## Business of Medicine:

# Managing and de-escalating discrimination and bigotry from patients

A GUIDE FOR FAMILY PHYSICIANS | PREPARED BY DOCTORS NOVA SCOTIA | DECEMBER 2022

Doctors Nova Scotia

## Need a helping hand?

Doctors Nova Scotia's physician advisors are ready to help physicians navigate these difficult situations.

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# Introduction

Conflict can happen between patients and physicians. Discriminatory or bigoted actions from patients may make the physician feel unsafe. Knowing how to manage these situations requires particular skills and resources, as they are different from other forms of conflict or disagreement between physicians and patients. This guide is intended to be one tool that can help physicians create safer practice spaces.

There is an important balance to consider in managing these clinical encounters. While all patients feel vulnerable seeking care, those from equity-deserving populations often avoid seeking health care due to fear of potential mistreatment. Unconscious bias can affect a physician's response to a patient, in the same way it can govern how a patient treats their physician. Equity-deserving physicians who are women or gender-diverse, queer, and/or Black, Indigenous and People of Colour (BIPOC) are more likely to experience patient aggression, regardless of the reasons for it. Balancing physician and patient safety requires continual assessment, critical evaluation and communication with all relevant parties. Physicians can use a combination of the approaches outlined below, alongside consultation with advisors at Doctors Nova Scotia, to navigate these situations.

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*Note: This guide is not intended as legal or professional advice or opinion. It is recommended that physicians and staff members seek legal or professional advice should concerns arise.*


# Creating the right conditions

### Making intolerance of bigotry clear to patients

Proactively set ground rules for what is expected and what is unacceptable behaviour. This also serves the purpose of making everyone feel welcome and safe. Doctors Nova Scotia (DNS) has prepared a suggested statement on discrimination against physicians and clinic staff that can be printed and posted in public areas. Download a poster and the statement at: doctorsns.com/contract-and-support/edi

This clinic strives to be a safe space for all patients and staff. Discriminatory behaviour directed at clinic staff and other patients will not be tolerated. All patients deserve access to care, and all health-care workers deserve to work in an environment that is free from racism, sexism, homophobia, transphobia, ableism, ageism or any other forms of bigotry and discrimination. Health care works best when everyone involved is supported and treated with respect.

Nova Scotia Health provides Nova Scotia Health Respectful Workplace resources, including posters, statements and a code of conduct.

# Bystander intervention

De-escalation and harm reduction are shared responsibilities involving all providers and clinic staff. When a patient creates conflict by expressing bigotry (including racism, sexism and homophobia), physicians should be prepared to engage in bystander intervention to support their colleagues. The tools below are useful for situations where a physician witnesses discrimination and the physician wants to support those who were affected while holding the perpetrator(s) accountable.

Bystanders and supervisors to incidents of discrimination in clinical settings can use the language and actions suggested in the following table to support their tcolleagues (Chary et al., 2021):

**Table: Sample language for addressing interpersonal racism from patients.**
Developed in collaboration with the Social Emergency Medicine Interest Academy of the Harvard Affiliated Emergency Medicine Residency

| Situation | Sample Language | Strategies Employed |
|---|---|---|
| Bystander outlines behavioral expectations for patient or visitor | "Racist language is not acceptable in our hospital. Please be respectful."<br><br>"I must remind you that our code of conduct outlines that discriminatory language and behavior is not tolerated."<br><br>"Racist remarks are not tolerated in our emergency department. Please remember that as we take great care of you."<br><br>"We are doing our best to take excellent care of you. Please refrain from making racist statements." | Rely on institutional policy to strengthen position<br><br>Take firm but professional approach<br><br>Remind patient/family of therapeutic intent |
| Bystander checks in with target | "I am sorry that happened. It upset me. I wanted to check in on how you are doing."<br><br>"I am sorry that happened. Please let me know how I can support you."<br><br>"I am sorry that happened. I would like to report this incident to our supervisors, if that is ok with you." | Acknowledge situation, name own feelings without projecting them onto target, offer support |
| Care team member leads debrief. | "Our patient's racist language and behaviors today are not acceptable. I'd like to remind everyone of our code of conduct." | Outline interpersonal racism as not tolerated<br><br>Remind staff of institutional policy |
| Care team member assists with provider transition of care when a physician has experienced interpersonal racism | [to colleague:] "I am sorry about what happened. I am willing to assume care of this patient."<br><br>"This patient has been stabilized and it is appropriate for their care to be handed off."<br><br>"We can have another provider take care of this patient primarily."<br><br>[to trainee:] "I'd like to have another provider take care of this patient primarily. You did nothing wrong, but I don't think it is a positive environment for you to remain in." | Acknowledge situation and offer alternative<br><br>Affirm appropriateness of care handoff<br><br>Recognize that victims of interpersonal racism, particularly trainees, may not feel empowered to voice a preference to not participate in the care of discriminatory patients |

