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The "Discriminating-Patient Paradox": Policies for Addressing Patients with Discriminatory Physician Preferences

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Healthcare entities are generally aware of their obligations not to discriminate against patients or their employees. However, patients also may have discriminatory biases when it comes to their healthcare providers, and the legal risks associated with this type of discrimination are becoming more pressing. According to a 2017 survey, 59 percent of physicians received offensive comments from patients about the physician's personal characteristics.[1] These situations create difficult decisions for healthcare entities, especially in a regulatory regime that may condition some Medicare reimbursement on positive patient satisfaction. Providers who adjust staffing to comply with patients' discriminatory preferences may risk litigation but save their ratings; providers who refuse to comply may mitigate litigation risk but could sacrifice ratings. This creates, what we call, the "discriminating-patient paradox."

This article highlights three policy approaches for addressing this paradox and considers the associated benefits and risks, with legal and business practicality in mind.

How the Law Considers Patient Preferences and Discrimination

Employment discrimination is governed by various federal and state laws, including, for example, Title VII of the Civil Rights Act of 1964[2] and the Age Discrimination in Employment Act. Generally speaking, these statutes require a plaintiff alleging discrimination to prove two elements: 1) discriminatory intent on the part of the employer and 2) an adverse employment action.[3] In some instances, employers might argue that they should be able to make decisions based on an individual's protected characteristics because such decisions are reasonably necessary for business operations. The Equal Employment Opportunity Commission (EEOC) (the agency responsible for overseeing federal employment discrimination laws) recognizes this so-called "bona fide occupational qualification" (BFOQ) defense and has issued regulations surrounding its use.[4] The BFOQ defense exception, however, is

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1 Bob Tedeschi, "6 in 10 Doctors Report Abusive Remarks from Patients, and Many Get Little Help Coping with the Wounds," *STAT*, October 18, 2017.

2 Title VII protects against discrimination on the basis of race, color, sex, religion, and national origin. This article does not address patient discrimination with respect to a physician's possible disability, which would be governed in part by other laws.

3 This is a diluted version of the standard McDonnell Douglas framework: *McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973). The difficulty with applying this framework here is that the patient expresses discriminatory intent, but the employer takes action. The consensus is that when an employer complies with a customer's clear discriminatory intent, it shares in that intent for the purpose of this analysis. While this may incentivize employers to inquire less robustly into the intent of patients when stating preferences, best practice is always to inquire thoroughly.

4 As noted, there are state laws that prohibit employment discrimination as well, but not all states may recognize the existence of a BFOQ defense and so results may differ under state law.

narrow[5] and customer preferences do not support a BFOQ defense.[6] The healthcare context is unique, though, which may lend for a more robust application of the BFOQ defense.[7] For example, a patient may have justifiable reasons to express concern about his/her physician's protected trait for reasons related to safety or privacy (e.g., a female patient may prefer a female OB/GYN). Still, complying with such a request can be a form of employment discrimination. Simply put, the law is vague, and its application to the discriminating-patient paradox is not cut and dry. Rather, addressing these issues requires an adept management team to consider all angles of patient preferences on a case-by-case basis.

Trying to Solve the Discriminating-Patient Paradox

There are dangers associated with focusing too narrowly in this context. While the above analysis may suggest a simple solution—adapt when safety or privacy are implicated, otherwise refuse—these decisions do not exist in a legal vacuum. Physician culture is well aware of matters regarding patient preferences,[8] thus placing relevant administrative policies under the microscope. Providers should consider all possible policies to best mitigate risk while maintaining patient-centered care.

5 *Dothard v. Rawlinson*, 433 U.S. 321, 333 (1977). The BFOQ defense only extends to certain types of discrimination and generally does not include race.
6 29 C.F.R. § 1604.2(a)(1)(iii),(2).
7 The EEOC often cites safety, privacy, and authenticity as the prevailing supports for accepting customer preferences. Consider a patient who has suffered sexual abuse by someone of a particular sex and doesn't want a physician of that sex. While discrimination against a particular sex would be unsupportable, this situation may transcend that standard.
8 As evinced by the recent #WhatADoctorLooksLike social media movement.

Key Board Takeaways

The board and management must work together to support medical staff and establish clear policies against discrimination. The following is a list of key takeaways for boards to consider when addressing the discriminating-patient paradox:

- Establish training for medical staff to recognize discriminatory behaviors and to react properly, whether through a top-down, bottom-up, or (almost) zero-tolerance model.
- Have management engage with patients to understand their justifications for discriminatory behaviors.
- Set guidelines for management to restaff or to counsel patients on the benefits of staying with their current attending physician or other provider.
- Understand the legal framework that governs employment discrimination through continuing education, and be sure that the compliance officer understands these concepts.
- Encourage open dialogue and include medical staff on policy improvement teams.

