquiries into racial/ethnic origins (33%), and questioning of credentials or ability (34%).[4]

In recent years, discriminatory patient behavior towards minority healthcare providers has unfortunately become quotidian. Patient discriminatory behavior was disproportionately prevalent for Latino, Black, and Asian residents in comparison to their White colleagues.[4] For example, 45% of Black or Latino residents reported experiencing refusal of care and requests to change physicians compared to 28% of White residents.[4] In another national survey, ethnic minority clinicians were more likely to hear biased remarks than White doctors, with nearly 70% of Black and Asian doctors reporting such events.[5] Minority physicians, including Asian (43%), Black (30%), and Hispanic (37%), are more likely to hear inappropriate ethnicity-related remarks compared to White (11%) physicians.[6]

With regards to medical education, 81% of trainees reported receiving 2 hours or less of training on encountering prejudiced patients during residency.[4] Although 72% of trainees received education on patient bias in medical school, 74% rated the content of their prior training as less than adequate.[4] Finally, 89% of residents identified the need for biased patient training and policies as necessary or very necessary. This study highlights the importance of training and policies to address biased patient behavior and support for affected physicians by healthcare systems within the U.S.

## Consequences: Increased Physician Turnover, Burnout, and Poor Patient Outcomes

According to the American Medical Association's (AMA) code of medical ethics, the patient-physician relationship is based on mutual trust in which the provider acts as the patient's advocate.[7] The goal is to alleviate suffering without regard to self-interest.[7] Regarding patient acts of discrimination, the AMA states that "patients who use derogatory language or otherwise act in a prejudicial manner toward physicians….such behavior, if unmodified, may constitute sufficient justification for the physician to arrange for the transfer of care…"[7] There is also a legal limitation on the extent to which physicians and healthcare organizations can respond to patient bias. The Emergency Medical Treatment and Active Labor Act (EMTALA) states that hospitals cannot refuse patient care in an emergency, making it difficult to reject a patient's reassignment request or ignore discriminatory behavior.[8] However, beyond these general principles, physicians and hospitals have only a modicum of instruction on how to balance physicians' employment rights, patients' interests, and duty to treat when encountering prejudiced patients.

It is common practice for healthcare institutions to honor patients' unreasonable requests, such as race-based physician reassignment. However, such practices have established a precedent of indifference towards the needs of the physicians without assessing whether these demands were justified or provoked discomfort toward clinicians.[9] Supervisors are ill-equipped to respond to patients' inappropriate comments and solicitation for physicians based on nonclinical factors.[10] This ignorance propagates a failure to respond to the psychological toll on the physicians and trainees, leaving them feeling humiliated, embarrassed, or unsettled.[11] Much of the literature on minority physician experiences, documents acts of bias by patients and illustrate that

many healthcare organizations provide little guidance on responding to patient bias, resulting in significant variability in how physicians respond.[10,12-14] A patient's biased behaviors are a pernicious and insidious malady in medicine because of the harm done to the physician's well-being. Physicians often struggle with the internal conflict between their aversion to the patient and their professional duty to provide care.[15-18] Some physicians may ignore the biased remarks due to the potential consequences of responding (e.g., victim-blaming, poor evaluations), or some may choose to accommodate requests for reassignment to avoid confrontation with biased patients.[19]

A study by Wheeler et al. provides insight into the painful emotions that patient-biased behaviors elicited.[3] This study interviewed internal medicine residents who encountered biased patients and reported that these residents' mental health was often affected negatively, with fear, self-doubt, exhaustion, and cynicism all reported. Co-residents that observed these events reported moral distress and were unsure as to how to best help their colleagues when these situations arise.[3] Some residents reported that their focus was often disturbed and would rather avoid clinical sites where those encounters were common, which could stymie learning experiences and opportunities.[3] A national survey among general surgery residents revealed that 47% experienced racial/ethnic discrimination from patients or patients' families.[20] In the same study, residents that encountered these occurrences were more likely to suffer from burnout and suicidal ideation.[20] Although many physicians believe they can dissociate negative emotions created by patients' animosity without compromising the quality of care, it has been suggested that affected providers may be reluctant to spend extra time with the patients.[11,21] This has multiple potential downstream results. Time spent with patients is positively correlated with better patient satisfaction, prescribing practices, and lower risk of malpractice claims.[22] Furthermore, patient satisfaction can also influence clinician reimbursement, career advancement opportunities, and leadership positions,[23] which could widen the disparity between minority physicians and their nonminority colleagues. As the U.S. physician population becomes more racially and ethnically diverse, it is likely that the frequency of racially biased patient encounters with minority physicians will increase. Therefore, addressing patient-biased behaviors is essential and should be a top priority for our healthcare system.

