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YES, I WANT HELP, I JUST DO NOT WANT YOU! UNDERSTANDING POLICY DEVELOPMENT REGARDING PATIENT DEMANDS FOR ALTERNATIVE CARE PROVIDERS

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There is an often-misunderstood fallacy that healthcare is a mostly customer service-based business with major hospitals competing for business dollars. Although healthcare is a business, and there is competition, hospital's missions are not to just advance the bottom line. Rather, most hospital mission statements relate to the health and well-being of those they serve and their communities.¹

Those seeking health services do so based on need rather than it being an exchange of goods based on consumer desires and choice. This is a complicated relationship for several other reasons, including that in the business of healthcare, the "customer" patient is not always right. Competent patients always retain the right to refuse any unwanted healthcare even when doing so might result in their death.² On the other hand, patients do not have the right to demand care providers who meet their preferences based on personal characteristics in a case of true emergent healthcare needs. In fact, if a patient's biased request were accommodated, it would be institutionalizing that bias in violation of Title VI.³

It is important to note the differences between patients suffering from minor or chronic conditions, which are easily cared for in an outpatient setting, and those patients suffering from acute, or emergent conditions, which require

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1. The mission statement at Henry Ford Health System is: "We improve people's lives through excellence in the science and art of health care and healing." *Our Culture*, HENRY FORD HEALTH SYS., <https://www.henryford.com/about/culture> (last visited Jan. 28, 2021).

2. See *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 271 (1991) (explaining the right of competent individuals to refuse medical treatment).

3. HEALTH AND HUM. SERVS., RESOLUTION AGREEMENT BETWEEN OFFICE FOR CIVIL RIGHTS AND HURLEY MEDICAL CENTER (last visited Jan. 23, 2021) ("OCR transaction number 13-156114, a compliance review opened on February 27, 2013, in response to media reports about Hurley's alleged discriminatory assignment of nurses in Hurley's Neo-Natal Intensive Care Unit (NICU) in response to a request by the father of a baby patient, beginning October 31, 2012.").

inpatient hospital care. Those patients who are seeking outpatient care have the right and opportunity to appropriately seek a care provider with whom they believe they will best be able to develop a good relationship. For example, a primarily Spanish speaking Latino female may seek out a Hispanic female primary care physician in the belief that the cultural congruence will aid in developing a better and more comfortable environment for a lasting provider/patient relationship.

I am working in a large healthcare system that offers a variety of identifiers to allow patients to learn about providers on doctor search sites. For instance, physicians may display rainbow emblems, languages spoken, where their degrees were obtained, and specialized board recognitions, among other identifiers.⁴ Patients seeking appointments may then enroll with that doctor or request to be placed on a waiting list if a doctor is not accepting new patients. Usually, patients are scheduled based upon their requests (desire) or first-come-first-serve. Thus, patient desires for a physician with certain characteristics may outweigh the urgent need for healthcare services in many outpatient situations. For example, one can elect to wait to have a non-urgent physical condition evaluated, an annual wellness visit, or an allergy shot to get the physician of their preference.

On the other hand, if someone needs acute medical care or treatment which requires hospitalization, the situation is vastly different. For example, consider chest pain that may precede a heart attack or injury following an auto accident. The situation has changed from one of desires to needs (specifically the need to have specialized health care treatment or evaluation), and from non-urgent to more urgent or emergent in nature. Further, the staffing of an acute care hospital is based upon the needs of the many, not the individual. Generally, hospital staffing includes a predetermined number of physician staff and specialists to cover each required service and a specific nurse to patient ratio to ensure that quality care can be provided to each patient.⁵ Hence, those providing treatment are assigned by hospital and unit needs and are not available for personal selection. Again, it is based upon the needs of *all* of those who require care or treatment and the efficient functioning of the institution.⁶

4. See, e.g., *Dr. Jennifer L. Hopp, MD*, UNIV. OF MARYLAND MED. CTR., <https://www.umms.org/find-a-doctor/profiles/dr-jennifer-l-hopp-md-1871548065?si=ummc> (last visited Jan. 23, 2021) (providing an example of such physician profiles).

5. See, e.g., SEAN P. CLARKE & NANCY E. DONALDSON, *PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES*, 2-126 (RG Hughes, ed. 2008).

6. NURSE STAFF ADVOCACY, AM. NURSES ASS'N, <https://www.nursingworld.org/practice-policy/nurse-staffing/nurse-staffing-advocacy/> (last visited Jan. 14, 2021) ("A Federal regulation has been in place for some time...[42 C.F.R. § 482.23(b)] which requires hospitals certified to participate in Medicare to 'have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed.'").

The following article will share how one large metropolitan health system worked through the development, education, and execution of a policy to protect the healthcare work force from the racist and biased demands of patients. The health system is comprised of five large hospitals providing over 2,400 inpatient beds throughout a large, midwestern metropolitan area. Both the patient population and the provider population share a wealth of diversity in cultures, religions, languages, norms, and expectations.

