Case #2: Providing Care for a Patient Who is Racist?[1]

Analysis using the Ethics Discussion Guide

Asha Jain is the Continuing Care Assistant (CCA) assigned to Joe Cashin who has been admitted to the general medicine unit of the hospital for treatment of his uncontrolled congestive heart failure, hypertension and diabetes mellitus. When she walks into his room to get him set up to do his personal care he looks surprised, then glares and tells her to get out. She begins to explain that she is the CCA assigned to care for him today, but he cuts her off, yelling, "I don't care who you are, I'm not having any nigger touch me! You just sashay on outa here and tell them to send me in a real nurse! I know my rights!" She tries again, but he just gestures at her and turns over to face the wall. She goes in search of the charge nurse, Sandra, to explain what has happened and ask for guidance. Sandra says she will get one of the other CCA's (a Caucasian) to exchange assignments with Asha, an option that provides relief in the moment but leaves her feeling uncomfortable, as if nothing has really been resolved and also wondering if there is something "defective" about her or the care she provides. So at the end of the shift she finds Sandra again to chat about it further and ask if there is some other way to deal with this type of situation since she knows of other colleagues who have experienced similar discriminatory comments. Sandra has also been thinking about it since the incident happened; she fears that as staffing cutbacks continue and cultural diversity increases among staff and patients, this sort of situation may become more common. Sandra thinks maybe an ethics debriefing/education session about what the duty to care demands of staff might be in order for the staff on the unit. Asha readily agrees. Sandra puts in a call to the ethics line and leaves a detailed message about the situation and her request for follow-up. How will your committee respond?

1. Identify your baseline understandings/assumptions

- What is your understanding of the "duty to provide care"? How strong is this duty? Do you think is it possible to modify care to lessen potential risk to a health care provider, e.g., risk related to infection, physical safety/psychological harm?

---

[1] *This "demonstration" case is provided as an example of how you might work with/apply the ethics discussion guide. The analysis of issues related to the case is by no means exhaustive and will of course differ depending on the particular situation and those involved. However it is provided to illustrate for your learning purposes potential concerns/issues that may surface as the different steps are considered and worked through. All attributions of Asha, Joe, Susan and the health organization perspectives are fictional. As well, some of the questions for different parts of the discussion guide have been summarized or shortened as appropriate for the case and ease of demonstration.*

i. ***Duty to care****: professional obligation to address needs of a patient (and family) as they have been identified and as they fall within a health care provider's scope of practice and level of competency. From Asha's perspective, she sees this duty as her priority obligation as a CCA, the one that defines her professionally and therefore her primary motivator in the work context, the thing that enables her to think of herself as a "good" CCA.. She also believes good care demands that she respect her patients' preferences and values as much as possible. She has prided herself on being able to quickly establish excellent therapeutic relationships with her patients due to her caring, compassionate nature and good communication skills. In her eyes this is what allows her to understand her patients' values and preferences so she can respect them. To have the colour of her skin be the reason she is prevented from even beginning to establish such a relationship undermines her sense of professional worth and instills doubts about her competence. Sandra (charge nurse) views the duty to care in much the way. However, she also believes strongly that "peace" and harmony on the unit are an important part of healing and therefore part of her sense of her duty to care involves taking into consideration not only the needs of patients and families on the unit, but also the staff. While she abhors racism or indeed any sort of discrimination or harassment, she is unsure what "rights" Asha has in this situation and what "rights" the patient has. She wants to do the right thing for both, but feels stuck between respect for this patient's autonomy concerning care preferences and her instinct to protect Asha from his prejudiced and very psychologically destructive verbal attack. In the moment Sandra had thought it seemed best to rescue her from the situation since there was someone else to provide for Joe's care and the change could be accomplished with a minimum of disruption to everyone on the unit. However, this solution just seemed to be lacking something and Sandra feels as if the "elephant" in the room has not been adequately dealt with.*

ii. ***Possibility of mitigating the harm****: after removing Asha from the situation, both she and Sandra feel the harm to Asha has been mitigated; this response may also mitigate potential "harm" to Joe, the patient (whose vehement outburst indicates he feels quite distressed at the thought of having a non-Caucasian nurse care for him); in the long term though both Asha and Sandra are concerned about how to respond in future to this sort of demand and the risk for harm/distress—Asha because of its potential to undermine her*

personal and professional sense of worth (feelings she would like to address in a helpful way for herself and her colleagues in similar circumstances). Asha also thinks her employer (the health care organization) has some responsibility for making sure she can deliver care and be safe/free from discrimination while doing so.
Sandra recognizes that it might not always be possible to mitigate harm the way she did today (there might be no Caucasian nurse available to switch assignments); plus she feels this solution is inadequate and does not address the underlying issues, but she wonders whether the health care organization has an official position or policy and/or a protocol for this sort of issue. The incident today seems in her eyes to qualify as a sort of adverse event, and if so, should it be reported and what sort of support might she expect to help her address such situations more proactively in future (quality and safety concerns)? Is there a policy relevant to this sort of thing? She thinks the health care organization has some responsibility with respect to the "duty to care" in the sense of enabling appropriate conditions and support for those charged with delivering front line care.