# Other language for bystander intervention

Other language for bystander intervention includes the following active witnessing response categories from F. Ishu Ishiyama (2014):

**1. Assertive interjections (interruptions):**
- Stop it.
- Wait a moment.

**2. Expressing personalized emotional reactions:**
- I can't believe you are saying this.
- I'm surprised to hear you say such a thing.

**3. Calling it racism or discrimination:**
- That's racist.
- It's not fair.

**4. Disagreement:**
- I disagree.
- I don't think it is true.

**5. Questioning the validity of a statement or an over-generalization:**
- Always?
- Everybody?

**6. Pointing out the hurtful and offensive nature:**
- It's a hurtful comment.
- Ouch! That hurts.

**7. Putting the offender on the spot:**
- What?
- Could you repeat what you have just said?

**8. Empathic confrontation:**
- You sound really annoyed.
- Would you mind telling me how you are feeling?

**9. Approaching and supporting the victim:**
- You are not alone. I'm with you.
- This is a terrible thing. I'll come with you. So, let's get help.

**10. Approaching externals (teachers, administrators, other third-party members):**
- You are one of the teachers I can trust. Can I talk to you about something very serious?
- I need to talk with you about what happened today.

**11. Approaching co-witnesses:**
- Did you hear what I just heard?


Introduction to ART Program

## How to de-escalate challenging patient encounters

When physicians are faced with discriminatory comments or behaviours, they should ideally be supported by colleagues and clinic staff. If this is not possible, and they find themselves alone with a patient, they may need to use de-escalation tactics to ensure their safety. Once physicians are removed from an unsafe situation – whether the threat is physical, psychological or both – they can access peer and system supports to address the harms caused and limit future incidents.

While it is not the responsibility of equity-deserving people to educate or support those seeking to oppress them, the unique nature of the physician-patient relationship may require a de-escalation approach. De-escalation is harm reduction for systemic problems and may also reduce the potential for harm or violence to occur during the encounter. This guide offers a range of responses, including having the physician refuse medical services in appropriate circumstances. The strategies shared for managing these encounters on an individual level are intended as a stop-gap measure in urgent circumstances.

## Strategies for dealing with bigotry from patients one-on-one

(Whitgob, Blakenburg & Bogetz, 2016)

This list is composed of suggestions directly from equity-deserving physicians.

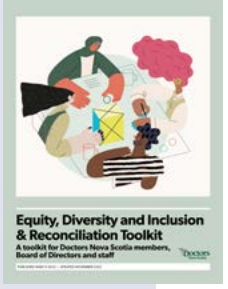
(1) Assess illness acuity – physicians may need to ignore remarks in a case of crisis

(2) Cultivate a therapeutic alliance – acknowledge the patient's remark but refocus on goals of care

(3) Depersonalize the event – helpful for situations where patient care must continue, in the moment

(4) Ensure a safe environment to the extent that you are able, prioritizing more vulnerable staff if needed and possible – share the experience with those who need to know, as soon as possible

**Further information about allyship** can be found in the DNS Equity, Diversity and Inclusion Toolkit. Additional learning and training on bystander intervention is highly recommended. Resources and courses can be found online.



# Domains of de-escalation for agitated or agressive patients

(Adapted from Richmond et al., 2011)

1. Give the patient physical space
2. Establish verbal contact, but be concise and calm in your communication
3. Identify the patient's wants and feelings
4. Agree or agree to disagree
5. Set clear boundaries for the interaction
6. Offer choices for how the interaction can continue
7. Review with the patient the choices they've made, and brief other staff as soon as possible

For any situation involving conflict between physicians and patients, the CMPA suggests the following measures:

- Make time for training all team members. Learn about effective patient interactions and conflict de-escalation from a trusted education provider.
- Practice effective communication with patients. Asking them about their concerns, actively listening without interruption, conveying empathy and communicating clearly can help the physician understand what matters most to patients. Also, be mindful of emotions – the patient's and the physician's – that inform the interaction.

