The *NEJM* recently published an article [1] on how doctors should deal with racist patients and it immediately struck a chord with me, not only because I m foreign-born, but I have worked with many other doctors who were also either immigrants or children of immigrants. Additionally, in the United States, graduates of international medical schools [2] comprise about 25 percent of the physician population and about 27 percent of physicians are foreign born [3].

In my training, one of the issues that was never taken lightly was cultural sensitivity. I know this because I have had to watch hours long videos and take tests afterwards to ensure that, A I had indeed watched the videos and, B if I actually paid attention. I wonder if some patients may not benefit from similar training.

The three issues I dealt with regularly were, my ethnicity, my age, and my gender, and they were not always pleasant. Working in the New York metro area, I ve had the pleasure and honor of working with doctors from the four corners of the world this city is not devoid of diversity in its patients nor its providers. But I often wonder, in more homogeneous communities, whether some of my colleagues face greater challenges with regard to their ethnicity and how they have responded.

Getting back to the article in *NEJM*, I read it with the real hope that it would give me some algorithm of how to deal with bigotry from patients in a similarly concrete manner as how I would deal with patients complaining of chest pain. Here s what they suggested:

- In an emergency situation, stabilize the patient first (hopefully, a sufferer of gunshot wounds would not have the wherewithal to yell racial slurs)
- The doctor s options are establishing mutually acceptable expectations and conditions for providing patient with the care he or she needs (um \[ok\)
- Physicians can decide among themselves how to reassign a racist patient
- Negotiate with the patient to allow the doctor to provide care, or allow a nurse/medical resident to conduct patient s evaluation (because this is not degrading?)
• Inform the patient it’s not ok to be a racist
• If a bigoted patient is a Vietnam vet they can refuse service from Asian doctors (because every Asian is a member of the Vietcong?)
• And the FINAL consideration should be the effect this has on the physician; they should subordinate their self-interest to best interest of the patient (but there are limits to this based on degree of unacceptable patient conduct)
• Outpatients are free to seek treatment elsewhere (in case a patient waits until our appointment to tell me they don’t want me to care for them)

I agree with three of the above points: stabilizing the patient if it’s a critical situation, informing them it is not okay to be a racist, and rising above it (which I would say is the same as subordinating your self-interest).

As I write this, colleagues and mentors are sending me their personal stories of various forms of racism/discrimination they have encountered when dealing with their patients. Some of these stories are very ugly and they make me very sad because these are great doctors.

My first order of business will always be, Primum no nocere, or first do no harm. But, in my humble opinion, I just can’t see how a bigoted person’s rights should trump mine. Did I not sacrifice the prime of my youth, holidays with my family, developing hobbies and whatever else, so that I could be someone you could trust with your life? I would hope that whatever institution I work for would feel the same as I do.

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