Policy 1: The Top-Down Approach

In a top-down approach, leadership directs whether the entity will comply with patient preferences. While this model aligns with traditional business strategy, it creates obvious vulnerabilities.[9] Cutting physicians out of the decision-making process creates significant physician employment discrimination litigation risk. However, this approach is not without value. It may be necessary in situations where streamlining is crucial, like when a patient presents with emergent needs or safety is otherwise implicated. It also removes the blurred line associated with other approaches, which favor a case-by-case determination of need.

Policy 2: The Bottom-Up Approach

In a bottom-up approach, leadership does not dictate compliance but rather motivates physicians to work together to make necessary coverage adjustments for the betterment of the patient, which are then communicated up to management. This model mitigates risk of litigation by removing the potential adverse employment action from the hands of the employer. Moreover, this approach supports clear communication between management and physicians. However, physicians may not efficiently make adjustments, if at all, in the face of discrimination. This approach requires robust training and aligned perspectives between management and physicians, otherwise it risks creating a culture of pressure on physicians to voluntarily comply with discriminatory orders, which both decreases morale and signals to courts that this may be a disguised top-down approach, thus eliminating any benefits associated with passing the decision-making power to physicians.

9 See *Chaney v. Plainfield*, 612 F.3d 908 (7th Cir. 2010) (in which a black certified nursing assistant was prohibited from caring for a white resident, and the nursing facility was found to have violated Title VII).

Policy 3: The (Almost) Zero-Tolerance Approach

An (almost) zero-tolerance policy can take two forms. First, a provider could acknowledge a patient's discriminatory preference and counsel him/her on finding care elsewhere. Second, a provider could disregard the preference and continue care. This hardline policy has physician support but increases

the risk of poor patient satisfaction ratings and must include some limited flexibility, which can be difficult to balance and may need to be cleared with physicians.[10] Management would need to weigh the business and legal risks. Note that any policy that contemplates transferring patients to another provider must consider whether any laws, like patient self-referral laws, etc., restrict such actions.

	PROS	CONS
Top-Down **Management directs restaffing**	Structured and consistent decisions Aligns with traditional business strategy	Increased threat of litigation Risks upsetting pro-physician social movements
Bottom-Up **Physicians direct restaffing**	Mitigates risk of litigation by taking decision out of employer's hands Supports clear communication between management and physicians	Risks non-action by physicians who may not wish to accommodate discriminatory behavior Too much pressure can make this a pseudo top-down approach
(Almost) Zero-Tolerance **Advising patients on transfer or value of assigned physician; no restaffing**	Draws a hard line, subject to reasonable accommodation Reduces risk of employment discrimination litigation Displays full support for physicians	Risk of poor patient satisfaction ratings Could lead to violations of patient self-referral laws

Key Takeaway: No One-Size-Fits-All Approach

The issues associated with the discriminating-patient paradox are complex, and no one policy solves the problem. Many practices would likely benefit from a hybrid policy, one which employs each approach under different circumstances. Regardless of the approach used, the goal is to strengthen the relationship between management and medical staff to prevent discrimination that impedes providers' mission of patient-centered care. To encourage this kind of partnership, management should 1) maintain constant communication with physicians to gauge perspectives, 2) require training and mandatory reporting on discriminating patients and always thoroughly investigate patients' reasons for refusing care from a particular physician, 3) take a proactive approach, and 4) seek counsel from an attorney for further guidance on the legal and practical effects of any policy or decision.

The board's role in circumstances of discrimination is to set policies and oversee their efficacy, and it is management's role to implement those policies. Consequently, the board must regularly engage with management on the entity's anti-discrimination efforts and maintain an open dialogue to ensure policy compliance and effectiveness. The board should receive regular compliance updates regarding 1) the occurrence of a discriminating patient, 2) how medical staff or management responded to said occurrence, 3) legal changes that affect the possibility of restaffing (e.g., justifications related to privacy and security), and 4) management and medical staff's reaction to internal discriminating-patient policy. An open discussion among the board, management, and medical staff will not only strengthen the policy, but also unite these levels of leadership.

10 Physicians may support a zero-tolerance policy because it is a hard line against discrimination and indicates that a provider supports and appreciates its physicians by not tolerating patients' discrimination towards them. See, e.g., Paula S. Katz, "Doctors-in-Training Dealing with Discrimination," *ACP Internist*, April 2017. Patients may be more willing to accept the physician they receive if they understand the entity won't tolerate any discriminatory intent.

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