## Coping Strategies: Confronting Bias & Seeking Support

Racial bias is a personal and sometimes unreasonable judgment made solely on an individual's race.[24] Experiencing racial bias from patients can be a stressful psychological process. Although the burden of defusing biases should not solely lie on its stigmatized targets, those targeted by intergroup biases are often in a unique position to respond effectively to shift the paradigm. An interpersonal confrontation may result when an individual brings awareness to an instance of intergroup bias to the offender, especially when there is a discrepancy between the offender's actions and egalitarian values.[25] The recognition of these discrepancies may elicit negative self-directed emotions and contemplation by the offender while establishing cues to prevent future occurrences of a value-discrepant response.[26] Racial bias studies have shown that both threatening and nonthreatening confrontation of biased responses may result in guilt, shame, behavior inhibition, retrospective reflection, and more importantly, decreased likelihood of future biased responses by the offender.[25,27] Victims of bias can then be empowered to recognize biased behaviors and act as a reminder for self-control on the offender's behalf.[25]

Physicians should employ bias-reducing strategies while establishing trust between patients and providers. One such strategy involves patient education on self-affirmation which can diminish threat responses in different domains. Self-affirmation theory focuses on how individuals adapt to information or experiences that threaten their self-concept by reflecting on and prioritizing personal values.[24] It has shown utility in developing receptiveness to a conflicting message[28] and reducing stress from social

identity threats.[29] One study demonstrated its utility in addressing ethnic bias towards Arab-Americans.[24] This study showed that prejudiced White participants were not interested in meeting Arab American individuals again if they were immediately confronted with the insistence that they take the perspective of Arab-Americans who have faced discrimination since the 9/11 attacks.[24] However, if the Arab-American first asked the prejudiced White participant questions to promote self-affirmation, they were more likely to express a desire to meet an Arab-American again even after the confrontational perspective-taking message.[24]

In addition to bias-reducing strategies, physicians should be equipped with appropriate coping strategies to reduce the detrimental impact on one's emotional well-being. Physicians who have experienced biased behaviors deserve to have their experiences and feelings validated by an ally, a colleague, or a loved one. Seeking support from support groups and social networks is an effective self-healing strategy[30] that can help one gain perspective, validate the experiences, and develop protective mechanisms.[31] Although social support may involve colleagues with similar firsthand experience, support from other empathetic individuals is also valuable in providing comfort and affirmation.[32] Aside from outside support, self-protective strategies should also be employed. Healthier strategies may involve repression or sublimation through hobbies.[33] In sum, as physicians, the goal should be to temper indignation, maintain professionalism, and attain satisfaction in our field.

## Framework for Responding to Patient or Visitor Bias Behavior

According to Title VII, clinicians have the right to a workplace free of discrimination.[34] However, healthcare professionals also have a fiduciary responsibility to address emergent situations in which patients' lives are at risk. Physicians must carefully balance their well-being with patients' rights and safety.[35] Clear policies and procedures are necessary to guide staff when discriminatory behavior occurs in the healthcare setting. This section will provide an algorithm (Figure 1) and scripts (Table 1) for responding to inappropriate patient or visitor behavior utilizing the previously discussed coping strategies.

### *Inappropriate Patient or Visitor Behavior*

First, clinician safety must be a top priority. If a patient is endangering the physician's well-being, physicians shall disengage from patients immediately and request additional assistance, such as a security team, supervisors, and law enforcement. In addition, they should report the incident to the organizational leadership and consider a transfer of care. When confronting prejudiced patients, providers must consider patient autonomy with the ethical principle of justice and nonmaleficence.[37] Physicians should treat all forms of disrespect with compassion. Thích Nhất Hạnh, widely regarded as a "father of mindfulness," described the best approach for managing interpersonal conflict as:

*"…If we are sincere in wanting to learn the truth, and if we know how to use gentle speech and deep listening, we are much more likely to be able to hear others' honest perceptions and feelings. In that process, we may discover that they too have wrong perceptions. After listening to them fully, we have an opportunity to help them correct their wrong perceptions. If we approach our hurts that way, we have the chance to turn our fear and anger into opportunities for deeper, more honest relationships…"*[38]

The intention of deep listening and loving speech is to restore communication because once communication is restored, everything is possible, including peace and reconciliation. Therefore, mental acuity and the patient's health condition must be considered before deciding on a response to discriminatory patient conduct. If the patient's behavior is not hostile, physicians should assess the patient's cognitive abilities, such as reduced decision-making capacity.[39] Then, the physician should de-escalate with empathetic language and address the inappropriate behavior or comments and inform the patient of their role as physicians: to improve his or her

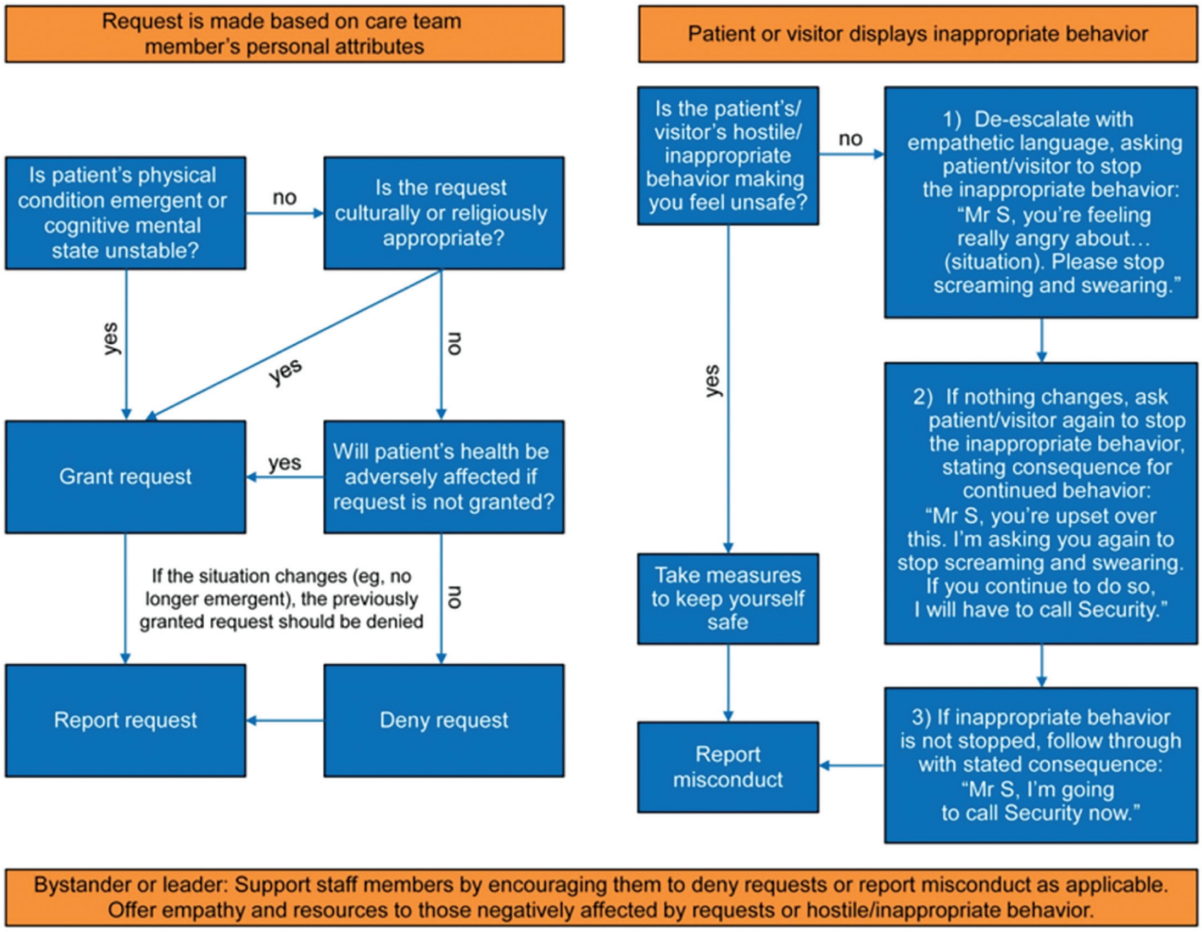


***Figure 1.*** *Algorithm for responding to inappropriate patient or visitor behavior.*
*Adopted with permission from Mayo Clinic's 5-Step Policy for Responding to Bias Incidents.*[36]

