Ethical dilemma

Dealing with racist patients

How should doctors handle racist patients? A general practitioner registrar describes the unease she still feels over the way she responded to a volubly racist patient she encountered while a house officer 10 years ago, and other authors comment, from different perspectives, on how they would deal with such a situation.

Doctors are people too

Mary Selby

It is 10 years since I met Mr B, who was perhaps the most unpleasant patient that I have ever had to deal with. I used to pride myself on the fact that I had treated him no better and no worse than any other patient … and of course that is as it should be … but I am still uncomfortable about my inability to respond to the things he said while he was on my ward.

I was a junior house officer when Mr B was admitted to hospital after a transient ischaemic attack. This turned out to be secondary to polycythaemia. Mr B's packed cell volume and haemoglobin concentration were abnormal, and it was decided that I should venesect him, and draw off blood daily until his haematological values returned to normal.

One of the other house officers was German. For some reason she took against Mr B, although she would not say why.

During the first venesection, Mr B asked what I was going to do with his blood.

"Sister wants it," I said cheerily, "for her roses."

"Fine, I don't care what you do with it, as long as you don't give it to Jews." Not sure that I had heard correctly, I smiled nervously.

Appallingly racist views

Mr B was, it turned out, a member of the National Front, and had once been one of Oswald Mosley's Brownshirts. He confided his appallingly racist views to me as I got on with the job in hand. And then he confided them to much of the ward. Many of his fellow patients were from ethnic minorities and were very upset. Eventually, the sister rearranged the beds to protect them, creating a "caucasian" corner for him. This quietened him down a bit, and was exactly what he wanted, of course. It was several days before he told me that he had assumed that the *BNF* in my pocket signified support for his organisation. Trapped behind the need to be courteous, I could only explain his mistake, and I was left with the uncomfortable feeling that my silence was interpreted as agreement, not only by him but also, perhaps, by the other, vulnerable patients in the ward.

Soon afterwards Mr B was discharged home, and then the German house officer told me that he had made Nazi salutes and antisemitic statements to her whenever she passed. She had felt as helpless as I, and for her there had been an added fear that perhaps her colleagues might somehow believe that these were indeed her views, purely because she was German.

Since then many patients have made statements I have disagreed with. Less often, I have been treated to racist remarks about other doctors. I am still unable to deal with this in any other way than to remain courteous and not respond or be drawn. I am sure this is the correct thing to do as a doctor—but as a person, when I reflect on it, I am not so sure.

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Commentary: A role for personal values ... and management

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It is undoubtedly true that a doctor or any other health professional has to remain courteous in dealing with patients. For that reason, they cannot have a shouting match with a patient or be truly rude in any other way. However, in the light of the strong line taken by many medical organisations—the General Medical Council (GMC) and the BMA, to name but two—it is now possible for an individual doctor to go further than Dr Selby suggests. Dr Selby says that a health professional must "remain courteous and not be drawn." She continues, "I am sure this is the correct thing to do as a doctor—but, as a person, when I reflect on it, I am not so sure."

First of all, doctors should be able to use their "personality" to some extent. While they must not bully their patients, they can say that they disagree. In the situation described by Dr Selby, where other patients can hear what is going on and are distressed, the doctor should be more "personal" than she would otherwise have been. Some of the most powerful therapeutic relationships are those in which the doctor is sufficiently confident to be himself or herself. In this case, additional power could be given to the therapeutic relationship with other non-white people in the ward, by a firm personal statement, even if the tone in which it is given is courteous. That statement, while not being used to punish the individual, shows to other patients that the doctor does not concur with the sentiments expressed. Similarly, the German house officer could have asked the patient not to make a Nazi style salute to her as she found it offensive, without saying that the patient was behaving badly.

This case illustrates how difficult it is for doctors to integrate their personal values and their professional behaviour, and it shows more than most why the medical school curriculum should include some thought about personal values. It also shows why it has been so important that the GMC, the BMA, and others have made it clear that doctors must practise without discriminating against anyone on the basis of their colour or religion, or whatever reason. That powerful statement within professional guidance means that a doctor who is appalled by a patient's racism can comment on it to the extent of saying that she disagrees—and that the profession as a whole disagrees, too—without creating a situation in which the patient is being victimised because he or she holds unpleasant views.

Finally, we must question whose responsibility it was to manage the ward. That person—nurse, doctor, manager, or whoever—should have made it clear to this patient that comments of the kind he was making were distressing to others and would not be tolerated in a hospital ward which had people in it against whom he held voluble prejudices. It is not easy to say these things, but those who are experiencing the hatred will benefit, and the individual racist patient is not harmed and may even learn from it.

Commentary: Isolate the problem

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Mary Selby writes about an incident 10 years ago. It was an unpleasant experience, and she still feels uncomfortable about the event and her reaction to it. Could she face the same problems now? I would make a reasonable guess that she could. The British racist has rich pickings in hospital situations. He (or she) will find large numbers of ethnic minority carers and fellow patients.

The difficult question of what Dr Selby should have done then still applies now. As doctors we have a duty of care to our patients. This involves not wilfully harming them and treating them with respect. If patients fail to treat us with respect or cause us harm by racial abuse, we will naturally feel aggrieved. However, this sense of grievance on a personal level should not be turned into aggression.

In the situation described by Dr Selby it seems that little could be done. However, as Dr Selby points out, the lack of action on the part of a white doctor was taken by the racist (and possibly some patients from ethnic minorities) as tacit agreement for his views. Silence from an ethnic minority doctor might seem cowardly and encourage further abuse. However, pitting rational argument against irrational beliefs is often a futile exercise, and a risky one for white and non-white doctors alike since it could escalate into an unseemly slanging match.

