sale and distribution of contraceptives. Nevertheless, shortly after the *Griswold* decision, William Curran of Boston University's Law–Medicine Research Institute observed that "physicians in general should be fairly comfortable with this action by the court," since it seemed to affirm the "code of silence" regarding the doctor–patient relationship that had "been part of medicine for over two thousand years."

Curran correctly predicted that the *Griswold* decision would pave the way for resolving other medicolegal issues involving "this newly identified fundamental human right" of privacy.[4] In 1972, the Court extended the right of privacy to unmarried persons seeking birth control, stating in their ruling *Eisenstadt v. Baird* that "if the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."[5] A year later, the right of privacy was extended to cover abortion in *Roe v. Wade*.

Clearly, moral and religious objections to abortion have persisted. Over the past 25 years, the Court has become more conservative and allowed certain restrictions on abortion access — such as parental consent and waiting periods — as long as they don't present an "undue burden" on women seeking abortion services. Among the latest tactics in the campaign against reproductive rights was the release of videos in July and August 2015 by an antiabortion group called the Center for Medical Progress purporting to show Planned Parenthood clinic personnel engaged in the illegal sale of fetal tissue and organs. (In January, a grand jury in Harris County, Texas, indicted the producers of the video on a charge of tampering with a governmental record, a felony, and on a misdemeanor charge related to purchasing human organs.) Although investigations by several states have shown no evidence of wrongdoing, Congress has tried several times to eliminate federal funding for the beleaguered organization.

Though this battle centers on abortion, it poses a threat to contraceptive access as well. Planned Parenthood is the single largest provider of contraceptive services for women living at or below the federal poverty level. Eliminating federal funding will put these services in jeopardy and recreate the economic disparity in birth-control access that the plaintiffs in *Griswold v. Connecticut* sought to alleviate.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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# Dealing with Racist Patients

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A 77-year-old white man with heart failure arrives in the emergency department of an urban hospital at 3 a.m. with shortness of breath and a fever. When a black physician enters, the man immediately announces, "I don't want to be cared for by a %$#!{& doctor!" Taken aback, the physician retreats from the room. She's offended by the man's rejection and demeaning language — but knows that he may have a serious medical condition and that she cannot treat him against his will. How should the physician proceed?

A patient's refusal of care based on the treating physician's race or ethnic background[1] can raise thorny ethical, legal, and clinical issues — and can be painful, confusing, and scarring for the physicians involved. And we fear that race-based reassignment demands will only increase as the U.S. physician population becomes more racially and ethnically diverse. So we've created a framework for considering and addressing such demands.