**Table 1. Examples of Scripted Response to Inappropriate Patient Request**

| |
|---|
| • "Help me understand your request." |
| • "We are here to help you as a team. We do not change doctors/nurses/etc., because of their race/ethnicity/religion/etc." |
| • "All [Name of Your Institution] team members are very qualified. Our top priority is that you receive the best care, and I know that our team members can provide that." |
| • "All [Name of Your Institution] staff are credentialed and licensed to practice in the State of _____. One of our core principles is that we treat everyone in our diverse community with respect and dignity. We are confident in _____'s character and clinical skills." |
| • "I would trust this physician/nurse/therapist/etc., to care for my own child/family member." |
| • "We want to provide you with excellent care and believe that _____ is the right person to do so." |
| • "[Name of Your Institution] hires the best and brightest people to care for our patients regardless of their race, ethnicity, gender, sexual orientation, etc." |

*Adopted and modified with permission from Mayo Clinic's 5-Step Policy for Responding to Bias Incidents.*[36]

health. Suggested language includes "I am surprised you thought that would be an appropriate comment/behavior," "Let's keep it professional," and "I am here to focus on your health." Furthermore, physicians should share their perspectives on how the patient's behavior makes them feel. For example, "When you said [inappropriate comment]/did [inappropriate behavior], I felt uncomfortable." Next, physicians should inform the patient that their behavior, if continued, would undermine the therapeutic alliance. For instance: "Your care team is made up of many different individuals who are all working to address your issues. I respect every member of your team and ask you to do the same to achieve the best outcome for you." If the patient's inappropriate behavior continues, physicians should consider temporarily retreating from the setting, with this suggested response: "We are going to come back in 30 minutes and hope you will be ready to move forward." In addition, bystanders are encouraged to step in when witnessing inappropriate behavior by affirming the physician's ability and addressing the inappropriate behavior. Physicians should consider that if the patient's or visitor's behavior towards the staff is derogatory or abusive, it will not be tolerated, and, if persistent, could result in termination of care depending on its severity and the setting. This determination should be made by members of the healthcare team most familiar with that individual patient's clinical, cultural, religious, and social background, in addition to the administration. If the patient's behavior is determined to be inappropriate, the physician may terminate service, offer a transfer of care to another healthcare institution, and should document the inappropriate behavior through the reporting system. In more complicated scenarios where attempts at dialogue reach an impasse, risk management/ethics teams should be consulted. Most institutions have such resources readily available and may have dedicated multidisciplinary patient experience teams to deal with potentially contentious situations which can reduce confrontation and litigation.[40] The team should apply policy consistently; clearly communicate expectations to patients, learners, and staff; and consider each situation with the aim to resolve conflict as amicably as possible.

*Vignette*

Dr. Mohammed entered her next patient's room to see Amy Smith, a 7-year-old White female. She was present with her father who looked at the physician suspiciously. After initial introductions, the patient's father interrupted Dr. Mohammed, saying that he would like his daughter to be seen by a White doctor. Having experienced similar situations in the past, Dr. Mohammed calmly and clearly responds: "Mr. Smith, I understand that you want the best for your daughter. I assure you that I am well-qualified and fully capable of evaluating her. We will discuss her symptoms and together, we will figure out what is the best course of action. I have a little girl that is about the same age as Amy, and I can understand the concern that you are feeling. We are in this together. I will have to inform you that it is not the policy of our institution to allow patients or their families to decide which physician they would like to see based on their race or sex. Why don't you take a few minutes to think about this, and I will be right back." Dr. Mohammed left the patient room. Upon her return, Mr. Smith apologized and agreed to be seen.

