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CASE AND COMMENTARY

How Should Clinicians and Trainees Respond to Each Other and to Patients Whose Views or Behaviors Are Offensive?

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Abstract

This commentary responds to a case in which a senior resident physician, an attending physician, and a medical student who is a person of color treat a patient expressing racial bias. By applying affect labeling (naming of emotions), this commentary illustrates how to balance patient preferences with a duty to treat and demands of justice in a way that can be healing for all stakeholders.

Case

Mr K is a 75-year-old man who presents to the emergency department at a metropolitan teaching hospital after falling in his home. SM, a fourth-year medical student who self-identifies as African American, notes that Mr K is agitated, confused, holds a confederate flag handkerchief, and has a faded Aryan fist (a white supremacist symbol) tattooed on his arm. SM is on a team consisting of an attending physician and 2 residents. SM begins to interview the patient by asking, "Mr K, can you tell me where you are?" Mr K turns to SM and shouts, "The 'hood!"

"No, Mr K, you are in the emergency department; you fell at home," SM clarifies. Mr K frowns and then his eyelids flutter closed. SM approaches Mr K, preparing to rock Mr K's shoulder to check his consciousness, but then pauses, afraid of Mr K's response. SM decides not to touch Mr K and leaves the room. Dr T, the senior resident physician standing just outside Mr K's room, asks, "What'd you learn about this patient? Let's go through the history."

"Dr T, I do not feel comfortable continuing Mr K's physical exam," reports SM.

"Why?" asks Dr T upon walking closer to Mr K. Dr T spots Mr K's handkerchief and tattoo, thinks, *Oh, I see*, and wonders what to do.

Commentary

Although this case raises many ethical questions, I focus on one here: Should racist symbolism displayed by Mr K influence SM's response to the patient? We will assume for sake of argument in this case that the patient's tattoo expresses his current—not just

his past—views on white supremacy, although it is worth noting that, in some cases, such an assumption could be worth questioning. In emergencies, a physician's duty to care should transcend his or her personal responses to racist symbolism and even take precedence over a patient's expressed wishes in emergent situations.[1] However, if a patient's speech or behavior is threatening, the patient's care may need to be transferred to another physician who does not challenge the patient's preference for a racially concordant clinician. Hand off among clinicians, if time allows, should entail some sort of formal ethics consultation.

It is important to note that reactions by persons of color to racist symbolism and images imbued with hate are not chosen in the sense that one chooses the color blue over the color green. Responses to racism tend to be visceral rather than intellectual. In this article, I argue that refusal to treat solely on the grounds of a patient's expression of bias is never morally justified. I suggest how *affect labeling* can be an effective way for an offended clinician to process and overcome a visceral reaction to offer superb care to a patient wearing symbols suggestive of the patient's assumption of racial superiority.

Decision to Treat and Affect Labeling as a Coping Strategy

Decision to treat. Paul-Emile and colleagues have proposed a decision tree for use in emergency settings when a patient has rejected a physician on the basis of race.[1] Following this decision tree, Dr T and SM should first assess Mr K's medical condition. If the patient is unstable, they should treat Mr K regardless of a patient's racial bias because Mr K could be suffering from delirium, psychosis, or dementia; refusal to treat the patient in such cases is unacceptable because such a cognitively impaired patient is not responsible for his or her actions.[1] However, I argue that, once a patient is stable, Dr T should recognize that repeated exposure to racial discrimination can result in a cascade of biopsychosocial sequelae for SM, including elevated blood pressure and cortisol, increased heart rate, hypervigilance, amygdala activation, aggression, risk of depression, and increased incidence of substance use or abuse,[2] and thus he should seek to intervene to the best of his ability. Appropriate intervention may entail requesting an ethics consult.

Affect labeling. However, some amelioration of the situation is within every clinician's grasp. One potential approach is to use affect labeling to get both SM and Mr K to put their emotions into words. Affect labeling is an evidence-based approach to regulating emotional states that can result from anxiety-producing stimuli.[3] SM's reaction to the confederate flag handkerchief and Aryan fist tattoo suggests that he is experiencing some degree of emotional distress. Likewise, Mr K's response to SM (uttering that he's in "the hood") suggests that SM's presence is an emotional trigger for Mr K. Clinicians faced with a patient's race-based bias must balance the ethical principles of respect for autonomy against the equally weighty principles of justice and nonmaleficence—not just for the patient, but for themselves and their fellow clinicians as well. In what follows, I suggest an approach to achieving such balance.

