

University of San Diego

Digital USD

Center for Health Law Policy and Bioethics

Law School Centers

2020

Empowering the Minority Healthcare Worker Amidst Racial Patient Bias & COVID-19

Rachel Tran

Follow this and additional works at: https://digital.sandiego.edu/law_chlb_research_scholarship



Part of the [Health Law and Policy Commons](#)

Digital USD Citation

Tran, Rachel, "Empowering the Minority Healthcare Worker Amidst Racial Patient Bias & COVID-19" (2020). *Center for Health Law Policy and Bioethics*. 73.

https://digital.sandiego.edu/law_chlb_research_scholarship/73

This Article is brought to you for free and open access by the Law School Centers at Digital USD. It has been accepted for inclusion in Center for Health Law Policy and Bioethics by an authorized administrator of Digital USD. For more information, please contact digital@sandiego.edu.

Empowering the Minority Healthcare Worker Amidst Racial Patient Bias & COVID-19

By: Rachel Tran

Abstract

While the discussion surrounding implicit physician bias has become more prevalent, patient bias is often overlooked. For decades, the United States' healthcare system has normalized accommodation of patients' racially biased requests, providing little to no support for minority healthcare workers. This paper presents social, ethical, and legal arguments for the creation of effective patient bias policies while challenging traditional barriers to implementation. It also advances a guideline of recommendations for healthcare institutions, civil rights organizations, and governments to draw from. These recommendations include the right to turn away patients who repeatedly discriminate against healthcare professionals.

Keywords: minority healthcare worker, racial patient bias, patient bias policies, racially biased requests, COVID-19, discriminate against healthcare professionals

1. Introduction

“Why are you Chinese people killing everyone? What is wrong with you? Why the f*** are you killing us?” Lucy Li, an anesthesia resident doctor, had just spent her day caring for high-risk COVID-19 patients when a man followed her down a city block, harassing her with racial slurs (1). Such situations have only escalated with the current pandemic. Patients have spat on Asian nurses, refused healthcare from those with “Asian appearances,” and labeled them “bat-eaters” (2). Over a third of the United States healthcare force is composed of racial minorities (3). Yet, little has been done to help these individuals making great sacrifices on the frontlines of the pandemic.

The United States' healthcare system has normalized the accommodation of patients' racially discriminatory requests for too long--failing to fulfill important social, ethical, and legal obligations. Though some believe “accommodation of patients' racial preferences in the hospital setting [do] not appear to adversely affect physicians by race,” the truth is that minority healthcare providers “are often silent about their experiences with racism...Majority providers, when they witness such acts, often fail to intercede on their colleague's behalf” (4-5). When Uche Blackstock became a physician, as a black woman, she repeatedly experienced “horrible and humiliating” racial slurs by dismissive patients (6). In a 2017 survey of over 1000 healthcare workers, 22% of physicians reported patients had requested a different caretaker due to their race and 32% due to their ethnicity (7). African-American (70%) and Asian doctors (69%) were more likely to hear biased comments from patients (8). Healthcare professionals deserve to work without feeling helpless or isolated by their employers. Though some institutions are making

policy changes, many more need to implement effective policies addressing patient bias and empowering minority healthcare workers.

2. Harmful Effects of Patient Bias

2.1 Social Analysis

Healthcare professionals already face an epidemic of burnout in the United States, and accommodating patient bias exacerbates the problem. A recent study involving physicians of color revealed a high correlation between racial microaggressions at work and symptoms of secondary traumatic stress (9). 23% percent of participants in the study experienced patients “refusing their care specifically due to their race.” Doctors admit honoring requests for white physicians “seems to affirm the legitimacy of racist views” and implies the minority worker is “inferior” to her white colleagues (10). These degrading racial implications are further magnified in the context of COVID-19, sometimes referred to as “Kung Flu” or “the Chinese virus” (2). One ethnic studies professor called the harassment of Asian physicians and nurses during COVID-19 “an additional level of trauma, anxiety, and stress that we don’t need to place on them” (11). Burnout leads to multiple problems, including depersonalization, poor job performance, cognitive impairment, substance abuse, absenteeism, and thoughts of quitting (12-14). Consequently, the quality of medical care declines. In a 2020 survey, 42% of physicians reported feeling burned out (15). 22% cited “feeling like a cog in the wheel” as the top contributor to burnout, 24% cited “lack of control,” and 17% cited “lack of respect from patients.” In the context of COVID-19, healthcare professionals already face heightened risk of PTSD or burnout everyday due to worry of potentially infecting their loved ones, shortage of PPE, and other burdensome issues (16). Effective policies must address healthcare workers’ concerns. Continuing the accommodation of racist requests, especially in a pandemic, is impractical because it negatively impacts healthcare professionals.