## After the Encounter

### *Vulnerability of Trainee/Supervisor, Bystander, and Peer Intervention*

Due to medical hierarchy, trainees are particularly vulnerable to patient mistreatment.[41] Many trainees may be concerned with drawing attention to incidents with the biased patient due to the risk of victim-blaming, poor evaluation, and being perceived as weak.[42] In this situation, supervisors and peers need to intervene on their behalf, as trainees are generally vulnerable with little authority to protect themselves.[43] In situations where the supervisor fails to address the incident, trainees often wonder if their supervisors question the validity of the complaint. This may, unfortunately, result in the decision to stay silent, as trainees often worry that requesting

assistance might jeopardize their career.[44] Therefore, the attending physician, as the care team leader, should address inappropriate behaviors as it may place other staff members in potentially abusive situation.[45] If a learner does not wish to participate in a patient's care as a result of abusive behavior by the patient or family members, it is the responsibility of the supervisor to evaluate the situation and respond appropriately. Lastly, the supervisor should offer support after the incident. When encountering abusive patients and/or family members, bystanders and peers should intervene on behalf of the victim, as they may be at a loss as to how to proceed.[46] A survey of trainees revealed that 50% of respondents who experienced or witnessed patient discrimination did not know how to respond while 25% believed nothing would be done if hospital leadership were notified.[47] After the incidents, bystanders might consult with affected trainees, acknowledge the incidents, and offer support and empathy. If bystanders wish, they may share past experiences with biased patients to reduce the affected trainee's feelings of self-doubt and build rapport.[37] Bystanders and peers can share additional resources to help trainees process or report the incident. Reporting events can improve data collection on the prevalence of discrimination and identify a potential area of improvement. This data can be implemented in new strategies to prevent biased incidents from reoccurring. For example, heat map analysis can detect trends and identify departments or groups of clinicians at a higher risk of experiencing patient bias and provide additional information to revised policies, support, and education in the future.[48] Creating this culture of accountability will allow healthcare professionals—especially staff who are more vulnerable to discrimination—to better support those that may encounter such situations in the future.

## Debrief/Reflection/Team Meeting/Offer Support

After the encounter, supervisors should host follow-up team meetings to acknowledge the event and debrief the affected individuals in a safe and nonjudgmental environment. The objective is to reiterate the seriousness of the experience and allow the trainees and care team to share and reflect upon the experience with the attending physician and/or other trusted source of support and guidance. Research has consistently demonstrated that the use of critical reflection to process emotionally challenging clinical encounters helps clinicians cope with discriminatory experiences.[49-51] It is essential that this meeting be structured and facilitated in a manner that promotes inquiry rather than minimize the individual's experience. Other team members should be allowed to empathize with the individuals and others, who experience of discomfort and vulnerability, so that they may develop the skills necessary to manage a biased patient.[52] Furthermore, this meeting should allow team members to care for each other, share experiences, and discuss alternative responses to episodes of biased behavior by patients and visitors. A supportive environment is crucial in crafting a meaningful future response, improving morale, and building camaraderie among the healthcare team.[37] In addition to debriefing, the supervisor needs to ensure that trainees report the incidents to the proper reporting outlet, which is essential for the administration to implement or revise policy relevant to the patient's biased behavior.

## Summary

Medicine is not immune to the prejudice and bias prevalent in society. It may even come from those whom physicians are dedicated to serving. In the face of an ever-shifting demographic landscape, modern medicine requires a change in the workplace culture to prepare an ethnically, culturally, and gender-diverse workforce for the increasing number of biased behaviors from patients and visitors. Therefore, all healthcare leaders and institutions should be urged to develop practices to protect and provide their healthcare personnel with a safe, supportive, respectful work environment and to create a sense of belonging where people feel comfortable, can make meaningful connections, and contribute to the success of the system.