- How do you understand the "duty to provide a safe work environment"? Who do you think is/should be responsible for this?
    i. ***Duty to provide a safe work environment****: health care providers have a right to feel safe when they are at work and this includes the expectation of a reasonable level of protection against injury or stress (physical or psychological) due to workplace hazards, violence, discrimination, bullying (by patients, families, colleagues, staff, or management) or unreasonable workloads. Asha thinks the organization and management are primarily responsible for ensuring that working conditions are conducive to the delivery to good care for patients. She acknowledges she has a part to play as well, in that she is expected to follow safety protocols, standards of professional practice, and refrain from doing things that will provoke or escalate potentially abusive behaviour by patients, family members, colleagues or staff members. But she is also sure that no one should have to tolerate racist or discriminatory treatment in their workplace so she believes that part of her and her employer's duty to ensure a safe work environment involves taking a strong stance against racism or discrimination in any form since both are a form of harassment. Sandra feels similarly although she worries about upsetting patients, particularly those who are elderly and have held racist views their whole lives in many cases.*

Still she is committed to supporting her nursing staff to be able to discharge their duty to care without having to accept verbal abuse or give in to discriminatory demands from patients or their family members. She wonders about the possibility that there are resources in place to address at least some aspects of the organization's and the health care provider's duty toward ensuring a safe work environment, i.e., what about OHSA legislation, the College of Nurses professional practice guidelines, or employers' obligations as outlined in the union contract?

- What is your role or position in the situation?
    - **i.** *Asha is personally involved as the health care provider assigned to care for Joe; Joe, the patient, is involved as the care recipient and also the one making the racist comments and demands; Sandra is involved as the charge nurse responsible for both Asha's and Joe's welfare as well as staff assignments*
- Is this more a clinical (individual provider/health care team) dilemma or organizational, or both?
    - **i.** *It is both.*

2. Clarify the issue(s), i.e., what is the nature of the dilemma/concern as it relates to these two duties?

- How are these two duties involved in the issue/problem you are facing?
    - i. *The two duties appear to be interrelated in some aspects and conflicting in others. The duty to care affects Asha as the health care provider, Sandra as the manager (charge nurse), and the organization (as overseer of the facility in which care is provided), and is therefore a factor at all levels. However, while Asha sees the duty to care as her primary obligation, she sees the duty to provide a safe work environment as the organization's primary obligation, and the two seem to be at odds currently in her estimation. She feels that the organization's duty to provide a safe work environment (free of discrimination and/or racism) is in tension with its concurrent duty to (provide) care (to the patient) via its nursing staff. She also feels her duty to care in this case is in tension with her duty to respect her patient's autonomy. Sandra, as manager/charge nurse, sees both duties as having implications at both the individual health care provider and the organizational level. Both Asha and Sandra wonder about whether there are ever any obligations incumbent on a patient when it comes to the duty to provide a safe work environment, or at the very*

least, not to knowingly make the environment unsafe. Does a patient have a responsibility to not make abusive, harassing, or racist comments?

- What potential "harm" or "risk" does the workplace environment impose for the health care provider in this situation? For the organization?
    i. *Potential harm or risk imposed by the workplace in this situation is two-fold: at the level of the health care provider there is potential psychological harm because the racist comments undermine her professional confidence and sense of self-worth and competency; at the organizational level there is liability risk which can impose financial harm due to lawsuits that could come from the patient (if his demands are not met) or from the health care provider (or her union)—such harms could be detrimental to other patients via opportunity cost and via loss of trust if the organization's reputation is damaged; at the patient's level (loss of trust, distress, potential health impact if leaves the hospital due to distress), also potential to distress other patients on the unit (hear the comments, feel tension, wonder about Asha's competence or feel badly for her, etc.).*
- What do you see as the main source of the tension between the duty to care and the duty to provide a safe work environment in this case? What issue(s) needs to be addressed in order to address this tension–can you describe it in a few words? Do/would others involved see the issue or question the same way? Why or why not?
    i. ***Main source of tension*** *- patient's expectation of receiving care according to his preferences and the professional and organizational obligation to provide care for the patient appropriate to his health needs v. health care provider's expectation regarding a (physically, psychologically, culturally) safe workplace environment and the organization's obligation to provide such.*
    ii. ***Issues that need to be addressed*** *- does the patient's right/expectation of care (as he envisions it) trump the health care provider's right to work in a (physically, psychologically, culturally) safe environment; how far does a patient's right to care go in a situation like this, i.e., what is a reasonable response by the health care provider, the manager, the organization when a patient makes discriminatory or racist remarks; do patients have any obligations connected to their rights/expectations related to receiving care; what factors, if any, might alter this situation and the response to it?*

- Do you think the individual provider's perspective, the organization's perspective, or both, should be the main focus? Why?
    - **i.** *Even though both perspectives are relevant, the focus needs to be on sorting out how to balance the two competing organizational obligations. If this is done, it will provide a framework or protocol to help guide the health care provider's and nurse manager's response in regard to their duty to care in the case of this patient.*
- Is there a decision to be made? If so, what is its scope? How urgent is it? Whose responsibility is it? If not, how is the issue to be addressed?
    - ***i.*** *A decision has already been made in this situation. The scope was narrow in the sense that it involved one provider and one patient/family. But the tension at the heart of this case is broad in scope because ultimately it is about the organization's duty to care juxtaposed with its duty to provide a safe work environment. Each health care provider's obligation to care for patients can be considered an extension of their employer's duty to care for patients seeking help at or being admitted to the hospital. So even though the issue may be viewed somewhat differently by those directly involved in the front line care delivery (patient, nurse, nurse manager), the essence of the tension arises mostly from the two duties as they co-exist at the organizational level.*
    - **ii.** *There is a sense of urgency when the situation is considered from the perspective of Joe and his particular care needs. However, these needs have been addressed for the time being, and the urgency now comes only from the perspective of how soon a similar scenario might appear or the possibility that at some point unit staff may not be able to switch care assignments.*
    - **i.** *If the organizational level is the prime focus, the "decision" to be made is more likely to be policy and/or protocol development at the organization's management level. There may also be a need for various professional practice organizations to consider this issue and develop guidelines for their members.*

3. **Consider who needs to be involved and what their perspectives are; i.e., who are the stakeholders (those who are most likely to be directly or indirectly impacted by or influential in this decision)?**
    - Who is/are the legitimate decision-maker(s)? What are his/her/their needs and concerns?

i. *When the focus is organizational, upper management (CEO or particular VPs, directors, representative of the Board of Directors) is likely to be the legitimate decision-maker. Their concerns may focus firstly on the legal requirements associated with their duty to provide care to members of the public seeking assistance from them, and then with their duty to employees with respect to a safe work environment. They will need to review any documents outlining these legalities including labour/union contracts, OHSA stipulations, Hospitals Act, and practice guidelines that govern the actions and expectations of certified/licenced professional front line care providers. They will likely need input from those more experienced in these aspects, e.g., union representatives, legal counsel/services, Dept of Health and Wellness representatives among others.*

- Who else should be part of the discussion? What are their values and interests?