Strategies for Intervening

Affect labeling by the medical student. When the situation permits, Dr T should address SM's feelings by asking SM why he does not feel comfortable continuing Mr K's physical exam. Based on my personal experience, I know that there are times in clinical settings when racist symbols or speech simply surprise us African Americans, and at times that experience is difficult to articulate—especially when a person of color is the clinician and the person implicitly or explicitly expressing racist attitudes is in need of care. Dr T can help SM navigate this role conflict by providing SM with affect labels such as shocked, surprised, upset, hurt, sad, confused, or angry. This type of affect labeling can modulate emotional, neural, autonomic, and behavioral responses to aversive stimuli.[4-7]

Affect labeling by the patient. Once Dr T has helped SM process and articulate his emotions, he can do the same with Mr K if necessary. In order to determine if affect labeling would be appropriate with Mr K, Dr T should request a psychological consult to assess Mr K's cognitive state and any potential barriers to following a treatment plan, such as adverse life experiences or refusal to follow an African American's instructions. If the patient is not opposed to being treated by SM or is cognitively impaired, affect labeling may not be appropriate. However, if Mr K expresses a desire not to be treated by SM, Dr T can help Mr K connect his emotions to his experience and thereby reduce his anxiety. For instance, Dr T could say, "When SM is in the room, how does that make you feel? So how does it feel when I tell you that SM is one of our finest physicians and that he is capable of providing you with excellent care?" Dr T could have an initial conversation with Mr K in order to accomplish this goal. However, a subsequent conversation should take place with Mr K, Dr T, and SM together in order to facilitate trust, dialogue, and learning. The rationale for this approach is to give both the patient and the clinician a chance to process and reconcile negative emotions in a way that is safe and conducive to healing for all involved parties. Eventually, one would expect SM to handle situations like this one on his own, so Dr T must be explicit with SM about what he is doing pedagogically.

Organizational Responses

Racial discrimination is detrimental to communication in health care relationships.[8] Whenever and wherever communication breaks down, care is undermined.[9] Thus, health care organizations have ethical and operational responsibilities to facilitate communication across all levels of the organization.

Affect labeling via expressive writing. In order to facilitate communication in situations like this case scenario, policies for dealing with patient bias in clinical encounters can be helpful. Medical schools and teaching hospitals are especially well equipped to help medical students and residents learn protective practices, such as expressive writing in response to bias incidents.[10] These institutions could require that students write about their emotions in response to people or symbols that are racist or threatening as a

means of affect labeling. Fifteen to 20 minutes of expressive writing about disturbing events over a few sessions has been shown to result in long-term reduction of harmful symptoms stemming from adverse emotional responses to noxious stimuli.[11] Medical education would be greatly enhanced if all stakeholders' experiences of bias could be reported and evaluated, perhaps through an expressive writing exercise that could be submitted to a staff bioethicist, for example, for consideration and response. Specifically, the staff bioethicist could evaluate whether and how the clinician or student connected his or her emotions with the experience of emotional threat induced by symbolic communication or other expressions of discrimination.

System-wide use of affect labeling. All clinicians should be taught to respond to racist symbolism through ameliorative practices such as affect labeling. Affect labeling heals through communication and dialogue—through language—which can build a better health system. Affect labeling is one way of increasing psychological safety in situations that are emotionally laden but morally ambiguous due to the conflict between the fundamental, overarching duty to treat and the principles of respect for autonomy and justice as they apply to clinicians as well as patients. Because of the potency of this intervention, all clinicians should be able to engage others in affect labeling. This practice can take place among clinicians themselves, between clinicians and patients, or between clinicians and other staff members as needed. So Dr T should be trained in and highly supportive of this approach to emotional regulation for the benefit of SM as well as Mr K. Dr T is also well positioned to mediate discussions between SM and Mr K. It is through safe encounters with others that we grow as persons.[12] A health system that fosters such dialogue is better prepared to care for its own clinicians as well as patients.

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Editor's Note
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