**Table 2. Resources for Physicians, Bystanders, and Institutions That Experience Patient's Bias**

| Resources | Description |
|---|---|
| 1. Operating with Respect by The Royal Australasian College of Surgeons (RACS)[a] | The Operating with Respect course provides advanced training in recognizing, managing, and preventing discrimination, bullying and sexual harassment. The aim of this course is to strengthen patient safety by enabling participants to develop skills in respectful behavior and practice strategies in responding to unacceptable behavior. The course follows the release of the RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery.<br><br>*Target Audience: Physicians, Trainees, and Other Healthcare Team Members* |
| 2. IHI Framework for Improving Joy in Work[b] | A guide for healthcare organizations to engage in a participative process where leaders ask colleagues at all levels of the organization, "What matters to you?", enabling them to better understand the barriers to joy in work, and co-create meaningful, high-leverage strategies to address these issues<br><br>*Target Audience: Healthcare Administrators and Healthcare Team Leaders* |
| 3. Mayo Clinic's 5-Step Policy for Responding to Bias Incidents[c] | A framework to address bias incidents and to cultivate work environments that are safe for employees and patients. This guideline created both policies to support staff and a reporting mechanism for accountability.<br><br>*Target Audience: Healthcare Administrators* |
| 4. Stanford Applied Compassion Training[d] | An 11-month training program to prepare professionals, including physicians, who feel a strong need to bring forth and integrate compassionate action into their occupations, professions, communities, and institutions, as well as into their personal development.<br><br>*Target Audience: Healthcare Administrators, Physicians, Trainees, and Other Healthcare Team Members* |
| 5. Stanford SHARE's Upstander Intervention Program[e] | A program and guide to promote a culture of community accountability where bystanders become upstanders that are actively engaged in the prevention of violence, realizing that all individuals are responsible for each other in addition to themselves.<br><br>*Target Audience: Healthcare Administrators, Physicians, Trainees, and Other Healthcare Team Members* |
| 6. The Fearless Organization: Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth[f] | A book offers a step-by-step framework for establishing psychological safety within a team and an organization. It is filled with illustrative scenario-based examples and provides a clear path forward for implementing a culture that thrives on the free expression of ideas and nurturing engagement.<br><br>*Target Audience: Healthcare Administrators and Healthcare Team Leaders* |

**Table 2. Continued**

| Resources | Description |
|---|---|
| 7. Addressing Patient Bias Toward Health Care Workers: Recommendations for Medical Centers[g] | An article offers guidance to organizations on devising effective policies that meet the needs of medical centers, patients, and healthcare workers across services and roles, including physicians, nurses, and trainees.<br><br>*Target Audience: Healthcare Administrators* |

[a]*Website: https://www.surgeons.org/Education/professional-development/all-professional-development-activities/operating-with-respect-owr-course.*
[b]*Perlo J, Balik B, Swensen S, et al. IHI Framework for Improving Joy in Work. In Improvement IfH, (Ed). Cambridge, Massachusetts 2017.*
[c]*Warsame RM, Hayes SN. Mayo Clinic's 5-Step Policy for Responding to Bias Incidents. AMA J Ethics. 2019;21(6):E521-529.*
[d]*Website: http://ccare.stanford.edu/education/applied-compassion-training/.*
[e]*Website: https://share.stanford.edu/get-informed/education-and-outreach-programs/upstander-intervention.*
[f]*Edmondson AC. The fearless organization: creating psychological safety in the workplace for learning, innovation, and growth. Hoboken, New Jersey: John Wiley & Sons, Inc., 2019.*
[g]*Paul-Emile K, Critchfield JM, Wheeler M, et al. Addressing Patient Bias Toward Health Care Workers: Recommendations for Medical Centers. Ann Intern Med. 2020;173(6):468-473.*

***External Resources for Physicians, Bystanders, and Institutions to Address Patient's Bias***

All physicians, clinical care team members, and institutions should behoove creating a comfortable work environment where all healthcare providers and patients are treated with equal respect and dignity irrespective of their social identity. This goal can be achieved by devising an effective policy that explicitly addresses patient bias, ensuring mandatory training for all team members, and cultivating a culture of compassion within the clinical setting. However, clinicians and administrators often encounter various barriers, including a lack of resources, guidance, and support, when attempting to foster a physically and psychologically safe workplace.[40] In Table 2, we describe a few readily available resources, including frameworks, step-by-step guides, and training programs, for both individuals and organizations. We hope these resources will offer practical recommendations and examples for advancing diversity, equity, inclusion, justice, and belonging within the medical community.

