FROM THE FIELD

Dealing with Racist Patient Requests: Law, Rights and Catholic Identity

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Background

Recently our ethics committee was approached with a request from the medical executive committee at one of our hospitals. An incident had occurred where a patient had been admitted through the emergency department and assigned to the hospitalist service. The hospitalist assigned to that unit, who is African American, attended to the patient. Later, the patient requested another physician be assigned to his care due to the physician's race. The request was not made to the physician but to the patient's nurse who then communicated with the African-American physician who in turn spoke with the head of hospitalist program as to how to proceed.

The head of the hospitalist program consulted the vice president for medical affairs who then conferred with the hospital's compliance officer who advised that the patient's preferences should be honored and another hospitalist assigned to the case. Briefly, the compliance officer's rationale was that we typically grant patients wide latitude in choosing their physicians and CMS regulations are clear regarding patients' right to choose their providers. Additionally, he argued that rejection of the patient's request might place the physician in a hostile work environment and subject her to additional distress. Accordingly the patient was assigned a different physician. The clinical course was unremarkable, but the physician who had been reassigned and her colleagues in the hospitalist program

were dismayed that the institution had complied with a racially-motivated request. This seemed to them contrary to our Catholic identity and espoused mission and values. They brought the matter to the medical executive committee. They asked the ethics committee for guidance and policy development.

This incident was not unique. In my career I've encountered several similar patient requests, although they involved nursing and other allied health professionals. With the growth in employed physicians, hospital medicine, and patients routinely being attended by other than their personal physician, the incidence has undoubtedly spread to physicians. Fordham University Law Professor Kimini Paul-Emile writes that "one of medicine's open secrets is that patients routinely refuse or demand medical treatment based on the assigned physician's racial identity, and hospitals typically yield to patients' racial preferences." [1]

The reasons offered by hospitals both anecdotally and in court proceedings typically mirror the initial reasoning by the compliance officer in this case. Institutions typically acquiesce to racially motivated staffing demands in order to prioritize the patient's needs above the caregiver and thus enhance the therapeutic milieu, patient satisfaction and to avoid stressful or hostile work environments.

Numerous accounts of these requests and the moral distress felt by physicians and other caregivers are found in both scholarly and popular literature.[2] In a 2013 essay, Dr. Sachan Jain described an encounter with a racist patient and his angry response.[3] The responses from fellow physicians, by way of letters to the editor, demonstrate a clear lack of consensus as to the appropriate professional and institutional response.[4]

How should Catholic institutions respond to these requests? Guidance can be found in the intersection of employment law, patient rights, secular bioethics, and careful moral deliberation in light of our Catholic identity and witness.

Legal and Regulatory Guidance

A review of the pertinent legal and regulatory environment is unanimous that reassigning **employees** to comply with racially-motivated requests violates

employment law. The Civil Rights Act (CRA) of 1964 was landmark legislation aimed at eliminating racial discrimination. Title VII of the CRA speaks to employment law and is applicable to our analysis. Title VII bars racial discrimination by employers based on race, color, sex or national origin. It further defines that "it shall be an unlawful employment practice for an employer to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race, color, religion, sex, or national origin."[5] The Equal Opportunity Employment Commission (EEOC) enforces Title VII and cites several cases where hospitals, nursing homes and home health agencies violated Title VII by reassigning staff based on patient/client preferences. These cases include nurses who were barred from caring for a white newborn baby due to the racial preferences of the baby's father, certified nursing assistants (CNAs) who were assigned by a home health agency based on client racial preferences and nursing supervisors who were reassigned based on a patient's racially motivated request.[6] Although these cases involved licensed and unlicensed nursing personnel, I believe they would apply equally to employed physicians and other employed caregivers. There are no recorded instances of physicians filing EEOC complaints or lawsuits but this may stem from their previous non-employee status and/or a professional ethos that addresses questions of reassignment among peer physicians and not through the employer relationship. As Paul-Emile notes in his extensive UCLA law review article "the decision to accede to patients' requests for same-race physicians is not made by hospital administrators but rather by physicians who are deciding among themselves how best to meet each patient's needs."[7] This may be true in some cases, but in the situation I have described, employed physicians were seeking guidance from hospital administration.