The provision of healthcare in the U.S. involves a complex matrix of obligations. One of the first things learned in healthcare is the obligation to treat all unstable patients who need care regardless of their personal characteristics.⁷ This is codified by the Emergency Medical Treatment and Active Labor Act (EMTALA) and accepted by all institutions accepting federal and state funds, regardless of a patient's ability to pay for services.⁸ Further, professional codes of ethics demand the provision of professional services to those who require them free from any form of bias or discrimination.⁹ In addition to meeting these necessary requirements, there is the constant striving of healthcare organizations for service excellence and improved scoring on patient satisfaction surveys.¹⁰ In the early 2000s, the goal of patient satisfaction was highlighted as looking to engage patients as customers we wanted to please as we strived to have them choose us for their care.¹¹

Patients sometimes request healthcare providers of a specific race, religion, culture, or gender to care for them in the hospital, clinic, or home.¹² Patients may also make rude, harassing, or disparaging comments or refuse to be treated by well-qualified providers based upon personal characteristics such as those listed above.¹³ These requests may be rooted in their cultural/religious backgrounds and/or personal beliefs and norms, or in historical tolerance for their bias or racist beliefs.¹⁴ In my work educating residents and interns, I started asking, “[h]ave you ever had a patient who did not want you to care for them based upon your personal characteristics such as skin color, sex, language or religion?” Almost

7. See, e.g., 42 U.S.C. § 1395dd (outlining the guidelines for examination and treatment for medical conditions and women in labor).

8. *Id.*

9. CODE OF MEDICAL ETHICS (AM. MED. ASS'N 2001).

10. *Patient Satisfaction Surveys*, NEJM CATALYST (Jan. 1, 2018), <https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0288>.

11. See Thom A. Mayer & Robert J. Cates, *Are They Patients or Customers?*, RELIAS MEDIA (July 1, 1998), <https://www.reliasmedia.com/articles/33620-are-they-patients-or-customers> (explaining the transition to viewing patients as customers).

12. Kimani Paul-Emile, *How Should Organizations Support Trainees in the Face of Patient Bias?*, 21 AMA J. OF ETHICS 513, 513 (2019).

13. *Id.*

14. Kimani Paul-Emile, *Patients' Racial Preferences and the Medical Culture of Accommodation*, 60 UCLA L. REV. 462, 470–71 (2012).

all stated that it happens regularly, that they, “rarely tell” the attending physician staff, and they just, “learn to move on,” by making switches amongst other residents or interns. When probed they admitted that these requests do bother them, “because it is so unrelated to my ability to care for them,” or “because it is based on things that I cannot change...my accent, my skin color” and “because my religion has nothing to do with my skills” along with many other reasons. They mostly shared, that although frequently ignored, when patients demand to change providers it is hurtful on some level.

It is the responsibility of operational leadership to create, maintain and ensure an atmosphere free of discrimination and harassment. It is also the responsibility of every employee to respect the rights of co-workers, patients and all other persons visiting healthcare facilities. In order to be fully supportive of federal, state and local laws including: Title VII of the Civil Rights Act 1964;¹⁵ the Age Discrimination Act of 1975;¹⁶ and the Americans with Disabilities Act of 1990,¹⁷ our health system created a strong policy starting to address occasions when patients request (or sometimes demand) to change their care providers to support our staff and allow an appropriately nuanced response.¹⁸

These demands often lead to real harms to those providing care.¹⁹ Kimani Paul-Emile developed one of the first positions and algorithms to guide those working in healthcare to address these situations when patients are requesting, often demanding to have changes in providers based upon their bias or racist beliefs.²⁰ Her article came out in 2016 and the work on our hospital system policy began in early 2017.²¹ Cultural change is slow, just like moral progress, and this policy development and rollout has been ongoing. The policy development required a multidisciplinary work team of physicians, administrators, human resource personnel, legal, ethics, and pastoral care, over nine months to draft the policy to address patient bias (“Request for Reassignment of Healthcare Provider Algorithm”).²² Additionally, it took another year to get approval from the System leaders and five institutions’ leadership councils. The policy was put into place in January 2019 and the educational components to teach staff the appropriate execution of the policy and the various outcomes is still ongoing.

15. The Civil Rights Act, 42 U.S.C. § 2000e.

16. The Age Discrimination Act, 42 U.S.C. § 6101.

17. The Americans with Disabilities Act, 42 U.S.C. § 12101.

18. See 42 U.S.C. § 2000e; 42 U.S.C. § 6101; 42 U.S.C. § 12101; see also Paul-Emile, *supra* note 14, at 482–83 (explaining the interaction between federal laws and patient care).

19. Paul-Emile, *supra* note 12, at 513–14 (citing Keerat Singh et al., *The Dilemma of the Racist Patient*, 44 AM. J. ORTHOP. E477–79 (2015)).