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## References

1. Nunez-Smith M, Pilgrim N, Wynia M, et al. Health care workplace discrimination and physician turnover. *J Natl Med Assoc*. 2009;101(12):1274-1282.
2. Sinsky CA, Shanafelt TD, Dyrbye LN, et al. Health care expenditures attributable to primary care physician overall and burnout-related turnover: a cross-sectional analysis. *Mayo Clin Proc*. 2022;97(4):693-702.
3. Wheeler M, de Bourmont S, Paul-Emile K, et al. Physician and trainee experiences with patient bias. *JAMA Intern Med*. 2019;179(12):1678-1685.
4. de Bourmont SS, Burra A, Nouri SS, et al. Resident physician experiences with and responses to biased patients. *JAMA Netw Open*. 2020;3(11):e2021769.
5. Tedeschi B. 6 in 10 doctors report abusive remarks from patients, and many get little help coping with the wounds. STAT News. Available at: https://www.statnews.com/2017/10/18/patient-prejudice-wounds-doctors/?s_campaign=medscape. Accessed Febrary 1, 2022.
6. *Credentials Don't Shield Doctors, Nurses from Bias*. WebMD.
7. *Code of Medical Ethics: patient-physician relationships*. American Medical Association. Available at: https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-patient-physician-relationships. Accessed March 2, 2022.
8. Services TCfMM. Emergency Medical Treatment & Labor Act (EMTALA). In: Services DoHaH; 1986.
9. Powers BW, Jain SH. The prejudiced patient. *AMA J Ethics*. 2014;16(6):417-519.
10. Warshaw R. When the target of bias is the doctor. Association of American Medical Colleges. Available at: https://www.aamc.org/news-insights/when-target-bias-doctor. Accessed March 2, 2022.
11. Filut A, Alexander L, Ray A, et al. "This happens all the time": a qualitative study of general internists' experiences with discriminatory patients. *J Gen Intern Med*. 2021;36(6):1553-1560.
12. Singhal U. Overcoming our red dots and confronting racism from patients. *JAMA Oncol*. 2022;8(4):518-519.
13. Selby M. Ethical dilemma: dealing with racist patients. *BMJ*. 1999;318(7191):1129.