Patient Rights and Medical Ethics

The legal landscape is fairly clear regarding these cases but we need to look beyond a naive legal positivism to examine other concerns. Patient rights, informed consent, capacity judgments, additional regulatory concerns, e.g. Emergency Medical

Treatment & Labor Act, the church's teaching on justice and human dignity, and the professional obligations of physicians, all play a role in an adequate examination of these requests.

A competent patient has the right to refuse medical treatment. This right is grounded in constitutional liberty interests and the doctrine of informed consent. It seems self-evident that this right would extend to refusing treatment from a particular provider, and the AMA code of ethics supports patient choice in selecting a physician.[8] Outside of the hospital setting a patient can routinely choose a physician based on any number of reasons that may be *prima facie* discriminatory. In the most benign example, it is uncontroversial that a patient may choose a physician based on gender due to the sensitive nature of the physical examination. Similarly a patient may choose their personal physician based on racial concordance, age, country of origin, religion or any number of qualifications which might be considered inappropriate and illegal from an employer perspective.

Currently when a patient is hospitalized or treated in an emergency room they are unable to exercise these preferences. With the advent of hospitalist medicine, patients are typically attended by physicians not of their own choosing. Assuming the hospitalized patient is either seriously ill or being evaluated for serious illness, it seems that our ethical obligations are not exhausted by simply refusing to comply with a racially-motivated request if such action on the part of the professional or institution might lead to a further deterioration of the patient's condition or even disability or death.

In a thoughtful 2016 article, K. Paul-Emile and his colleagues consider five practical and ethical considerations in evaluating racially-motivated patient refusals: "the patient's medical condition, his or her decision-making capacity, options for responding to the request, reasons for the request, and effect on the physician."[9] The authors argue that each case must be evaluated on its particular circumstances. They present several scenarios that might call for accommodation on the part of the professional and institution, e.g., a patient with diminished mental capacity might

make a racially motivated treatment refusal but we would not hold that patient morally responsible due to their diminished cognition; a minority patient might request a racially concordant physician due to "a history of discrimination or negative experiences with the healthcare system" or "a veteran with post-traumatic stress disorder who refuses treatment from a clinician of the same ethnic background as former enemy combatants."[10] They contrast these examples with rejections that are motivated by bigotry and argue that these bigoted rejections "are less deserving of accommodation."[11]

Each of these examples differs in significant ways and the justification for each accommodation would rest on different conceptual and empirical grounds.[12] In urgent circumstances a physician might need to treat a hostile patient even in the face of antagonistic and racist behavior. In balancing employment interests with the obligations of the doctor *qua* physician the authors tilt towards professional obligations arguing that physicians in these cases "should also subordinate their self-interest to a patient's best interests and overcome any aversions they may have toward patients."[13]

Without closely examining each of these examples it seems reasonable to acknowledge that some racially motivated requests may be deserving of accommodation based on prudent clinical judgment and principles of medical ethics and medical professionalism. The authors also provide a helpful decision matrix for clinicians and hospital officials to utilize in evaluating requests for reassignment.

Legal and regulatory guidance instruct us that racially motivated reassignments should probably not be permitted. In broadening our scope to include patient rights and preferences and the ethical obligations of physicians we acknowledge that some accommodations may be appropriate. How would these considerations play out in light of our Catholic identity and traditional moral analysis?

