

# Confronting Racial Violence: Resident, Unit, and Institutional Responses

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## Abstract

By describing an instance of racial violence by a patient against a resident physician, the authors hope to stimulate further discussion by addressing three specific questions about managing racist patients: (1) How should the resident (or any level of trainee) respond to the immediate situation? (2) How should

the unit respond to the event as a community? and (3) How should the institution (hospital and/or academic institution) respond to the event? The authors argue that responses to such incidents should acknowledge the history of structural racism in U.S. society and in medicine. The

authors recommend an approach that names the racism directly while addressing the safety of the patient and the providers in the moment, supports those affected in the aftermath, and considers appropriate consequences for the perpetrators of violence.

One late night, as the on-call resident, I was called to see a patient on an inpatient unit. The nurse on the phone reported that the patient was being loud, belligerent, and disruptive, and I should come to assess her. When I arrived, I quickly realized who the nurse was referring to—a short-statured, elderly Caucasian woman who was yelling obscenities to the staff members. I gently approached her at the nurse's station. She turned around to look at me and proclaimed, "I don't want no nigger doctor."

My heart sank. The other patients and staff on the floor froze and looked at us. "Get that nigger away from me," she yelled. Her racist remarks became like theater for the other patients and staff as they waited to see my response. I did not let the patient's hateful remarks deter me from trying to be a compassionate caregiver. I attempted to readdress her: "I am Dr. Williams; how can I help you?" The patient would not speak to me directly or even make eye contact. To her, I did not even exist; I was not human; I was just a nigger. I wondered, "How do I begin to be a compassionate provider when the patient does not even acknowledge my humanity?"

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My presence only seemed to escalate the patient's behavior to a point where she was calling other staff racial slurs and posturing aggressively toward them. She was forcefully escorted to her room to maintain the safety of other patients and staff and was given sedating medications against her will. I retreated back to my call room feeling defeated. There was no processing of the incident with me or the staff, and no report of the event was generated. The incident was simply not addressed. The patient continued to receive treatment on the unit for several days thereafter, and despite numerous attempts at verbal redirection from the treatment team, she continued to be intermittently verbally abusive toward staff. I felt anguished, not from the racial castigation that I suffered, but for the other minority staff. Aside from my role as the physician, as a fellow minority person, I felt an added sense of responsibility and concern for their well-being. Not only did I feel unprepared and untrained to address this issue with the patient, but I was also a novice at facilitating a debrief conversation with staff.

With this Invited Commentary, we hope to stimulate further discussion about management of racial violence by addressing the historical context and language used to describe and respond to the racist patient and by addressing three specific questions about managing racist patients: (1) How should the medical resident (or any level of trainee) respond to the immediate situation? (2) How should the unit respond to the event as a community? and (3) How

should the institution (hospital and/or academic institution) respond to the event? By addressing these questions, we hope to provide a framework that supports residents and others who have been the targets of racism, affirm values of caring for patients and of diversity and inclusion, and suggest a process for managing these complex situations at the institutional level.

## How Should the Resident (or Any Level of Trainee) Respond to the Immediate Situation?

Residents (or other trainees), who may be at higher risk of abuse from patients,<sup>1</sup> have little guidance, if any at all, on situations involving explicit racism and bigotry. Verbal and physical abuse from patients is surprisingly commonplace. A meta-analysis published in 2014 found that the prevalence of racial discrimination for residents was estimated to be 26%.<sup>2</sup> A study by the Southern Poverty Law Center<sup>3</sup> showed that the number of hate groups and incidents of hate speech have increased over 2015 and 2016. The changing political and social climate, which notably includes a growing white nationalist movement, may have contributed to these increases as some people have found their racist beliefs emboldened by the change in presidential administration. It also seems likely that in the current political context, these incidents are more salient in the minds of trainees, faculty, and institutions.

A resident might categorize the interaction described above as a "hateful"

and/or “disruptive” patient, which alludes to a rich body of literature with well-established clinical approaches.<sup>4,5</sup> In summary, that literature suggests addressing the underlying cause of the disruptiveness via various de-escalation techniques or therapeutic approaches and/or the temporary use of various kinds of restraints (i.e., chemical, mechanical, environmental) when necessary to ensure patient and staff safety. Although we acknowledge the usefulness of that literature, we believe that the patient in the scenario described above and others like it does not easily fit into the categories defined in that literature (e.g., entitled demanders, manipulative help rejectors).