The healthcare system and society, in turn, suffers. When the quality of healthcare declines, so does the individual’s health--the last thing a country needs in the middle of a pandemic. Even though the United States is a first-world country with an advanced economy, it ranks near the bottom in terms of efficient healthcare spending. Burnout in healthcare costs the United States approximately \$4.6 billion annually, and increasing healthcare costs only makes access even more challenging for the average American (17). Moreover, the continued accommodation of racially discriminatory requests fuels the idea that the “Other” spreads disease. For instance, throughout history, discourse such as “Spanish flu” and “Mexican swine flu” were used to stigmatize immigrants (18). This ideology is dangerous for healthcare workers who may be shunned or attacked, but also for the average American citizen. People may falsely believe they will not contract the illness as long as they avoid interacting with certain racial groups or only receive care from healthcare providers of a certain race.

2.2 Ethical Analysis

Accommodation of racial patient bias is simply immoral and unethical. Acceptance of a patient's racist requests is no different than acceptance of systematic racism, or of racial minorities' "otherness." By accommodating biased requests, the healthcare system perpetuates the majority's privilege, while the victim (and eventually society) are left to deal with the consequences. Health professionals study, research, train, and practice for many years to help others. Critiquing poor performance from an employee is valid, but discriminating against one is not. Moreover, the very idea that minority healthcare professionals lack the capability of serving the white majority is questionable. Ample literature contains evidence of racial inequities in healthcare delivery, favoring the white patient. One 2018 study analyzed over 4000 images in textbooks, assigned at top medical schools, and found an overrepresentation of light skin tone (74.5%), while only 4.5% of the images showed dark skin tones (19). Researchers concluded "racial minorities are still often absent at the topic level. These omissions may provide one route through which bias enters medical treatment." That is, medical education itself reflects white dominance. However, the healthcare system *and* its customers are composed of all kinds of racial groups; to further ostracize racial minorities, in practice settings, is to create more ethical conflict.

3. Barriers to Drafting Patient Bias Policies

3.1 Prioritizing the patient, always

One of the most common misconceptions is that the Hippocratic Oath bars physicians from turning anyone away. First, both the original as well as the modern Oath begin by prefacing the physician will perform "according to [her] ability and judgment" and "to the best of [her] ability and judgment" respectively (20). In other words, physicians can only follow the oath to the best of their capabilities, which can surely fluctuate when dealing with racially tense situations. Medicine requires a therapeutic connection, and hateful patient bias injures that bond (7). Secondly, a number of issues mar the practice of healthcare, but are left unmentioned in the Hippocratic Oath. For example, the Oath says nothing about physician bias or avoiding conflicts of interest such as profiting by ordering pricier prescriptions (21). This silence does not mean such issues are nonexistent or non-problematic in the real world.

Aside from the Oath, some simply argue patient care takes priority over personal morals, social activism, or politics. However, the very idea of separating healthcare from its multiple implications is unrealistic for three reasons. First, in the United States, healthcare is essentially a business. There are CEO's, stakeholders, clients, deals, and all kinds of transactions. Healthcare workers have a unique position in society due to their skillset, but they are still employees and human beings with rights. Secondly, social and political issues already permeate the practice of healthcare. Abortions, vaccines, transgender healthcare, and other issues are intertwined with politics, law, or society. Lastly, if one argues healthcare institutions are not the place for social issues or politics, then one should simultaneously argue patients should avoid expressing racial biases when entering, in the first place.

Another concern is the complete transfer of power or autonomy from the patient to the healthcare worker, but this situation is highly unlikely. Patients are still able to express valid concerns about workers' performance. The purpose of policies addressing racial patient bias is simply to minimize discrimination against employees. In addition, by bringing in a neutral party or ethics consultant and documenting the entire incident, such situations can be minimized. Even without a consultant on-call, training can help workers learn when they can or cannot turn a patient down. Employees who appear to abuse this policy should be investigated by their employers or law enforcement. Patients receive a warning when they first engage in discriminatory behavior, and are not turned away outright unless they refuse care for a second time. Unstable patients are still treated first and foremost.

3.2 Failure to acknowledge nuance

Healthcare institutions performing diversity workshops once a year cannot be the extent of support for minority workers. In the American Medical Association Journal of Ethics, one article noted "it is virtually useless to sponsor yearly cultural competence or diversity trainings, which do little, if anything, to address racism, power, and privilege on the interpersonal or institutional levels *in the absence* of concerted, ongoing organizational commitment" (22). Other methods such as diversity training, recording systems, and reporting to law enforcement are somewhat helpful, but lack significant impact; these methods do not give the employee any agency or defense in the heat of the moment, nor do they force employers to stand in solidarity with their workers consistently.

Some institutions may permit all racially biased accommodations on the basis that patients and healthcare professionals will have more successful interactions when they are the same race. For example, a Native American patient may feel better understood with a Native American nurse than with an Asian nurse. This paper does not discourage such requests. There are certainly benefits to reassignment on the basis of shared heritage, such as better communication, care, and cultural understanding (4). The situation only becomes ethically and legally problematic when the patient degrades the employee and considers them inferior, especially to their white counterpart. For example, a case where a Native American patient requests a Native American physician is justifiable on the basis of shared, unique culture. A case where an elderly Jewish patient requests a non-German surgeon is justifiable on the basis of traumatic, historical power dynamics. However, a case where a white patient refuses healthcare from an African American on the basis of racism and supremacy is not justifiable. A case where any patient refuses healthcare from an Asian American because of racist "Kung Flu" rhetoric is not justifiable. Healthcare institutions need to acknowledge this nuance in their patient policies. Certain requests are justifiable and understandable in the context of culture and history. Others only serve to demean the person trying to offer care and cause future repercussions.