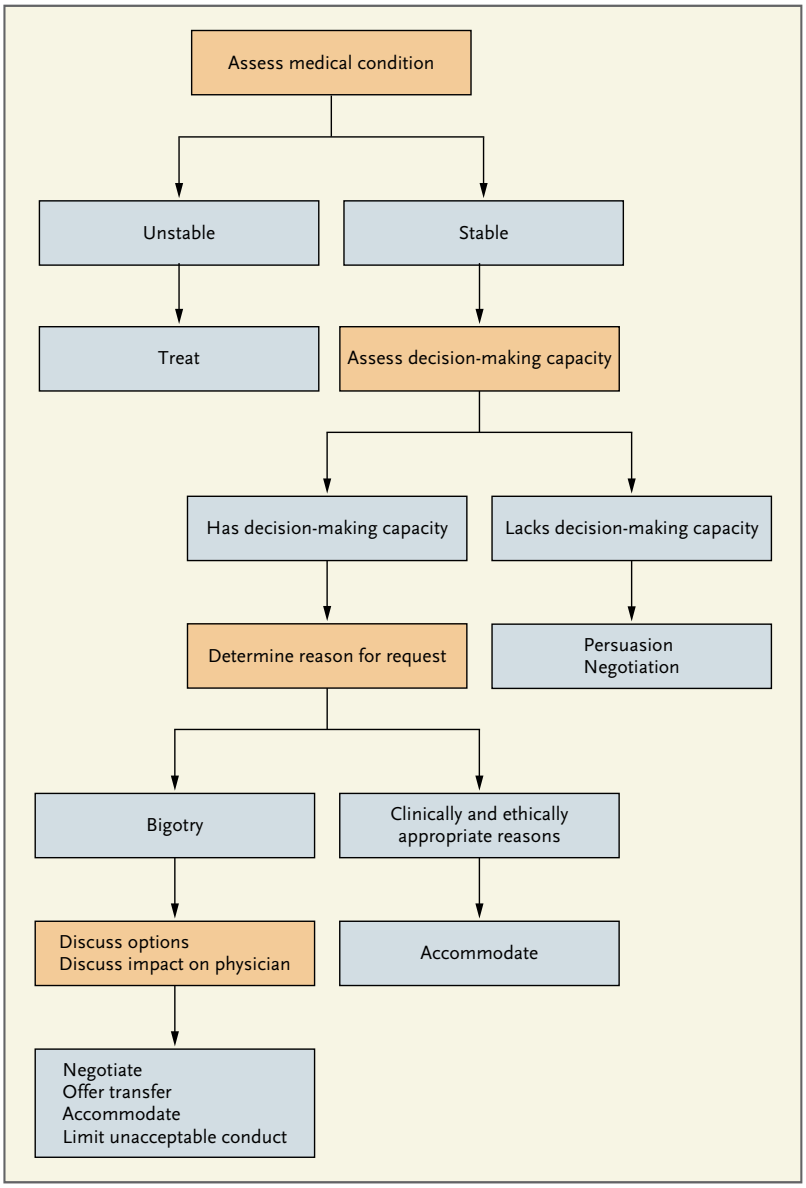
Competent patients have the right to refuse medical care, including treatment provided by an unwanted physician. This right is granted by informed-consent rules and common law that protects patients from battery. Patients presenting with an emergency

medical condition are also protected by the Emergency Medical Treatment and Active Labor Act (EMTALA),[2] which requires hospitals to screen and stabilize patients and provide medical treatment, if necessary, or arrange for a transfer, with patient consent, to a facility able to provide appropriate treatment.

Physicians and other health care workers have employment rights that must be balanced with patients' rights. Employees of health care institutions have the right to a workplace free from discrimination based on race, color, religion, sex, and national origin, according to Title VII of the 1964 Civil Rights Act.[3] Organizations that make race-based staffing decisions or compel employees to accede to a patient's request for reassignment on the basis of a worker's race or ethnic background may violate Title VII. Nurses and nursing assistants have successfully sued employers who require employees to accommodate such demands by patients.[4]

Physicians, however, have not brought such lawsuits, perhaps for two reasons. First, unlike nurses, many physicians are not hospital employees but rather "independent contractors," who are not covered by Title VII unless the hospital exercises a substantial amount of control over how they perform their jobs. Second, physicians commonly decide among themselves how to address reassignment requests and thus probably are not often forced by a hospital employer to accommodate such requests.

Beyond these general legal rules, when patients reject physicians on the basis of their race or ethnic background, there is little guidance for hospitals and physicians regarding ways of effectively balancing patients' interests, medical personnel's employment rights, and the duty to treat. We believe that sound decision making in this context will turn on five ethical and practical factors: the patient's medical condition, his or her decision-making capacity, options for responding to the request, reasons for the request, and effect on the physician (see flow chart). It's helpful for physicians to consider these factors as they engage in negotiation, persuasion, and (in some cases) accommodation within the practical realities of providing effective care for all patients.




**Considering a Patient's Request for Physician Reassignment Based on Race or Ethnic Background in an Emergency Setting.**

Actions in the orange boxes address factors that physicians should consider when confronted with a request to change clinicians because of a clinician's race or ethnic background. Such requests may be deemed to be clinically and ethically appropriate if, for instance, they are motivated by a desire for racial, ethnic, or language concordance or if the patient has specific mental health issues.