  Minimally, consider the following when identifying stakeholders:

  i. *health care providers* - front line professionals directly involved in the delivery of one-on-one clinical care (assessment, diagnosis, treatment) and for whom the duty to care is a major factor in professional identity, e.g., MDs, RNs, LPNs, SWs, OT/PT, psychologists, spiritual care, patient advocates; also potentially affected by a work environment lacking in safety (physical, psychological, relational, cultural); in this case including Asha, the health care provider immediately impacted by the current situation, could be helpful; could also include one or more providers from other visible minority backgrounds
  ii. *patients and their intimate others/caregivers* - care seekers/recipients and those they view as family or providers of regular informal support, access to care may be affected by the decision; decision might also affect obligations in regard to health care providers
  iii. *middle management* - unit managers, service coordinators, professional practice coordinators
  iv. *staff* - non-professional support workers, e.g., lab and diagnostic services technicians, cleaners, those employed in the kitchen and/or cafeteria, orderlies, porters, secretarial/administrative support, security services, HR, accounting - decisions about workplace environment may impact them
  v. *others…?*

- What key values (personal, professional, and organizational) relate to each of the duties in this situation (remember to consider perspectives at both individual and organizational levels)? How are they the same or different for

each of the stakeholders? Remember that different stakeholders may view the same key value differently. Possible values (more are listed in Appendix B) to consider:

i. **urgency/need for care** - *health care providers tend to feel a heightened obligation re: duty to care (tolerate more risk for harm) when a patient's needs are more urgent and there is no one else available with necessary competencies; this is also made explicit in many professional practice guidelines; organizations support this as well, i.e., in acute situations there is more tolerance of risk to health care providers and greater expectation they will provide care despite increased risk; in this case there is some urgency for the care because Joe has serious health concerns, but these are being addressed for the time being, so urgency is not as high a priority value in this particular case; however, it may well be a factor in future cases and therefore needs to be considered in how such cases might be dealt with differently than those in which a patient's needs were not so urgent (life-threatening).*

ii. **justice** - *the goal of adapting care to patient's needs, i.e., treating like individuals in a like manner, and responding differently when needs are different in a morally significant way; justice as a value also pertains to how employees are treated and their expectation for "fair" or "just" treatment–in this case (and others with a similar theme) is it "just" to allow discrimination or racism to go unchallenged or to simply accede to care preferences that have a basis in discrimination? Notion of vulnerability also pertinent - individual or groups experiencing morally relevant disadvantage are considered to be more vulnerable/more at risk for harm; may place heightened demand on health care providers (such that more risk tolerated and viewed as acceptable, i.e., duty to care seen as outweighing right to work in a safe work environment); managers' concern when situations arise with racist or discriminatory patients (is the health care provider part of visible minority? Is the patient? What about gender discrimination, e.g., the patient who says she will not tolerate a male nurse helping to bathe or toilet her...); justice appears to be a relevant value in this case*

iii. **vulnerability/risk for harm** - a significant value at all levels: *from the patient's perspective (what harm may ensue if care demands are not met; how is patient vulnerability to be assessed–what factors should be considered, e.g., social determinants, illness severity, culture/ethnic background, social history, etc.; from the health care provider perspective - the risk/potential for harm to the healthcare provider is*

primarily psychological in such scenarios, but this type of distress can result in cumulative damage to professional identity, confidence, and self-esteem; it may impact how one is viewed by one's peers due to schedule and workload management issues; from the perspective of other staff members - if racist remarks or discriminatory demands to one employee go unchallenged morale and trust in the employer generally may be undermined; from the organizational perspective - potential for harm in terms of reputation, public trust, liability and/or opportunity costs, and their potential negative impact on other patients/families, staff members, health care providers, society

iv. **respect for persons/autonomy** – *a central value for much of Western health care and certainly in cases of this sort, i.e., patients' preferences related to care tend to dominate ethics and legal considerations even though from an ethical perspective this is just one value/prinicple among many; some degree of professional autonomy is also part of the health care provider's role; the organization has an obligation to help guide efforts aimed at balancing patients' and healthcare providers' autonomy; in cases like these where a racist patient requires (urgent) care, how might this balance be achieved?*

v. **duty to protect** - *concern for the wellbeing of patients/families, staff members, health professionals, society requires that all health care providers and the organization overall make appropriate efforts to mitigate known risks for harm.*

vi. **professionalism** - *cluster of values associated with fulfilling a professional role, e.g., altruism/service, competence, integrity, dependability/ trustworthiness, justice - a major value in health care provider perspective; may also figure in the organization's expectations of the health care provider in situations such as this case presents; part of the tension for Asha comes because of her strong association of this value with her sense of identity and self-worth which are at risk when she is unable to fulfill her role as she envisions it.*

vii. **good governance** - *cluster of values associated with fulfilling organizational mandate/obligations, e.g., accountability, justice, transparency, trustworthiness - a relevant value from the organization's perspective in this case, being able to achieve good governance here requires being able to provide well thought-out, clear, fair guidelines, protocols, and/or policies about expectations of health care providers, managers, and the organization in regard to responding to this sort of situation; to satisfy the value of good governance these guidelines*

need to achieve a good balance between expectations of care provision and safety (in its broadest sense) for all concerned.