Although workplace violence is a well-documented hazard in medical training, incidents of racism are not typically incorporated in the current conception of workplace violence. Instead, terms like disruptive or hateful wash over the specific effects of the racial abuse and decontextualize the impact of it, thus allowing for the use of algorithms and communication scripts meant to address disruptiveness (rather than racial violence) that are considered to be “objective” and timeless. We believe that naming the racism as violence and addressing the racism directly may mobilize communication scripts that are more helpful in managing such situations. Naming and addressing the racism represents a decisive confrontation with the nation’s legacy of structural racism and an acknowledgment that African Americans, in particular, have been subject to dehumanizing, violent language and stereotypes, and acts of violence, including violence situated in medical settings. Assessing such situations as one of a typical disruptive or difficult patient could result in an ineffective communication script or exacerbation of the racism and represents a violent avoidance, silence, and complicity to the insidious nature of white supremacy, which is deeply embedded in the structure and culture of medical institutions.

A resident might complete a competency exam to determine whether the interaction is based on the patient’s baseline beliefs or is a product of intoxication or mental illness.<sup>6–9</sup> However, whether or not the patient is deemed

“competent,” the racialized abuse still impacts all who were exposed to it. It is our intent to address the potential damage in the moment and its aftermath, regardless of the patient’s state of competence. Furthermore, it is often impractical to perform a comprehensive competency assessment during these emotionally charged incidents, especially during states of agitation. Making decisions based on competency also presupposes that the origins of the racism (e.g., baseline beliefs or intoxication or psychosis) should dictate the response from the resident, unit staff, and institution. It is our argument that no matter the etiology of the racism, a consistent approach to address it should be followed.

There have been efforts to stimulate conversation and debate about how to handle these types of incidents<sup>10–13</sup> and to generate broad guidelines on managing racist patients. Paul-Emile and colleagues<sup>14</sup> provided an algorithm for navigating the legal and ethical issues regarding racist patients, including negotiating with the patient. Whitgob and colleagues<sup>15</sup> sought out the opinions of experienced faculty through interviews and qualitative analysis. These faculty made several suggestions, such as attempting to form a therapeutic alliance to address the underlying fear beneath the discriminatory remarks and “depersonalization” from the event. Although undoubtedly well intended, the interventions suggested in Whitgob and colleagues’<sup>15</sup> paper were generated by faculty who were not affiliated with an underrepresented in medicine racial or ethnic group and may be unrealistic as well as ethically problematic. Our nation’s long history of racism heightens the intensity and assaultive nature of these acts of race-based aggression. We need only to recall the atrocities of slavery, lynching, legalized segregation, and/or the continued incidents of police brutality to acknowledge that for centuries, African Americans in particular have encountered racism in very real, life-threatening situations, and thus fear of harm is deeply ingrained in the African American consciousness. For many African Americans, racism is not something that can be depersonalized; it is deeply personal and relates closely to personal safety. We feel that using tactics such as establishing a therapeutic alliance

under these circumstances is simply unrealistic. Furthermore, if the patient rebuffs initial efforts, it would arguably be ethically reprehensible to negotiate with a patient who continues to use overt racial slurs and blatant racial hostility. In our opinion, a passive stance would only serve to validate the patient’s white supremacist views and suggesting that residents develop a therapeutic alliance, use depersonalization defenses, or negotiate with the patient are all highly problematic in this context.

In our view, the resident and unit staff should feel empowered to name and address the racism and to set limits with the patient in the moment. The purpose of a firm, appropriate, limit-setting communication script is not punitive but corrective, reinforcing the expectations of respect on the unit. For example, using a firm, assertive voice, a resident might say: “We do not use language like that in our hospital. Our teams are made up of people from many backgrounds, and since we want to provide the best care for you, you must stop using that language.” Residents should be provided with tools, including techniques for redirection and correction, as well as de-escalation training. Residents should also be taught an arsenal of limit-setting scripts that could be employed when dealing with explicitly racist patients. Training should also address how to safely manage a patient who refuses to cooperate with further assessment. These trainings should not only be provided to all residents but also to all staff and faculty so that everyone, including those who are not members of minority groups, can intervene in situations in which they witness racist remarks or behaviors from patients.

Importantly, we are not suggesting that the needs of the resident supersede those of the patient. Rather, the approach should address the therapeutic needs of the patient *and* the resident in the moment, address the racism *directly*, and support those affected in the aftermath. Although the communication script and clinical approach for racist patients differ from those of the prototypical hateful patient, limit setting is a common therapeutic approach in both. We acknowledge that this approach may be seen as representing a departure from the traditional self-sacrificing, self-

denying, objective physician role; for example, Sapién<sup>16</sup> suggested developing an “emotional scotoma” (i.e., blind spot) in response to a racial microaggression so as to focus solely on the patient and their needs. The approach we suggest moves toward a more humanistic approach of thinking about the physician as having a body with valid subjectivity and is, we believe, consistent with recent trends to address physician wellness and burnout.