The doctor could tell the racist that his comments are inappropriate in a hospital setting, and that he is offending staff and other patients. The racist patient might then declare that this is a free country in which he is entitled to freedom of speech. The doctor could threaten to report the racist patient to a senior clinician or manager. The racist might then question what one senior person could do. He pays his taxes and has a right to treatment. The racist may thus view all threats as empty ones. So what, if a more senior figure tells him off? He knows that he cannot be refused treatment or thrown out of the hospital.

At this point, take a deep breath. If the racist patient continues his abuse, I think that people from ethnic minorities should be protected from him and his views. A question arises: should they be moved or should he be isolated? Either way, as Dr Selby shows, our "little Englander" may feel that he has won. Despite this, if he refuses to keep quiet after an official warning, I think that some sort of isolation may be the best solution. Ideally, hospital staff should be able to consult specific health authority policies. However, at a time when nurses, in particular, seem to be subjected to increasing amounts of physical and verbal abuse, we may have to accept that an easy answer is some way off.

Commentary: Courteous containment is not enough

Pippa Gough

This is not an isolated incident. Nurses as well as doctors are often faced with similar situations of racist abuse, which is often directed at them as well as other patients. Remaining courteous and passive in the face of these remarks is not enough; this will be interpreted by the racist as tacit acceptance of their views. Ultimately, some greater sanction, such as withdrawing the service, may be warranted where the abuse is persistent and intentional.

Nurses' professional practice is founded on their code of professional conduct.[1] This is premised on respect for the autonomy and privacy of individual patients. Our starting point is that we treat and care for our patients regardless of who or what they are, and whatever their attitudes, values, or beliefs. But this is insufficient in the case of racist abuse and bigotry. Where individual action encroaches on the mental and physical welfare of other patients, the response should be positive intervention of some kind, not just containment.

In the case described by Dr Selby, action took the form of creating "a 'caucasian' corner." This may have lessened the distress of the other patients, but did it imply acceptance of the abuse being perpetrated? Treatment continued once the environment had been modified to suit the racist view. A mini apartheid was created. Mere containment, with no expression of repugnance for the views being aired or more positive action, seems to be professionally and morally questionable.

What is the ethically acceptable way of responding? Is it too extreme to suggest that one way forward might be to withdraw care until the patient changes his (or her) behaviour. This action is not without precedent. Nurses have withdrawn care where their own physical wellbeing or that of others is at risk, most frequently from drunken patients in accident and emergency departments, and this move has been given strong government support. Why should racial abuse, which is assault by any definition, be different? Moreover, doctors also have a right to expect a duty of care from their employer and from the organisation within which they are working. How much easier this doctor would have found the situation if there had been a clear organisational policy setting out the action to be taken in the situation described, and this was clearly displayed and publicised.

We cannot separate what is professional from what is personal in this situation. Such a position is too close to the unjustifiable notion of "only following orders." As health professionals our code of conduct does not allow us to condone tacitly the actions described, and as members of a civilised society we cannot be co-conspirators in the systematic oppression of minority populations. To contain racism without condemnation is arguably a failure of our duty to care for all of our patients (vulnerable and captive within a ward) who are subject to the assault, as well as our duty to society as a whole. We can remain courteous, while at the same time firmly rejecting the racist's views and taking action to prevent them injuring others. Although this might infringe the individual's autonomy and right to freedom of speech and action, it affirms our duty of care to the public at large.

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1 United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *The code of professional conduct.* London: UKCC, 1992.

A salutary lesson

Patients sometimes behave like our Snoopy

Hummingbirds need a lot of food in the evening. Then they roost and drop their body temperature. This bedtime calorie load and reduced metabolic rate enables them to survive the night.

We had just moved a few blocks across a suburb in the north of San Diego. Some young relatives of my German wife visited us almost immediately in a new house that was in chaos. An afternoon project was to obtain and install a new hummingbird feeder (I could not bear to harm the birds by removing the old feeder from our previous house, which was still unsold).

Hummingbird feeder technology is simple: a red apparatus with a yellow centre attracts the birds. A glass reservoir of 33% solution of granulated sugar provides the calories (running short of white sugar a few months before, I found that brown sugar is of no interest to hummingbirds). To the delight of our young guests, within five minutes of feeder installation, the first hummingbird arrived. Within two hours, five of them were competing for this new food source hanging under the eaves of our house.

Usually, hummingbirds are extremely territorial. A dominant male will vigorously defend, for hours on end, an artificial feeder, or even a single fuchsia plant. To my surprise, the dominant hummingbird at this new house had an entirely different strategy from the one who was king of the feeder at the old place. This new chap sat on top of the feeder, thus being dubbed Snoopy by our young German guests, and drove off any competitor who attempted to feed three inches below. The boss at the old house perched and chirped in a nearby tree, and attacked his competitors at high speed, developed by diving from his sentinel position.

And then it happened. Just after sunset, the belligerent Snoopy permitted no fewer than five other hummingbirds to share the four feeding apertures. In a moment, the ingrained, reproducible behaviour of a unique hummingbird had changed into exactly the opposite.

Sometimes we are surprised by the choices that our patients make. People often request treatments which their doctors think are suboptimal. People who cannot afford yet another baby still fail to take precautions that they understand well. Some patients inexplicably withdraw halfway through a clinical trial. Well informed patients often take decisions that are not evidence based.

For some good reason, Snoopy, an identifiable individual hummingbird, suddenly reversed his ingrained, biologically predicated behaviour. Surely our patients deserve the same opportunity at a moment's notice, even if they mystify us.

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