viii. **mutual obligations** *- a value relevant to both the health care provider and the organization in these cases. Asha feels she has a responsibility to the patient, to herself, and also to the organization that employs her — her responsibility is to care well for the patients assigned to her, but not at the risk of significant harm to herself, and to be aware of and abide by any guidelines, protocols, and/or policies that are relevant to the sort of unsafe situation she has experienced with the patient. When such guidance is lacking she feels her duty to care implies a responsibility to bring the situation to the attention of her manager who in turn feels a need to bring it forward via the ethics committee or a legal challenge if all else fails. The organization's responsibility is to support Asha's efforts to fulfill her duty to care well for the patient and to not be at risk for undue psychological harm while doing so, i.e., via development of and education about guidelines, protocols, and/or policies and support to apply them appropriately when workplace safety breaches occur.*

ix. **See the list in Appendix B** for other values than may be pertinent

- Who may need support and how best to do this? Are there other supports or services (such as ethics consultation, legal/risk management, etc.) that would be helpful?

    i. *If the health care provider is included, she may be glad to have some sort of support. If a patient/family is included and holds very racist or discriminatory views, there may also be a need for support. Certainly the inclusion of legal services, risk management, seems logical.*

4. What is known about this issue/situation?

- What might help to understand it better? Are you aware of any information or resources that might be relevant to "duty to care" and/or "duty to provide a safe work environment"? i.e., policies, legislation, professional codes, etc.

    i. *These have been mentioned in previous steps.*

    ii. *Literature on this type of situation is relatively sparse. References for relevant articles are included at the end of this demonstration case. One of the key points in the literature is that an approach, such as the one Susan took in this situation, may be variously received by health care providers, such as Asha – is it supportive or not is a fundamental question that needs to be addressed by those involved. As well, evidence about possible improvements in health outcomes when there*

is racial concordance between the health care providers and patients (see Paul-Emile's article) raises challenging questions about how we approach and respond to these types of situations.

- Are there contextual, organizational, or interpersonal issues that may be adding to the complexity of the situation?
    i. **uncertainties** – are there crucial unanswered questions or ambiguities? Is there anything about this particular situation that adds to the inherent uncertainty, e.g., unknown infection–risk for spread, risk for morbidity and/or mortality? Can this uncertainty be lessened?
        1. *Crucial unanswered questions or ambiguities include: Are there any relevant institutional guidelines or policies that could help in this case? What are the mitigating circumstances, if any, to be considered when deciding how to respond to racist or discriminatory behaviour (verbal or physical) by a patient or a patient's family member? Is it different if the behaviour is by a colleague or staff member? On a spectrum of professional actions bounded on one end by the duty to care and the other by the duty to provide (and work in) a safe work environment, what factors influence what can reasonably be expected of a health care provider? In this particular case, how vulnerable is the patient and on what basis? How might it affect him to be told that each patient is assigned a competent health care provider and that staffing protocols do not permit patient choice on the basis of race, religion, gender, etc? How could the team assess this and how negative would the effect have to be before it would be reasonable to acquiesce to this patient's racist request for a change of health care provider? Also, in comparing this case to others such as when female patients ask for a female health care provider – are there any relevant differences? Why do we typically accommodate this request? Does this offer any insight into how we should approach this case?*

    ii. **setting of care** (risk for harm, safety, vulnerability, etc., associated with the particular care venue) - is there anything about the setting that increases vulnerability in this situation–for health care providers? patients? organization? Anyone else…? Can this be altered?
        1. *There appears to be nothing about this particular care setting that imposes undue risk for racism or discrimination, i.e., this risk is inherent in any setting where patients come seeking care from health care providers of varying races and ethnicities.*

From the patient's perspective it is his health care needs that increase his vulnerability (and potentially his personal history and social location). None of this is alterable in the short-term and perhaps not ever.

iii. **constraints and facilitators**, e.g., what economic, legal, policy, organizational, clinical, personal, and/or professional factors , e.g., labour laws and policies, if any, are applicable in this situation? What about professional certification/disciplinary requirements? Is there anything that provides guidance for some aspect of the situation?

1. *There are definitely numerous facilitators to aid deliberations in this case–legal ones such as the Canadian Charter of Rights and Freedoms, labour laws such as Occupational Health and Safety Act (federal and provincial), policies on Workplace Employee Hazards and Incidents–Reporting, Investigation, and Documentation***;** *healthy workplace and safety policies, professional code of ethics; union and employment contract stipulations; ±organizational policies if any exist; statements from professional organizations such as the NS College of Nurses; guidelines from groups like the Human Rights Commission*
2. *Possible constraints include respect for patient autonomy, employment contract requirement, staffing levels, economic concerns/limitations–also liability concerns (financial cost)*

- Who has "power" in this situation; who does not? Is this a relevant consideration in this case?

i. *Power understood in its traditional sense resides with the organization because it is the employer and therefore has the authority to fire the health care provider; the organization is also in a position to develop and enforce guidelines, protocols, and/or policies in relation to this issue. The patient, although vulnerable and dependent for care, also has some power in this situation as is evident from the immediate response to accede to his demands for a change of caregiver. However, part of this case revolves around how best to balance the "power" of the various players/roles. The manager also has power in the sense of how to respond to Asha's experience–ignore it, accede to the patient's demands and leave it at that, or bring the issue forward and support Asha in challenging the status quo. Power therefore appears to be an important factor in this case.*