14. Olayiwola JN. Racism in medicine: shifting the power. *Ann Fam Med*. 2016;14(3):267-269.
15. Easmon C. Ethical dilemma: dealing with racist patients. Commentary: isolate the problem. *BMJ*. 1999;318(7191):1130.
16. Gough P. Ethical dilemma: dealing with racist patients. Commentary: courteous containment is not enough. *BMJ*. 1999;318(7191):1131.
17. Neuberger J. Ethical dilemma: dealing with racist patients. Commentary: a role for personal values … and management. *BMJ*. 1999;318(7191):1130.
18. Coopes A. Operate with respect: how Australia is confronting sexual harassment of trainees. *BMJ*. 2016;354:i4210.
19. Paul-Emile K. Patient racial preferences and the medical culture of accommodation. *UCLA L Rev*. 2012;60(462). Available at: https://ir.lawnet.fordham.edu/faculty_scholarship/503.
20. Hu YY, Ellis RJ, Hewitt DB, et al. Discrimination, abuse, harassment, and burnout in surgical residency training. *N Engl J Med*. 2019;381(18):1741-1752.
21. Choo E. *An Emergency-room Doctor Explains Why Being Racist is Bad for Your Health*. Quartz. 2017.
22. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient-physician relationship. *J Gen Intern Med*. 1999;14(Suppl 1):S34-S40.
23. Sara Berg M. In patient satisfaction scores, what role does bias play? Accessed March 2, 2022.
24. Wolsiefer K, Stone J. 13 - Addressing bias in healthcare: confrontation as a tool for bias reduction and patient and provider self-advocacy**The writing of this chapter was supported by the National Institute On Minority Health And Health Disparities of the National Institutes of Health under Award #1R01MD008940-04. In: Mallett RK, Monteith MJ, eds. *Confronting Prejudice and Discrimination*. Academic Press; 2019:275-297.
25. Monteith MJ, Ashburn-Nardo L, Voils CI, et al. Putting the brakes on prejudice: on the development and operation of cues for control. *J Pers Soc Psychol*. 2002;83(5):1029-1050.
26. Monteith M, Aimee Y. Changing one's prejudiced ways: awareness, affect, and self-regulation. *Eur Rev Soc Psychol*. 2005;16:113-154.
27. Czopp AM, Monteith MJ, Mark AY. Standing up for a change: reducing bias through interpersonal confrontation. *J Pers Soc Psychol*. 2006;90(5):784-803.
28. Harris PR, Mayle K, Mabbott L, et al. Self-affirmation reduces smokers' defensiveness to graphic on-pack cigarette warning labels. *Health Psychol*. 2007;26(4):437-446.
29. Martens A, Johns M, Greenberg J, et al. Combating stereotype threat: the effect of self-affirmation on women's intellectual performance. *J Exp Soc Psychol*. 2006;42:236-243.
30. Samora J, Denning J, Haralabatos S, et al. Do women experience microaggressions in orthopaedic surgery? Current state and future directions from a survey of women orthopaedists. *Curr Orthop Pract*. 2020;31:503-507.
31. Franklin AJ, Boyd-Franklin N. Invisibility syndrome: a clinical model of the effects of racism on African-American males. *Am J Orthopsychiatry*. 2000;70(1):33-41.
32. Torres MB, Salles A, Cochran A. Recognizing and reacting to microaggressions in medicine and surgery. *JAMA Surg*. 2019;154(9):868-872.
33. Lewis J, Mendenhall R, Harwood S, et al. Coping with gendered racial microaggressions among black women college students. *J Afr Am St*. 2012;17:51-73.
34. Davis AK, Reynolds PP, Kahn NB Jr, et al. Title VII and the development and promotion of national initiatives in training primary care clinicians in the United States. *Acad Med*. 2008;83(11):1021-1029.
35. Vogel L. Doctors on their own when dealing with racism from patients. *CMAJ*. 2018;190(37):E1118-E1119.
36. Warsame RM, Hayes SN. Mayo clinic's 5-step policy for responding to bias incidents. *AMA J Ethics*. 2019;21(6):E521-E529.
37. Shankar M, Albert T, Yee N, et al. Approaches for residents to address problematic patient behavior: before, during, and after the clinical encounter. *J Grad Med Educ*. 2019;11(4):371-374.
38. Thích NH. *Fear: Essential Wisdom for Getting Through the Storm*. 1st ed. New York: HarperOne; 2012:164.
39. Youmans QR. The N-word. *Ann Intern Med*. 2019;171(5):380-381.
40. Paul-Emile K, Critchfield JM, Wheeler M, et al. Addressing patient bias toward health care workers: recommendations for medical centers. *Ann Intern Med*. 2020;173(6):468-473.
41. Weeks LD. When the patient is racist, how should the doctor respond? Stat News. Available at: https://www.statnews.com/2017/06/12/racism-bias-patients-doctors/. Accessed March 10, 2022.
42. Okwerekwu JA. What happened when I talked about what others ignore — racism in medicine. STAT News. Available at: https://www.statnews.com/2016/04/27/racism-medicine-lessons/?s_campaign=medscape. Accessed March 10, 2022.
43. Baker K, Sen S. Healing medicine's future: prioritizing physician trainee mental health. *AMA J Ethics*. 2016;18(6):604-613.
44. Okwerekwu JA. The patient called me 'colored girl.' The senior doctor training me said nothing. STAT News. Available at: https://www.statnews.com/2016/04/11/racism-medical-education/. Accessed March 10, 2022.
45. Jain SH. The racist patient. *Ann Intern Med*. 2013;158(8):632.
46. Cooper LA, Beach MC, Williams DR. Confronting bias and discrimination in health care—when silence is not golden. *JAMA Intern Med*. 2019;179(12):1686-1687.
47. Whitgob EE, Blankenburg RL, Bogetz AL. The discriminatory patient and family: strategies to address discrimination towards trainees. *Acad Med*. 2016;91(11 Association of American Medical Colleges Learn Serve Lead: Proceedings of the 55th Annual Research in Medical Education Sessions):S64-S69.
48. Weiner S. Pushing back against patient bias. American Association of Medical College. Available at: https://www.aamc.org/news-insights/pushing-back-against-patient-bias. Accessed March 10, 2022.
49. Sandars J. The use of reflection in medical education: AMEE Guide No. 44. *Med Teach*. 2009;31(8):685-695.
50. Wald HS, Davis SW, Reis SP, et al. Reflecting on reflections: enhancement of medical education curriculum with structured field notes and guided feedback. *Acad Med*. 2009;84(7):830-837.
51. Shapiro J, Bezzubova E, Koons R. Medical students learn to tell stories about their patients and themselves. *Virtual Mentor*. 2011;13(7):466-470.
52. Sue DW, Capodilupo CM, Torino GC, et al. Racial microaggressions in everyday life: implications for clinical practice. *Am Psychol*. 2007;62(4):271-286.