Catholic Identity and Racism

Our Catholic tradition makes clear that racism is unacceptable and a sin. *The Catechism of the Catholic Church* declares: "Every form of social or cultural discrimination in fundamental personal

rights on the grounds of sex, race, color, social conditions, language, or religion must be curbed and eradicated as incompatible with God's design."[14] In 1979, the U.S. bishops spoke powerfully that "racism is a sin: a sin that divides the human family, blots out the image of God among specific members of that family, and violates the fundamental human dignity of those called to be children of the same Father. Racism is the sin that says some human beings are inherently superior and others essentially inferior because of races."[15] This pastoral letter went on to call on Catholic institutions "such as schools, universities, social service agencies, and hospitals, where members of racial minorities are often employed in large numbers, review their policies to see that they faithfully conform to the Church's teaching on justice for workers and respect for their rights."[16]

The church and Catholic health care as a ministry of the church are challenged to denounce racism and defend victims of racism. As we read in the *Ethical and Religious Directives*, "Catholic healthcare should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination."[17] This obligation certainly should begin with our fellow co-workers in the ministry who are victims of discrimination within our very walls whether they are physicians, nurses or other staff. Returning to our original case, we hear in the voices of the physician who was rejected and her colleagues the voice of prophecy and solidarity asking the ministry to be faithful to its identity.

As our ethics committee pondered policy implications we agreed with the authors of the NEJM article that not every racially motivated refusal or request is racist. If an African-American patient requests a racially concordant physician because of positive experiences with concordant physicians he would not be denying the human dignity of a white physician. This would not be a racist act. However, we believed these cases were the exceptions, i.e., most cases of providers being rejected based on race are indeed racist acts. Is complying with such a racist request furthering the evil of racism? The principle of cooperation can guide us.

Christian discipleship requires us to be in the world, a world of much good as well as a world of sin and evil. Catholic health care

serves people and people will sin. Even our Holy Father, Pope Francis, introduced himself by saying, "I am a sinner."[18] Many patients, including those guilty of crimes, engage in morally objectionable behavior that does not limit their right to receive care. We are called to serve sinners but not to cooperate in sinfulness. The ERDs speak to this in Part I of the Directives in reference to not offering morally wrong medical procedures.[19] We could extend that principle to other evil acts like racism.

How would the principle of cooperation apply to a racist request[20] for reassignment by a patient? If the patient simply refused care based on a racist proposition and left the facility there would be no cooperation, but if the facility acquiesced to the request there could be cooperation in the evil act. Clearly it would not be formal cooperation. There would be no intention on the part of the physician or hospital to participate in the racist act, but rather a desire to serve an ill person who is acting in a morally objectionable manner. Compliance would be material cooperation. Material cooperation is only licit when certain conditions are met. As Germain Grisez, (following St. Alphonsus Ligouri) outlined in his magnum opus *The Way of the Lord Jesus,* "The first condition for the moral acceptability of material cooperation is that the cooperator's act be "good or indifferent in itself"—that it not be evil independently of its constituting cooperation. The second condition is that the cooperator have in view as his or her end a reason that is "just"—that is, have a reason that is morally acceptable in itself. The third condition is that the morally acceptable end in view that is the cooperator's reason for acting be proportioned to two things: the gravity of the wrongdoing to which his or her action contributes and the proximity of that contribution to the wrongful deed—in other words, how closely the cooperator's outward behavior involves him or her in the outward behavior that carries out the wrongdoer's bad choice."[21]

In our case the first two conditions appear to be met. Assigning someone to provide care to a seriously ill person is a morally good act and the intent of the hospital is "just;" its intent is to prevent a deterioration in the patient's condition. As to the third condition it would depend on the circumstances of the case: Is the request truly racist, how recalcitrant the patient is in his demands, the seriousness of the patient's