- What resources, if any, are needed or what do you think might help? What resources, if any, are available to ease the situation and for whom?
    - **i.** *This is a case that would be helped significantly by identifying and exploring relevant resources. Have any other organizations grappled with this issue, and if so, what was the outcome? Who might be able to shed more light on the relevant issues to consider–labour lawyer, professional practice representative(s), human rights lawyers, etc? What documents or communications exist to provide additional background and enhance insight about this issue (see also Appendix D for a bibliography that may help)? Resources related to the duty to care from both the health care provider and the organizational perspective would be helpful. So too would be anything related to the duty to provide a safe work environment as this pertains to cultural and psychological safety; resources related to the nature, risk, prevention, and treatment of negative effects from racism and discrimination for targeted individuals, for their employers, for others seeking or giving care in the facility.*
- Do you need to gather any additional information before continuing?
    - **i.** *Clearly there is a need to gather the above identified resources, as possible.*

5. Reflect and contemplate

- Consider potential similarities and differences between the perspectives on these two duties and the associated values for those involved in the situation (See Appendix C for examples). What might account for these differences?

Note: You can use the following table to track your thoughts concerning key values associated with each of the duties and the different perspectives (Asha, Susan, the health organization, etc.).

For example:

Perspective	Duty to Care	Safe Work Environment
Asha	professionalism, justice, respect for persons/ autonomy; urgency/ need for care; trust; non-maleficence	mutual obligation; personal vulnerability/risk for harm; advocacy
Susan	professionalism, justice, "peace" on the unit,	duty to protect and care for both patients and

	respect for persons/ autonomy; urgency/ need for care; trust	staff; vulnerability/risk for harm; trust
Health organization	mutual obligation; justice; urgency/need for care; respect for persons /autonomy; trust	good governance; vulnerability/risk for harm; justice; duty to protect; non-maleficence; trust

- **Summary** - even though many values are "shared," the stakeholders – Asha, Susan, and the health organization - put different emphases on them depending on which duty and which "agent" are under consideration. It can also be argued that the patient's perspective should be included as part of this discussion and analysis – accordingly, this could be added to the above table too.
    i. *urgency/need for care* - shared value, focus for everyone seems to be the patient
    ii. *respect for persons/autonomy* - although all see the need to respect the patient's autonomy (care preferences), the health care provider values her own professional autonomy (being able to exercise her professional expertise and judgment) as well; organizational representatives may prefer to err on the side of the patient's autonomy rather than the care provider's unless there is significant benefit for them to do otherwise
    iii. *vulnerability/risk for harm* - risk for harm *to the patient* is a concern for both health care providers and the organization; risk *to Asha's* sense of professional worth and overall wellbeing holds more importance for the health care provider herself; risk *to the organization* viewed in terms of legal liability (financial and opportunity costs), potential loss of reputation and trust with both employees and patients; harm has already happened for the health care provider, but is still "potential" for organization (more uncertainty on this level, but potential "cost" more tangible)
    iv. *non-maleficence* - Asha sees this as part of professional clinical identity, i.e., do no harm to *this or any patient*; organization sees it from level of *this patient but also all patients* depending on the cost of the response to the organization; Asha and Susan are also concerned to prevent future harm to *themselves and other health care providers* or staff members; harm viewed differently as well, i.e., health care provider feels the psychological harm from the patient's demands and potentially from the organization if nothing put in place to deal with this

sort of issue in future (feels not valued by her employer), whereas organization sees harm in terms of patient being upset about care provider, not receiving care he wants and needs, care provider being upset by patient's words and potentially able to hold the organization accountable in some way.

v. *justice - health care provider-oriented view* sees justice in terms of how the organization will respond (or not) to the wrong (racist remarks) perpetrated against her by the patient, whereas the *patient-oriented view* sees justice in terms of being entitled to be cared for by a health care provider of Caucasian descent; *organization-oriented view* sees justice in terms of trying to provide needed care for the patient in a way that is acceptable to him and that does not contravene accepted human rights standards related to non-discrimination and workplace safety broadly understood

vi. *trust* - (one aspect of vulnerability, i.e., trustworthiness is never assured) all stakeholders see it as an important value, but understand it differently depending on the particular trust relationship - patient needs to trust in the organization as "caregiver" (duty to care, justice, respect for autonomy; non-maleficence, duty to protect); health care provider needs to trust in the organization's integrity as employer (good governance, justice, duty to provide a safe work environment, duty to protect) and also as supportive and supervisor of care for patients; patient and organization place trust in the health care provider to deliver competent timely care; patient and health care provider and organization all trust in unit/nurse manager to make appropriate decisions regarding staffing and care provision; trust may be affected for different agents depending on the ultimate decision made in regard to this situation (does it focus more on patient rights, health care provider safety, organizational outcomes?)

vii. *professionalism* - values such as altruism, respect for persons, honesty, competency are central to the health care provider's sense of herself as clinician, whereas dependability, reputation, good governance, are primary focus for the organization in this situation

viii. *advocacy* – Asha's focus may be to advocate for justice/safe work environment on behalf of herself and any colleagues/staff members vulnerable to racist or discriminatory treatment from patients or their family members

ix. *duty to protect* - organization has patients', employees', and self-interest as focus whereas health care provider has her own and her patient's wellbeing (which are somewhat at odds in this situation), as well as that of others who are vulnerable to discrimination

