Invited Commentary

Confronting Bias and Discrimination in Health Care—When Silence Is Not Golden

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In this issue of *JAMA Internal Medicine*, Wheeler et al[1] report results from a novel qualitative study in which the investigators examined how physicians and trainees perceive, react, and respond to incidents of biased patient behavior. Study participants reported varied experiences with discriminatory patient behavior, ranging from mildly disparaging comments to openly racist, sexist, or homophobic stereotyping remarks and absolute refusals of care. They also described myriad reactions to these situations, including pain, fear, anger, and confusion. Barriers to appropriate responses included a lack of skills in confronting patients exhibiting biased behavior, lack of support from colleagues and guidance from the institution, and uncertainty about whether responding to these experiences would be perceived as unprofessional. This study provides insights into the gravity of the problem of discriminatory patient behavior, raises key unanswered questions, and calls for action from the medical profession.

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The results reported by Wheeler et al[1] are troubling, but not surprising. Health care settings are a microcosm of our larger society. Although explicitly racist and homophobic attitudes have declined over time in the United States, the resurgence of openly racist and homophobic attitudes in recent years has led many to question whether the apparent progress in social attitudes over the past several decades is real. Fortunately, a recent analysis of data from more than 4 million internet-based tests of social group attitudes showed that explicit and implicit biases associated with race, skin tone, and sexual orientation declined between 2007 and 2016.[2] Yet, across the United States, persons from racial/ethnic minority groups, immigrants, and sexual and religious minorities continue to experience discriminatory and disrespectful treatment. Of grave concern is the increasing number of violent acts of terrorism toward persons from socially marginalized groups by persons with extreme racial and homophobic beliefs. Moreover, discrimination is experienced not only in interpersonal relationships, but also perpetuated by unjust practices and policies throughout our institutions and organizations.

The literature on discrimination in health care has largely focused on when and how physicians exhibit bias in their interactions with patients from socially marginalized groups, particularly racial and ethnic minorities. However, the physician workforce is becoming more diverse with regard to race, ethnicity, sex, gender identity, and sexual orientation. The Wheeler et al[1] study is one of few providing empirical data on the topic of how unjust and biased patient behaviors affect physicians, especially those from socially marginalized groups. A 2017 survey found that almost 60% of responding physicians reported experiences of biased treatment from patients based on their own race, ethnicity, sex, gender identity, sexual orientation, or religion.[3] Other reports have included case reports, personal narratives, recommendations for trainees, a framework for considering patients' requests for physician reassignment based on racial or ethnic background,[4] and hospital policies for responding to bias incidents. Thus, many unanswered questions remain. Which professional codes of ethics govern individual physician and institutional responses to biased behaviors from patients? To what extent are physicians and health care institutions putting their own stated values into practice to establish institutional climates of respect and equity? What lessons can we draw from organizational change and bias reduction interventions?

Most professional codes of ethics are built around protecting patients, who experience vulnerability in health care by virtue of their role. These codes fail to equip individual physicians and health care organizations with guidance on how to respond to patients who engage in disrespectful behavior towards health professionals. Physicians know they have an obligation to treat patients with compassion and respect and to make the patient's welfare the priority. When faced with discriminatory behaviors from patients, clinicians often chose—admirably—to put the patient's interest first. But what if doing so places them in conflict with their obligation to protect their own well-being?

The article by Beach et al[5] describing a relationship-centered care framework provides some guidance. It reminds the medical community that relationships in health care ought to consider the personhood of all participants, including physicians, and acknowledges that the notion of the physician-as-person has been underdeveloped in most bioethical frameworks of the patient-physician relationship. Bioethicists have an important role to play in moral analysis, scholarship, education, policy development, and public dialogue about how individual physicians ought to manage conflicting personal and professional priorities when caring for disrespectful patients and how institutions should develop and implement policies to protect physicians who may be vulnerable to discrimination based on their membership in a socially at-risk group.

The culture of medicine has been described by many as a hierarchical one that favors individual privilege and autonomy, leading to disrespectful treatment, particularly of persons who are lower in the hierarchy,[6] such as nurses, residents, students, patients, and groups who experience discrimination in the larger society. Patients can only be expected to behave respectfully towards physicians if the culture of health care is also respectful. Thus, there is much to be learned and applied from efforts to create a culture of civility and respect in health care. One civility intervention with health care workers (not physicians) was successful in reduc-

ing supervisor and coworker incivility; increasing respect, trust in management, and job satisfaction; and reducing worker burnout and absences.[7] However, another initiative failed to reduce medical student mistreatment over a 13-year period; the authors speculated that aspects of medicine's hidden curriculum may have undermined their efforts.[8]

There are also important lessons to be learned from clinician and societal interventions to reduce discriminatory behavior. The literature suggests that stereotype replacement (eg, recognizing one's own stereotyping behaviors, checking one's assumptions, and considering what a better response might be), counter-stereotype imaging (eg, thinking about examples of people who do not conform to a particular stereotype), individuation (eg, focusing on the various things that make people individuals), perspective-taking (eg, imagining oneself to be a member of a stereotyped group), and increasing interracial contact among clinicians, and enhancing empathy, perspective-taking, and emotional connection among lay persons, are potential strategies to reduce individual-level prejudiced attitudes and behaviors towards socially marginalized groups.[9] Interventions with lay persons included the use of essays, films, nonconfrontational conversations, and role plays, many of which could be adapted for use with health care personnel. Additionally, bystander antiracism training, which can be used by lay people to respond to incidents of interpersonal or systemic racism,[10] has potential as an organizational strategy because of its capacity to change social norms of intolerance and discrimination. Actions addressed by this training include confronting the perpetrator, recruiting other active bystanders, supporting persons from targeted groups after an experience of discrimination, formally reporting the incident, and/or seeking assistance. These actions have led to positive effects for targeted persons, bystanders, and perpetrators.

We recommend several strategies to begin to address biased behavior in patients. Codes of professional ethics should provide guidance to individual physicians and health care organizations on how to respond to patients who engage in disrespectful behavior by recognizing the dignity of physicians as persons. Physicians and institutional leaders should acknowledge the personhood of all health system personnel by becoming more attentive to protecting their well-being. Additionally, physicians and health care leaders should embody the change they desire to see in biased patients by enhancing their own respectfulness and civility toward all persons within their institutions. Leaders should develop and support policies and practices that create a culture of equity, regardless of the roles and social identities of individuals within their institutions. Bystander antidiscrimination training for all health professionals, staff, and trainees holds promise as an organizational strategy. Health professionals who experience biased treatment from patients should not have to tolerate it alone or struggle to decide how to respond without support from the entire organization. Finally, leaders should provide role modeling to instill group responsibility for action to enhance respectfulness and reduce biased behavior by all persons in health care. Physicians and health care institutions must remain committed to the welfare of patients; however, when anyone, including a patient, exhibits biased and disrespectful behavior, silence is not golden. It is tacit approval. We all have the responsibility to speak and act.

ARTICLE INFORMATION

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