### How Should the Unit Respond to the Event as a Community?

We believe the language used in describing these incidents will inform the adjudication of the response to them. It is therefore imperative that hospitals and academic institutions use language that describes the incident in a manner that will elicit an active, substantial, and systematic response. During the incident referenced above, the patient’s speech and behavior contained acts intended to cause apprehension of harmful or offensive contact and caused apprehension of such contact in others. This combination of speech and behavior approaches meeting the legal definition of verbal assault. The term *verbal assault* may help institutions establish a consistent response to incidents of overt physical violence and race-based verbal violence. Using the language of assault signals a sense of urgency both interpersonally and systematically. In cases of physical assault, for example, a staff supervisor is routinely notified, the target of the assault is evaluated, the need for further evaluation or medical care is established, and incident reports are generated. Data from these reports are typically tracked, and investigations are initiated to determine whether there were other means available to prevent or better manage the event.

Just as would be the case when a staff member is physically assaulted or in any other episode of violence, the importance of the unit staff coming together to support one another after racial violence cannot be overstated. After such an incident, the unit leader should alert supervisors, and the unit should come together as a community to check in and debrief, provide support for the targets of the racism, and plan for how the incident will be addressed. Community debriefing should always occur and should include

those who witnessed or were impacted by the racial aggression, including other patients. Staff and trainees should be trained in the institutional procedures, including leading a debrief session and submitting an incident report, and be familiar with the resources available for backup and transfer of care.

The goal of the debriefing is to determine the needs of and elicit feedback from the targets of the racial violence; these data should then be used to make decisions as a team on how to proceed. The resident may need some time alone or to vent to other staff members before they continue to care for the patient, or it may be appropriate to transfer the patient to a backup team member, new unit, or treatment team either temporarily or permanently. It should be clear that the transfer of the patient is not an effort to accommodate a race-based request but, rather, to quell potentially escalating tensions and preserve the culture of inclusivity on the unit. If the resident or staff is deeply emotionally affected or having overt symptoms of psychological distress, additional support, such as calling in a backup provider or consulting with a supervisor, chaplain, clinician, or ombudsperson, should be used. The clinical supervisor and program director should also follow up with the resident in the days following the incident to assess whether additional supports are needed.

### How Should the Institution (Hospital and/or Academic Institution) Respond to the Event?

Reducing incidents of racism and bigotry must be a high priority for hospitals and academic institutions committed to fostering an environment that supports diversity and inclusion. The hospital milieu ought to be a healing community built on values of respect and professionalism. Unfortunately, incidents of aggression from patients have become a routine part of the hospital setting, with 80% of violent incidents in such settings being caused by patients.<sup>17</sup> Again, the explicit use of the term verbal assault for incidents such as the one described above would promote an active response from the hospital or academic institution because the term assault mobilizes an entire management structure and medicolegal precedents. Linking

such events to workplace violence is warranted given the potential harms to the employee, including traumatic stress,<sup>18</sup> anxiety and depression,<sup>19</sup> lower self-esteem,<sup>20</sup> decreased life satisfaction,<sup>21</sup> decreased organizational commitment, and increased intention to leave the organization.<sup>22,23</sup>

Most hospitals have developed processes to address violent or aggressive behaviors from patients. These procedures often include committee review of incident reports generated after the violent episode and developing interventions to ensure the safety of staff and other patients. Incident reports of racially motivated verbal assault should also be reviewed by members of this committee, followed by preparation of an action plan for addressing the patient’s behavior. The summary data from incident reports should be made available to the institutional community to reinforce the values of diversity within the community and to hold the institution accountable for actionable responses. The above case is an obvious example of racially motivated verbal assault, but in many other situations, verbal aggression may be more nuanced and less overt, which highlights the importance of the review process to adjudicate these matters. Interventions might range from a letter to the patient reinforcing the institution’s policies about respect and inclusion to transferring the patient to another provider, referring them to another facility, or discharging them from the hospital.<sup>24</sup> Such interventions are supported by the American Medical Association, which, in its opinion 9.123, states that hostile language or acts of prejudice toward physicians “may constitute sufficient justification for the physician to arrange for the transfer of care.”<sup>25</sup> Although this statement applies to individual physician practice, we feel that this stance should be extrapolated, with appropriate adjudication processes, to the broader hospital system. The complicated nature of this issue is exemplified in medicolegal precedents in which providers of care have prevailed in lawsuits against employers who granted patients’ race-based requests.<sup>26</sup> Assembling a review committee which is representative of the diversity of patients, trainees, staff, and faculty that constitute the broader workplace community will be important to ensuring a fair adjudication process.