- How do these various perspectives influence and shape what you think?
    - **i.** urgency/need for care - *because the patient is at the heart of the health care endeavour and how badly s/he needs care as well as the sort of care required determines to a large degree who can respond (what expertise is required) and how quickly; important from both health care provider and organization perspective; agree on this*
    - **ii.** vulnerability/risk for harm - *the nature of the risks and for whom is a big part of tension, i.e., how much distress is patient experiencing if his request is refused? What liability exists for the organization if it does not support health care provider? If it does not support the patient? Is psychological or cultural safety as important as physical safety? The nature of "harm" beyond physical understandings, e.g., risk for cultural and/or psychological harm, has not been a prominent focus in workplace safety considerations to date – this case provides an opportunity to deepen and broaden the discussion*
    - **iii.** respect for persons/autonomy - *always a central value in health care, but not often explored in terms of patient autonomy versus professional autonomy and how to decide when to emphasize one over the other*
    - **iv.** justice - *an important consideration from human rights, ethical, and legal perspectives; figuring out how to maximize justice for all the agents is at the crux of the question of how to balance the two duties*
- Take time to explore the relevant values. Are people “on the same page” in terms of how they understand the key values identified and in particular how they may apply in terms of the duty to care and the duty to provide a safe work environment?
    - **i.** *Getting consensus on what the key values are and how to prioritize them in this case is difficult, but for the most part everyone is on the same page as far as the overall goal is concerned, i.e., finding a way to balance the duty to care with the duty to provide a safe work environment that includes being "safe" from racist or discriminatory remarks or behaviour. Values that all have agreed are important include: urgency/need for care, vulnerability/ risk for harm; and justice.*
- What factors affect your weighting of the values related to each duty as these apply to the differing perspectives, e.g., does "urgency/need for care" outweigh values related to "vulnerability/risk for harm"? When, if ever, could you see this not being the case?

i. *Yes, the patient's need for care seems to outweigh the risk for harm to the caregiver in this case in the moment, but if the risk was related to physical violence rather than psychological and it was significant, this balance would shift.. The lack of attention to risk for psychological and cultural harm to caregivers that is inherent in racist/discriminatory/ abusive comments or behaviour by patients (or their family members) heightens the weight of value put on the duty to provide a safe work environment (when viewed from the individual health care provider perspective). It is weighted heavily by the organization as well because of the potential high cost of resulting labour/union conflicts and possible damage to the organization's reputation as an employer. Civil rights abuses can be very damaging. On the other side, the potential cost of "refusing" to provide care to a patient who is clearly quite ill and in need of this care can also be costly in terms of litigation and reputation as a health care institution. Sorting out which of these costs is likely to be greater will help sort out which value/duty is weighted more heavily by the organization (at least in this respect). Solutions need to provide some criteria for how both need for care and risk for harm are weighed. In particular, this case highlights a much broader issue that needs to be addressed by the organization in terms of care and safety overall.*

- What are some possible approaches/options for addressing this situation? Describe each approach and consider what values and principles support and/or conflict for each one.

  Possible approaches:

  1. doing nothing other than what has already been done, i.e., continue to make patient assignments that ensure Caucasian care providers are on duty for Joe

  2. develop a "patient's charter of rights and responsibilities" (this could include the responsibility to act and speak in non-discriminatory, non-racist, and non-abusive ways) - seek to have this charter adopted by the organization and posted on the website and prominently in ED, lobbies and elevators of care facilities; include in information given to patients/families at time of admission

  3. return to regular assignment roster and meet with Joe to explain this and the hospital's philosophy of care, outline his options given that Asha will occasionally be assigned to care for him

4. meet with Joe to advocate on Asha's behalf - outline her credentials and experience, seek his agreement to have her provide his care when assignments work out this way

5. recommend changes at the policy level in the organization; also at professional licensing body; have Asha (and one or more colleagues) participate in this process

6. establish a sub-group of the Safety Committee - interested individuals to explore responses in other jurisdictions locally, nationally, internationally - incorporate the most relevant and helpful aspects of these to develop guidelines on philosophy of care and guidelines for applying them when safety issues arise; educate/work with staff to enhance capacity to respond more appropriately to situations like this when they arise

i. Does the option balance the duty to provide care with the duty to provide a safe work environment, or is one duty favoured over the other? If so, why, i.e., what is the justification?

1. *doing nothing other than what has already been done* - privileges duty to care over duty to provide a safe work environment; privileges patient's autonomy and need for care over employee's risk for harm and professional autonomy; justification is it is relatively easy to do for now and circumvents any confrontations with the patient and possible legal repercussions from him
2. *develop a "patient's charter of rights and responsibilities"* - privileges duty to provide a safe work environment over duty to care; privileges employee safety over patient autonomy; justification - justice concerns; also alarming increases in numbers of assaults and safety violations against health care providers and how many are off on stress leave or struggling with burnout/compassion fatigue highlights a pressing need for health care organizations to find ways of preventing and responding to it (in all its forms) more adequately; increasing cultural diversity in both patient and employee populations will lead to potential increase in this sort of situation and therefore a need to respond to the justice and human rights aspects of workplace "safety".
3. *return to regular assignment roster and meet with Joe to explain the hospital's philosophy of care and the implications for him and discuss his options* - as in #2, but this also requires sufficient effort is put into developing and writing down the

"philosophy of care" which needs to include something about mutual care and safety obligations (patient, family, health care providers, organization)

