COMMENTARY

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Discriminatory and Sexually Inappropriate Remarks from Patients and Their Challenge to Professionalism

As a medical team enters the hospital room for bedside rounds, the patient points to the female attending physician and says, "I like the way you look—you're very attractive." The patient's comment angers and offends the physician, and in her surprise, she is not sure what to say or do next. She is anxious to respond professionally, but quickly realizes she is unsure how to address the comment without embarrassing the patient or undermining the treatment alliance.

The medical literature has burgeoned with algorithms, scripts, and personal narratives on how health care professionals should respond to racially discriminatory or sexually inappropriate and potentially harassing remarks from patients.[1,2] Although these uniformly advocate defending the health care professionals' right to be free from workplace discrimination, there is less emphasis on how to simultaneously safeguard other professional obligations to patients. How do health care professionals advocate for themselves and others while also ensuring that the good of the patient is the ethical priority?

The fiduciary nature of the patient–provider relationship requires health care professionals to maintain a virtuous disposition. Society expects the professional to act with a humility, respect, and forbearance far beyond what is considered normative for many other professionals. Unique professional duties that distinguish clinical encounters from everyday interactions include ensuring that patients' well-being is paramount, and to act with unconditional regard and care for the patient regardless of the patient's behavior toward the physician. These obligations are often harder to fulfill when there is (justifiable) moral outrage over unfair discrimination.

Worse, these challenges may fall to a greater degree upon some health care professionals who may already confront bias and inequality in their personal and professional lives. Indeed, health care professionals do not experience discriminatory or sexually inappropriate remarks equally across race, sex, and sexual orientation.[3] Female health care professionals and trainees report higher rates of both sexually inappropriate remarks from patients and sexual assault than their male counterparts.[4] Physicians of color commonly report racial discrimination,[5] but there are no empirical studies yet examining the relative rates of such behavior toward different races.

Calls for a universal code of conduct in clinical settings have included policy and expectations for patient and health care professional behavior.[6,7] Institutions have adopted administrative and legal methods to protect health care professionals from discrimination. These policies or codes of conduct are laudable efforts at developing approaches based on mutual fairness and respect. Yet, when a policy permits nonemergent patients to be discharged from a clinic or hospital if they discriminate against or sexually harass health care professionals, it may unwittingly prevent patients from receiving clinically indicated care. Although mitigating racism in health care settings is a critically important goal, reducing access to care undermines basic ethical principles of the profession.

Institutional policies may not provide health care professionals with sufficient practical guidance or flexibility to respond to these distressing encounters. Policy, by its nature, cannot encompass the particularities of clinical context that inform and shape a potentially discriminatory encounter. First among these considerations is the difficulty in identifying what constitutes a discriminatory remark, behavior, or attitude toward a health care professional. Some expressions of discrimination are both blatant and egregious, but others may be subtle, borne of ignorance or fear, or even misinterpreted. The lack of accepted standards to guide physicians in reliably distinguishing when a

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remark or behavior meets criteria for invidious discrimination only confounds physician uncertainty about how to respond. Second, some forms of race or sex-based preferences are clinically justifiable. For example, accommodating a minority patient's racial preference for their physician (eg, race-concordant care) is a well-established way of improving patient satisfaction and other critical patient-centered outcomes.[8]

Determining the optimal response to discriminatory or sexually inappropriate comments or behaviors involves assessing patient responsibility. Patients with major neurocognitive impairment often display sexual disinhibition as an intrinsic symptom of their illness. Even for cognitively intact patients, there may be illness-related considerations that reframe what would otherwise be obvious discrimination. Patients with posttraumatic stress disorder may make racially discriminatory remarks that are rooted in their traumatic combat exposure. For example, Vietnam-era veterans may experience fear, distrust, even hatred of Asians that may be entrained with chronic combat-related posttraumatic stress disorder. Their preference to not receive care from an Asian health care professional may warrant reasonable accommodation, when the same behaviors in a person without this history and diagnosis would justly be considered discriminatory. Collectively, for these reasons, clinicians should avoid unproductive and even retaliatory pejorative labels like "racist patient," and instead focus on clinically meaningful descriptions of the problematic behavior (eg, potentially discriminatory) and reasonable efforts to understand it.

It is understandably difficult to engage health care professionals to positively and productively manage patients who intend, and are responsible for, their inappropriate actions. Even the most consummate professional is still a human being with a life story that may include violations of their own civil rights, sexual harassment, or institutional persecution. Identifying ones' own negative reactions is thus a critical step to promoting empathy, as are the communication skills that help providers reflect, reframe, and focus on the needs of the patient.

There are no simple solutions, but there are basic approaches that are more likely to meet patients' needs without compromising fundamental personal and professional values. Like other clinical skills, practicing compassion and respect toward patients who have belittled and even shown contempt for the professional requires deliberate reflection and practice. This includes developing and expressing empathy for the patient's clinical concerns and psychosocial situation while simultaneously setting clear and explicit boundaries when problematic behavior arises.[9] Providing one response without the other will leave both the clinician and patient frustrated and dissatisfied, with the clinician feeling he has either condoned the offensive behavior or the patient feeling his care has not been prioritized. Recognizing that a patient's illness may be a contributing element to a problematic encounter reminds providers of their primary obligation to serve patients. However, excusing, tolerating, or appeasing such behavior is ironically paternalistic in that it fails to hold the patient as a person reasonably responsible for civil interactions with health care professionals.

Communication in psychologically challenging situations benefits from a prepared and structured response that can reduce stress and improve performance. Scripts are both teachable and learnable, and allow a professional to draw upon a practiced response, especially when their own cognitive resources are limited due to strong emotions.[10] These scripts also allow for a consistent and measured approach regardless of the etiology of the remark. A nonjudgmental response may thus help identify the source of the problem, especially when the patient's intent was not derogatory.

The physician described earlier in the introduction could respond in a number of ways that will simultaneously honor her professional obligations to the patient as well as her right to protect herself from potentially discriminatory behavior.[11] When confronted with the comment, she could pause and say, "Your comments about my appearance make me uncomfortable. I wonder if you think you have to compliment me to get good care. For now, I want to focus on your healthcare. Please tell us how you're feeling and how we can help."

The profession should undoubtedly maintain a strong moral commitment to effectively address discrimination toward health care professionals. However, promoting this agenda cannot be at the expense of the primary commitment to care for patients, no matter how objectionable a patient's behavior. Our moral outrage when patients make racist and sexist remarks is both understandable and often justified, but it can distract us from our primary professional obligations and undermine our own ability to display the virtues so central to professionalism. The health care profession can support both patients and professionals to negotiate these charged encounters, but only when it acknowledges the competing obligations that characterize these dilemmas.

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