illness, their capacity to make decisions, the distress felt by the rejected caregiver, the ability of the patient to transfer to another facility for care, etc. We take seriously Grisez's admonitions that material cooperation "can have bad moral effects on the wrongdoer, scandalize third parties, lead to disharmony between the cooperator and the victims of the wrongdoing, impede the cooperator from offering credible witness against the wrongdoing, and/or impede the cooperator from carrying out his or her vocation in other respects."[22] Indeed we experienced some of these effects in the responses of the physicians who were involved in these cases. Taking this analysis into account we decided that in our policy the default position would be that refusals based on racial characteristics would be honored as treatment refusals but that the hospital would not reassign staff in order to assist in a racist refusal. We believe that such requests for reassignment must be rejected in light of our Catholic identity and the requirements of Christian witness. Patients who make such requests will be informed of our policy and counseled to accept care in a respectful manner from the treating physician. Rude, hostile or otherwise unacceptable behavior will be addressed according to current policy. Patients who are stable will be offered the opportunity to transfer to another facility. In those cases where a patient continues to refuse treatment, and in the clinical judgment of the medical staff a serious deterioration of the patient's condition might result, we believe the requirements for licit material cooperation would be met and the reassignment could occur when all other efforts fail. This policy was presented to the medical executive committee and there was concurrence that this was an appropriate position both medically and ethically.

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[1] Paul-Emile, K., et al. "Patients' Racial Preferences and the Medical Culture of Accommodation," *UCLA Law Review*. 462 (2012)

[2] Chen. P., "When the Patient is Racist," *The New York Times*. July 25, 2013

[3] Jain. S., "The Racist Patient," *Annals of Internal Medicine* 2013: 158:632.

[4] Galishoff, M. et al. "Comments and Responses. The Racist Patient." *Annals of Internal Medicine*,159:227-228

[5] The Civil Rights Act. Title VII. SEC. 2000e-2. *[Section 703]. Online:* https://www.eeoc.gov/laws/statutes/titlevii.cfm

[6] The Equal Employment Opportunity Commission. Significant EEOC Race/Color Cases. Online:

https://www.eeoc.gov/eeoc/initiatives/e-race/caselist.cfm

[7] Paul-Emile,K. "Patients' Racial Preferences and the Medical Culture of Accommodation," *UCLA Law Review* 462 (2012) p.484

[8] American Medical Association. *AMA Principles of Medical Ethics.*Chicago, IL: American Medical Association; 2001. Online: https://www.ama-assn.org/delivering-care/ama-code-medical-ethics

[9] Paul-Emile, K., Smith, A., Lo, B., and Fernandez A. "Dealing with Racist Patients." *NEJM*. 374:8 p. 709.

[10] Ibid. p. 710

[11] Ibid. P. 710. See also Kyle Anstey and Linda Wright, Responding to Discriminatory Requests for a Different Healthcare Provider" *Nursing Ethics* 2014 (21:1) 86-96, for a careful analysis of cases similar to this and an algorithmic chart that plots different outcomes.

[12] Cooper, LA, Roter, DL, Johnson, RL, Ford, DE, Steinwachs, DM, Powe, NR. "Patient-centered communication, ratings of care, and concordance of patient and physician race." *Annals of Internal Medicine* 2003;139

[13] Paul-Emile, K. et al. "Dealing with Racist Patients," NEJM. 374:8 p. 710.

[14] *Catechism of the Catholic Church,* 1997 #1935 Online: http://www.vatican.va/archive/ccc_css/archive/catechism/p3s1c2a3.htm

[15] USCCB, "Pastoral Letter on Racism: Brothers and Sisters Among US," 1979.online: http://www.usccb.org/issues-and-action/cultural-diversity/african-american/brothers-and-sisters-to-us.cfm

[16] Ibid.

[17] *Ethical and Religious Directives for Catholic Health Care Services*. Fifth Edition. 2009 p.8.

[18] Bullivant, S. "'I Am a Sinner': The Deep Humility of Pope Francis." *America.* September 25, 2013

[19] *Ethical and Religious Directives for Catholic Health Care Services.* Fifth Edition. 2009 p.8.

[20] See Anstey and Wright who believe it is important to determine if the request is indeed racist, or if it is the result of cultural or religious factors, or past negative or traumatic experiences (93).

[21] Grisez. G., *The Way of the Lord Jesus*. Appendix 2. Online: http://www.twotlj.org/G-3-A-2.html

[22] Ibid.