4. *meet with Joe to point out Asha's credentials and expertise and advocate on her behalf* - attends to both duties, i.e., duty to care by letting Joe know his concerns have been heard and not dismissed, while also letting Asha know that those above her value her professionally and personally; somewhat favours duty to care over the duty to provide a safe work environment because this sort of advocacy/intervention is not the norm – i.e., other patients do not have anyone coming in to "sell" them on the merits of the health care provider assigned to them; may seem somewhat paternalistic to Asha (to have to have someone "sell" her expertise to a patient); justification - may solve the problem with a minimum of fuss, but does little to prepare or build capacity for future situations of this sort.
5. *recommend changes at the policy level*, i.e., develop clear policies and protocols covering this aspect of workplace safety and health care providers' duty to care - in this sense it attends to both duties and is a likely goal no matter what other decision is/is not made; justification - provides guidance for handling future dilemmas of this sort.
6. *establish an ad hoc sub-group of Safety Committee to work on policy and protocol development with the goal of establishing a clear and systematic response to issues of this nature according to an established timeline* - attends to both duties; justification - clear goal, dedicated group to study the problem in depth, not react in knee-jerk fashion, benefit from research into others' experience and ideas, more likely to address various nuances of the issue

ii. What are the potential benefits (what are the likely positive outcomes, for whom and how) and burdens (what are the likely harms, for whom and how) of each approach? How are these distributed? (Remember to include “doing nothing or maintaining the status quo” as one of the approaches to assess.)

1. *doing nothing other than what has already been done* - <u>benefits</u>: less distress for patient; <u>burdens</u>: more distress for Asha and nurse manager and potentially for organization depending on what course of action Asha decides to follow; potentially more burden for colleagues whose schedules have to change to

accommodate patient's demands; also capacity for handling future situations of this sort not enhanced in any way

2. *develop a "patient's charter of rights and responsibilities"* - benefits: potentially for Asha, nurse manager, organization in the sense of feeling they have tried to do something about the issue, but not likely to change anything unless there are consequences spelled out for violating the charter; burdens: for patient whose care preferences not as likely to be honoured if contrary to the charter (if charter enforced); stress for those (providers/organization) tasked with enforcing it.
3. *return to regular assignment roster and meet with Joe to explain the hospital's philosophy of care, implications for him, and his options, ensuring his most urgent care needs are addressed* - benefits: for Asha who feels heard, supported and valued; for nurse manager who feels she has responded to protect a staff member from harm; for the patient whose most urgent health care needs are taken care of as well as possible in the circumstances; burdens: for the patient whose preferences no longer are being honoured; potentially for nurse manager and organization depending on what option (going to the media, initiating a lawsuit or doing nothing) patient chooses to pursue; for the organization and staff whose capacity for future situations not really changed.
4. *meet with Joe to advocate on Asha's behalf* - benefits: for Asha because a superior is responding to her needs and acknowledging the harm done to her; possibly for the patient whose cultural horizons may be broadened if he agrees to be cared for by Asha; burdens: for Asha whose self-esteem may suffer by having to have a superior intervene on her behalf with a patient; for the patient who may feel pressured to accept care he finds distressing; for the nurse manager who may find such confrontations distressing; the organization which may bear an increased cost depending on how the patient reacts.
5. *recommend changes at the policy level* - benefits: relatively straightforward response that puts the onus on the organization which, if it follows through, will increase its capacity for response to these issues; also decreased potential for distress for health care providers who will have set standards to guide response; if policy implications publicized adequately, patients and employees may have more realistic expectations and thus decrease likelihood of such situations arising; burdens: stressful

for those tasked with developing the policy due to the breadth and complexity of these issues and expectations on them to produce something useful and balanced, i.e., re: the two duties as well as the various players involved; possibly stressful for patients/families and/or employees due to increased expectations in this regard, which may feel more onerous for having been made more explicit.

6. *establish an ad hoc sub-group of Safety Committee to work on policy and protocol development with the goal of establishing a clear and systematic response to issues of this nature according to an agreed upon, finite timeline* - <u>benefits</u>: increased capacity in the organization to handle these issues; enhanced capacity to justify responses in individual cases because there is a standardized approach/criteria; employees' trust in the employer may be enhanced if the policy and protocol balanced and enforced; may have positive impact on frequency of staff stress leave/burnout which in turn can positively impact the organization's ability to provide care for all patients; <u>burdens</u>: as in #5 for those named to this committee; for anyone (patients/families, employees, colleagues, etc) exhibiting racist or discriminatory or abusive behaviour if policy and protocol balanced and enforced.

iii. Are you considering any "out of the box" ideas? Addressing tension between the duty to care and the duty to provide a safe work environment may require a new or "one off" approach.

1. *None of the ideas suggested are very radical or "out of the box". If a sub-committee is established this may be the venue for some more imaginative thinking especially if the literature review and interaction with other health care jurisdictions provide additional ideas for creative solutions.*

- How does this situation compare to others you have experienced or heard of? What gaps, if any, still exist in your understanding of the situation? Is there any relevant ethics, health care, labour-related, or other literature that might enhance your understanding or consideration of the situation?

i. *The situation is slightly reminiscent of those in which a patient inflicts physical harm on a health care provider. In such cases we tend to respond more quickly and there are clearer guidelines set out by labour legislation and union contracts. So how does this situation relate to other workplace "safety" concerns, or does it, i.e., risk for harm via violence by a patient with capacity - would there be a different type or*

degree of response if Joe was physically assaulting Asha as opposed to verbally assaulting her? Seems as if there are still lots of gaps, so more research would be helpful especially finding out how other jurisdictions have handled or approached this sort of issue.

6. Make a decision

In this case, several options are selected:

In the short-term, support nurse manager to return to the unit's regular assignment roster and meet with Joe to explain the hospital's philosophy of care, the implications for him, and his options, ensuring his most urgent care needs can be safely addressed.

For the long-term, establish an ad hoc sub-group of Safety Committee to work on policy and protocol development with the goal of establishing a clear and systematic response to issues of this nature according to an agreed upon, finite timeline. Part of this work would include the development of the organization's philosophy of care and the "patient's charter of rights and responsibilities." Broad stakeholder input to be solicited as part of the process of policy and protocol development and evaluation.