The patient's medical condition and the clinical setting should drive decision making. In an emergency situation with a patient whose condition is unstable, the physician should first treat and stabilize the patient. Reassignment requests based on bigotry may be attributable to delirium, dementia, or psychosis, and patients' preferences may change if reversible disorders are identified and treated. Patients with significantly impaired cognition are generally not held to be ethically responsible.

The assigned physician's options for responding include establishing mutually acceptable expectations and conditions for providing the patient with the care he or she needs and is seeking. Family members may be able to persuade the patient to accept necessary medical treatment. If other emergency physicians are available, it is reasonable for physicians to decide among themselves to assign the patient to another physician, within the practical constraints of providing appropriate care for other patients. If only one physician is available, or if the physician does not wish to reallocate patients, she may negotiate with the patient to allow her to provide care until another physician comes on duty. Another option is to allow a nurse or medical resident to conduct the patient's evaluation, although the patient should know that the assigned physician is still responsible and that having someone else perform the physical evaluation is not the standard of care. Regardless of the approach taken, patients should be informed that hateful or racist speech is not allowed.

The reasoning behind a patient's request for reassignment may be clinically and ethically important. Requests for an ethnically or a racially concordant physician may be ethically appropriate in certain cases — for instance, for reasons of religion or culture (e.g., Muslim women requesting female clinicians) or of language.[4] Patients who are members of racial or ethnic minority groups may request concordant physicians because of a history of discrimination or other negative experiences with the health care system that have resulted in mistrust. In such cases, physician–patient concordance is associated with greater trust, comprehension, and satisfaction.[5] Practically speaking, distinguishing such requests from those in which an assigned physician is rejected on the basis of race or ethnic background is usually straightforward. Accommodation in these cases is justifiable, and many institutions facilitate linguistic and ethnic concordance for their patients.

***For many minority health care workers, expressions of patients' racial preferences are painful and degrading indignities, which cumulatively contribute to moral distress and burnout.***

In contrast, rejection of a clinician that is motivated by bigotry is less deserving of accommodation. Such refusals are generally directed at physicians who are members of racial or ethnic minority groups that have historically suffered discrimination. Still, in some rare cases, refusal of a physician may be reasonable or worth accommodating — if, for example, the patient has had a very negative personal experience with people of a particular race or ethnic group (e.g., a veteran with post-traumatic stress disorder who refuses treatment from a clinician of the same ethnic background as former enemy combatants).

The final consideration is the effect on the physician. For many minority health care workers, expressions of patients' racial preferences are painful and degrading indignities, which cumulatively contribute to moral distress and burnout. Physicians must balance several ethical obligations. They should respect patients' informed refusals of medical interventions. They should also subordinate their self-interest to a patient's best interests and overcome any aversions they may have toward patients. Still, no ethical duty is absolute, and reasonable limits may be placed on unacceptable patient conduct. Institutions can track and collect data on these physician–patient encounters, including their effects on physicians and their ultimate resolution, with the goal of supporting staff and improving the handling of these situations.

Hospitals and other institutional providers have their own factors to consider when responding to race-based requests. Hospitals must meet EMTALA requirements while respecting physicians' employment rights; their ability to remove physicians from cases

in response to patients' race-based requests is thus circumscribed. An on-call administrator can inform patients of their right to seek care elsewhere and their responsibility to refrain from hateful speech. We believe that institutions should not accommodate patients in stable condition who persist with reassignment requests based on bigotry. Outpatients may be informed that they are free to seek treatment elsewhere if they object on racial grounds to their assigned physician, and inpatients in stable condition can also be assisted in transferring to another hospital.

Patients who demand accommodation for racial biases present health care providers with a difficult conflict involving their professional obligation to provide nondiscriminatory care, their sense of social justice and personal integrity, and their ethical obligations to respect patients' autonomy and medical best interests. Although institutions should not accommodate, for individual physicians the decision to accommodate may be sound when the accommodating physician is comfortable with the decision, employment rights are protected, and the decision does not compromise good medical care.

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