## Managing incidents of bigotry from patients when de-escalation is not possible

If de-escalation is not possible, or there is a direct threat to immediate safety, the physician may ask the patient to leave the practice or, if necessary, call 911.

### Practice safety for immediate threats

The College of Physicians and Surgeons of Nova Scotia (CPSNS) guidelines state that the physician must, "when limiting health services provide legitimate reasons, do so in a manner that respects patient dignity and autonomy, upholds professional duties to the patient, and does not impede equitable access to care for existing patients, or those seeking to become patients."

This means that physicians should consider whether they can continue to safely provide care to the patient, regardless of the patient's actions. (Note that "safety" may include mental and emotional well-being.) Limiting service to a patient by asking them to leave the practice should only be employed in situations where harm (including verbal comments) has been caused. Physicians should not limit services in cases where they only suspect harm could be caused. If physicians feel uncomfortable but no harm has been caused, they should engage their colleagues and/or health system supports to determine appropriate solutions (e.g., avoiding having physicians see patients when alone in the clinic).

The CMPA recommends the following in the case of threat (or potential threat) to physician safety:

- Recognize the value of both a workplace security policy and workplace safety plan.
- A workplace security policy should outline how the physician and staff will respond to offensive language and aggressive behaviour. In a hospital or large clinic, be familiar with the organization's policy and discuss it with staff. In an office, develop and implement the policy, discuss it with staff, consider renewing it annually, and post it in an area visible to all.
- A workplace safety plan should provide guidance on making the workplace environment safer. In a hospital or large clinic, be familiar with the organization's plan and discuss it with staff. In an office, adopt a safety plan that could include giving staff a clear view of patients in the reception area; using controlled access to certain areas (e.g., having a code entry system); ensuring everyone can make a rapid exit; securing medical records, computers and medical equipment; storing medications in designated areas; having security alarms; having sufficient lighting near entrances and parking lots; and having additional security measures such as a lockdown procedure accompanied by drills with staff.

### Care for patients with mental health concerns and/or who use drugs

It is important to note that patient discrimination based on bigotry may differ from incidents involving patient hostility due to mental health concerns and/or substance use. For situations where patients are being treated for mental illness and/or substance use, physicians should consult the CPSNS Standards and Guidelines on Caring for Legacy Patients and Benzodiazepines and Z-drugs.

Physician safety is the priority but given the vulnerability of these patients and the barriers they face to accessing health care, it is important to consider how physicians can work together and with the health system to facilitate this essential care. Questions about how to make the practice safe for the delivery of care to patients who used drugs can be directed to DNS for support. Doctors Nova Scotia also continues to advocate to the health system for the resources needed to ensure physicians can access and create safe spaces in which to practise. The strategies in this guide are tools for harm reduction, not solutions to system problems.

### Prolonged conflict: Alternative options for care

If a patient has repeatedly demonstrated bigoted behaviours which make the provision of care by all or some physicians unsafe, there are some options which can be leveraged independently or in combination:

- The patient can be assigned to a different physician within or outside the practice.
- The patient can be cared for using virtual care as much as is appropriate.
- The patient can be scheduled for specific times when there are appropriate personnel in the clinic and/or fewer other patients.

## When to engage law enforcement

It is appropriate to engage law enforcement in helping to manage patient behaviour, including physical violence, direct threats of violence (in-person or over phone/messaging) or hate crimes. If physicians (or any clinic staff) call 911, they may provide the patient's name.

## Discharging patients from a medical practice

After following various strategies to maintain a relationship with a patient, there may come a time when the only alternative is to discharge them from practice. A patient would typically only be discharged when their behaviour has been egregious, personal safety is at risk or the patient has failed to demonstrate respectful behaviour after corrective steps have been demanded. Doctors Nova Scotia has created a guide called "Discharging Patients from a Medical Practice" to help physicians in these situations.