Table 1

**Suggested Concrete Actions for Confronting Racial Violence in Hospitals and Academic Institutions**

Type of response	Concrete actions
Immediate response from residents, <sup>a</sup> unit staff, and faculty	<ol style="list-style-type: none"> <li>1. Trainees, unit staff, and faculty recognize the racist hate speech as a violent incident or verbal assault.</li> <li>2. Resident and unit staff use communication scripts to educate the patient about institutional values and set firm limits against the use of racist hate speech.</li> <li>3. Resident and unit staff ensure safe management of the patient during and after the event. This may require transferring the patient to another provider or unit.</li> <li>4. Resident contacts faculty supervisor, and nursing staff contact their supervisor to report the violent incident.</li> </ol>
Postincident response from unit	<ol style="list-style-type: none"> <li>1. Supervisors, trainees, and unit staff come together as a community to debrief and provide support for the targets of the racism.</li> <li>2. Supervisors use the debriefing to drive an action plan depending on the needs of the resident targeted by the racist hate speech. This plan may include allowing the resident to spend some time alone, to vent to the other team members, and/or transferring the care of the patient to a backup team member, new unit, or treatment team either temporarily or permanently.</li> <li>3. Supervisors and unit staff name the violence an incident of verbal assault and generate an incident report through an established tracking system.</li> </ol>
Postincident institutional response	<ol style="list-style-type: none"> <li>1. Faculty supervisors check in with the resident in the days after the violence to ensure that sufficient support is provided or offer additional supports as necessary.</li> <li>2. Committee reviews the incident report to determine whether and how patient behavior should be addressed.</li> <li>3. The committee tracks incidents to determine whether certain factors are correlated with a higher frequency of events and to target interventions to support staff and diminish the frequency of incidents.</li> </ol>
Other institutional responses	<ol style="list-style-type: none"> <li>1. Hospitals and academic institutions collaborate to develop, disseminate, and evaluate communication scripts that educate trainees, staff, and faculty about the historical context for racist hate speech and techniques for managing it.</li> <li>2. Hospitals and academic institutions recognize hate speech as a form of violence, develop policies and systems to encourage reporting, support targets of racist speech, ensure institutional response, and track incidents. Hospitals and academic institutions make summary data from incident reports available to the broader community.</li> </ol>

<sup>a</sup>Or trainees. The terms resident and trainee are used interchangeably throughout the rest of the table.

Residents are often affiliated with academic institutions that have a responsibility to respond to various forms of workplace discrimination and/or harassment. Academic institutions have policies and procedural precedents set by Title IX, which mandates the “responsibility to respond promptly and effectively ... [and] take immediate action to eliminate ... sexual harassment...”<sup>27</sup> Although Title VII under the Civil Rights Act of 1964<sup>28</sup> outlaws discrimination on the basis of race, in our experience, institutional policies and practices surrounding racial discrimination are less transparent and concrete than those related to sexual discrimination. There appears to be a disparity between the rigor of response commanded by Title

IX and that commanded by Title VII; harassment and assault based on race need to be brought to the forefront and assertively addressed. We believe that the institutional responses and systems of accountability mandated by Title IX should serve as a model for reporting, support services, and adjudication processes for racial discrimination or harassment in academic institutions.

### Conclusions

Much remains to be done to assist residents, unit staff, and institutions to respond to overtly racist patients. The history of racial violence in this country must be confronted when developing recommendations about how

to respond to racist patients. We have attempted to suggest concrete actions that residents, units, and institutions could use to address racial violence (summarized in Table 1); all stakeholders should be trained in these procedures, and significant effort may be required to reinforce that racism is considered a form of assault or violence. These actions may also be useful for assisting residents who are subject to harassment and verbal assault due to other forms of bigotry (based on ability, body habitus, gender identity or expression, religion, sexual orientation, etc.), though the history of each type of bigotry should be considered when formulating specific recommendations. Although we have focused on residents in this manuscript, we believe that these recommendations are also pertinent to other trainees, unit staff, and faculty. Hospitals and academic institutions must be proactive in designing systems that will support diverse trainees in maximizing their learning and contribution to the organization’s mission.

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