20. Kimani Paul-Emile et al., *Dealing with Racist Patients*, 374 N. ENGL. J. MED. 708, 709 (2016).

21. *Id.*

22. See *infra* Appendix 1.

2021] YES, I WANT HELP, I JUST DO NOT WANT YOU! 153

The purpose of our policy is to provide guidance for leaders responding to patient or family member requests or demands to have assigned care providers changed based on those assigned providers' personal characteristics, and to ensure consistency of response and practice, in accordance with the mission, vision, and values of our health system. The policy is designed to assist operational leadership in promoting and maintaining a positive and diverse workforce that is free from discrimination and in compliance with applicable laws.²³ The first thing you will notice is that the policy does not have one endpoint for how to handle bias situations. The policy has five potential options on how to appropriately manage a patient's request for an alternative care provider at any level.²⁴ Ethics, by nature, is a discipline that lives in the grey areas and often has a range of options that may be ethically allowable depending on the unique aspects of each situation. This policy exemplifies that range of options which are detailed below:

Option A: If the patient is unstable, we will find a way to simply treat the patient.

Option B: If the patient is lacking capacity, we will attempt to utilize persuasion and/or negotiation, possibly by using family or other supports to be able to treat the patient. Those persons who are lacking in the ability to understand their behaviors cannot be held accountable.

Option C: When the request is ethically and clinically appropriate and when it may be possible to meet the patient request, we will attempt to accommodate the patient. Often, this is in the case of a request based upon religious reasons that requires a caregiver of the same gender, but, there may be other appropriate reasons to allow the request to be honored.

Option D: When a patient's behavior is disruptive, it may be necessary to discharge him or her. This is the only option that can result in the administrative discharge of a patient. This can only occur once it is determined that the patient is medically stable, has decision making capacity and is able to control their own behaviors, has been informed that their current behavior or requests directed towards hospital employees is unacceptable, and it is disruptive to routine hospital operations or disrespectful to staff. They must have been offered the option of transfer to another facility and if the behavior

23. See *supra* note 18 and accompanying text.

24. See *infra* Appendix 1 for an algorithm of the policy.

continues to occur without a plan for transfer, then the process for administrative discharge will be followed to remove the patient from the hospital.

Option E: This option is also for those patients who have capacity and have been informed of the policy and are given an opportunity to transfer to another facility or to change their behaviors. It is utilized when patients have voiced a desire to remain in our hospitals and are willing to alter their bias behaviors and accept the qualified care provider assigned to treat them. This option allows the initial provider to remain on the case if, after discussion, they decide that they would like to remain treating the patient. At times, there are those employees who will welcome an opportunity to change someone's bias perceptions. If the provider decides that *they* are still uncomfortable treating a patient who has expressed bias towards them and if an available switch can be made to any other provider (even another with the same personal characteristics), then a change may be made based upon a commitment to supporting the employee and their comfort level. After each outcome decision, an incident report ("RL") tracking form is to be completed to allow tracking requests and outcomes over time.

Given the multiple endpoints in the algorithm, one can imagine the struggle we faced in attempting to develop a method that communicates how to appropriately interact and respond to those patients who request a change in provider. Simply sharing the new policy and algorithm seemed unlikely to produce the desired outcomes. We initially searched for existing materials, videos, or interactive trainings to serve as models for disseminating this policy. However, we were unable to locate anything that we felt would support our policy in the way we were hoping. Therefore, we spent another eight months developing our own learning module. This included PowerPoint slides breaking down each step of the algorithm and a video clip (using scripts we developed and employees as our own actors) modeling the language we wanted leaders to use when addressing these patient/family situations. The learning module is now placed on our electronic based platform and reached by searching for "patient request to change provider" or may be assigned by a leader for completion. The policy and existence of the learning module was also shared in large groups of nursing forums, and leadership groups as well as an "Ethics for Lunch" lecture started in October 2019.

So, how has this policy rollout been going now that we are through 2020? Although we have a solid policy backed by our top levels of leadership that is aimed at providing support and protections for our workers in these situations, it has gone largely unused since its inception. Most employees are still unaware of the existence of the policy or the learning module. Like many

2021] YES, I WANT HELP, I JUST DO NOT WANT YOU! 155

other initiatives, the COVID-19 crisis has derailed most of the educational roll-out that we had hoped to achieve.²⁵ The political and social environment currently experienced across the nation has also prompted us to re-evaluate some of the scripts that we originally included in our training module. We are viewing our policy and training modules as ongoing works-in-progress and we hope to have a visionary final product to widely share with others seeking to make serious efforts to support diversity and eliminate bias against healthcare workers.

25. EMMA GARCÍA & ELAINE WEISS, COVID-19 AND STUDENT PERFORMANCE, EQUITY, AND U.S. EDUCATION POLICY, *ECON. POL'Y INST.*, 5 (Sept. 10, 2020), <https://files.epi.org/pdf/205622.pdf>.

APPENDIX 1

REQUESTS FOR REASSIGNMENT OF HEALTHCARE PROVIDERS ALGORITHM

Requests for Reassignment of Healthcare Providers Algorithm