- Why is this approach the best or most appropriate one in terms of balancing the duty to care with the duty to provide a safe work environment? Can you explain it to others? Is it something you "can live with," all things considered? Would you be comfortable to see it or your justification of it in the newspaper or on the broadcast news?
    - ***i.*** *This approach, by addressing the immediate situation as well as long-term responsiveness to related future situations, seems to balance the many competing needs, e.g., this patient versus all unit patients, Asha, nurse manager, health care team members, and the organization. It ensures that workplace "safety" is about more than risk for physical harm, which may over the long-term help to improve statistics related to stress leave and professional burnout. This type of positive outcome can in turn improve organizational capacity to care for patients overall. It is explainable to others provided some parameters are set around the ad hoc committee, i.e., clearly articulated and publicized goals for content and process. It is something we can "live with" and are comfortable to see published by the media.*
- Is this decision precedent-setting or establishing a change in practice related to the duty to care and/or the duty to provide a safe work environment? If so, what are the implications—for patients/intimate others, health care providers, staff, management, the organization, professional associations, others…?

i. *It may establish a change in practice depending on what the ad hoc committee develops with respect to policy and protocol. The potential seems good that some precedent will be set because of the broadening of the concept of "safety" so that risks for psychological or cultural harm are taken as seriously as risk for physical harm when these pertain to the workplace environment.*

7. Move forward

- Describe your plan for implementing your decision(s). Who needs to hear the decision(s)? Who will/may be affected by it? Who will communicate it and how? Is there an established timeline for this communication?

i. Plan*: meet with nurse manager and Asha to explain the recommendations for the immediate situation and the goal for the longer-term development of a more comprehensive, balanced policy and protocol to handle these sort of situations as they arise in future. Part of the protocol will involve the articulation of the organization's "philosophy of care" and a "patient's charter of rights and responsibilities", both of which will require broad stakeholder input and a well thought-out publication strategy. Consult with Asha and nurse manager about suggestions regarding key stakeholders to be part of the policy and protocol development.*

ii. Who needs to hear about the decision:

1. *Asha - to hear the result of the consultation and the plan for going forward; to solicit her input in regards to identifying key stakeholders; to know her concerns have been heard and the needs acted upon; to assure her of good governance at least this far into the issue*
2. *Nurse manager - to have clear guidelines for how to respond to this patient regarding who will provide his care and why, Asha regarding the care of this patient, the team regarding the unit's staffing schedule going forward*
3. *Upper management - to establish the ad hoc committee and establish terms of reference, goals, and timeline*

iii. Who will communicate it?

1. *Ethics consultation group involved in this process to date will with Asha and nurse manager concerning the short-term decision to return to regular staff schedule now that the patient's most urgent needs have been addressed. Support for*

the nurse manager to meet with the patient to explain that the organization's philosophy of care and a safe work environment does not permit staff assignments on the basis of race or religion and what the patient's options are now. Following this the group will report to the Safety Committee and relevant VP to discuss the long-term plan for policy development. This part of the plan to be communicated to Asha and nurse manager once agreed to by upper management.

iv. Established timeline for the communication

1. *Ethics consultation group meeting with Asha and nurse manager to happen as soon as possible. Report to be sent to Safety Committee once the meeting with the relevant VP has taken place.*

- Is there a plan for evaluating and following up on the outcome(s) of the decision(s)?
    i. *Plan to have a rep on ad hoc committee to take part in and monitor the process as it moves forward. Have various stakeholders submit example scenarios for the group to work through using the policy and protocol as developed. Put in place a process to solicit feedback whenever the policy and/or protocol are applied to situations arising in the workplace. Include key dates for the organizational ethics committee to request up-dates from group(s) working on developing the policy and protocol.*
- Is there any "residue" from the situation that needs to be considered or acted upon? Is an ethics "debriefing" indicated in this case, or would it perhaps be helpful as a way to address lingering concerns/residue or to promote further learning and capacity building?
    i. *Residue likely for Asha and possibly nurse manager who may have had to deal with this type of situation or others like it in the past. May be helpful to have a team debriefing as other members are also affected by scheduling changes, so offering such a service is indicated. Invite feedback from team members who may have insights or experience related to the issue.*
- Were there any broad policy or organizational issues raised that warrant further investigation or that need to be shared or followed up with others in the health care organization? Were there any gaps identified related to practices or policies concerning the duty to care or the duty to provide a safe work environment? If so, how will you address these gaps?

    i. *The whole scenario is about a major gap in policy; the plan addresses this gap.*
- Is there anything you want to retain or change based on this process for next time? What learnings have come out of this process that could enhance capacity for and/or enrich and strengthen similar analyses in future?

Related readings:

Racism and racial preferences in health care

DoktorMo. (2004). A bioethical dilemma – Complying with patient's request regarding racial preference. (Online source)

Selby M. (1999). Dealing with racist patients. *BMJ* 318, 1129-1131.

Guanaratnam Y. (2001). 'We mustn't judge people...but': Staff dilemmas in dealing with racial harassment amongst hospice service users. *Sociology of Health & Illness* 23(1), 65-84.

Jonson H. (2007). Is it racism? Skepticism and resistance towards ethnic minority care workers among older care recipients. *Journal of Gerontological Social Work* 49(4), 79-96.

McGibbon EA, Etowa J. (2009). *Anti-racist health care practice*. Toronto: Canadian Scholars' Press.

Paul-Emile, K. (2012). Patients' racial preferences and the medical culture of accommodation. *UCLA* 60 Rev. 462.

Stevens M, Hussein S, Manthorpe J. (2012). Experiences of racism and discrimination among migrant care workers in England: Findings from a mixed-methods research project. *Ethnic and Racial Studies* 35(2), 259-280.