4. Legal Obligation to Help Minority Healthcare Workers

Healthcare professionals deserve a work environment free from prejudice and discrimination, as do all racial minority workers in the United States. Healthcare institutions can also avoid increasing lawsuits by implementing policies that follow the law. Common law battery, Title VII, 42 U.S.C. §1981, and recent case law all support refusal of patients' racially biased requests.

The doctrine of battery states that competent patients or legally designated decision makers retain the constitutional right to refuse unwanted medical treatment (23). Therefore, healthcare providers must respect the patient's rejection, and cannot forcefully provide treatment against the patient's will. However, the common law of battery does not demand providers go out of their way to accommodate a racially biased request.

Title VII of the 1964 Civil Rights Act also discourages the accommodation of biased racial requests because it states "it shall be an unlawful employment practice for an employer to...segregate...employees...in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race" (24). Conceding to reassign a minority healthcare worker due to a bias request would then equal segregation. A bona fide occupational qualification defense would not apply because discrimination of race and color are explicitly banned in Title VII.

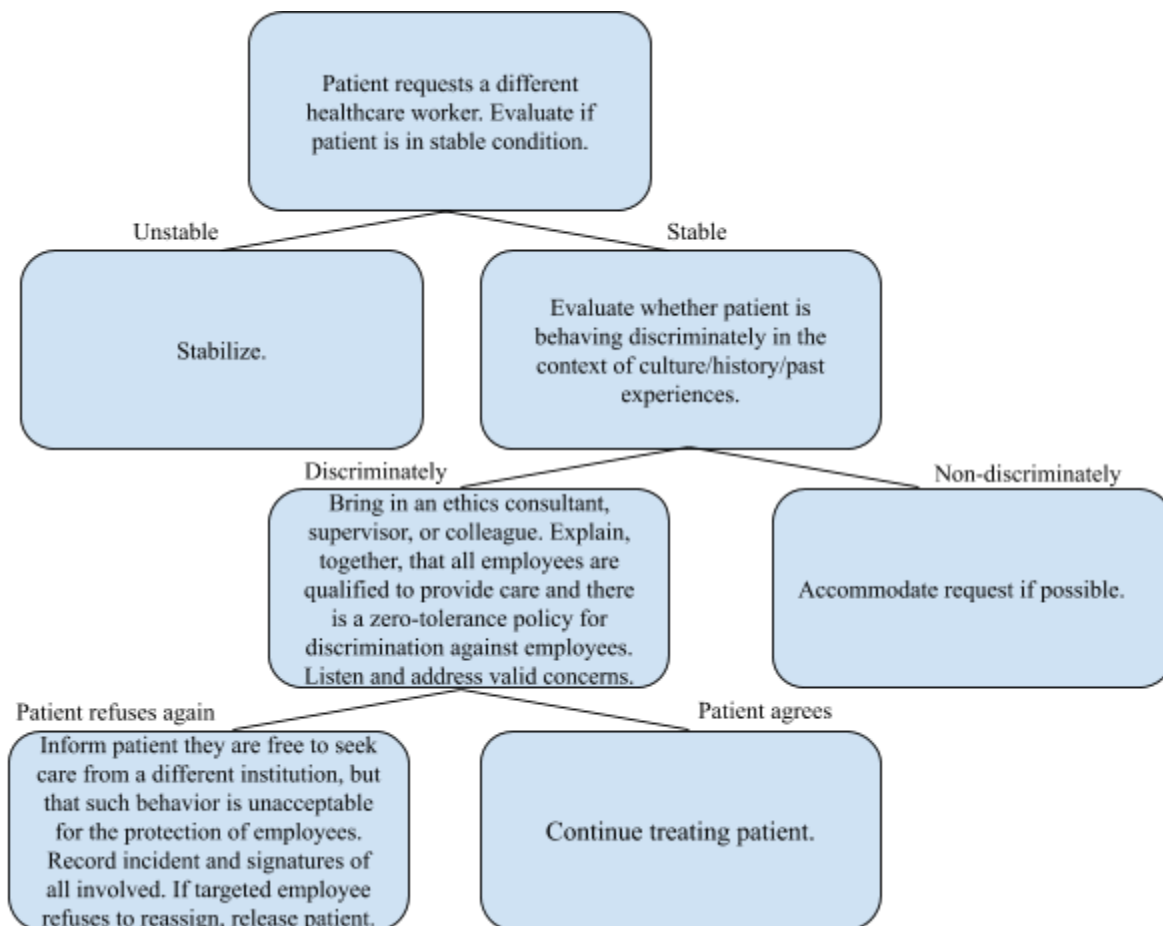
42 U.S.C. §1981 also bars patients' racially biased requests because it states "all persons within the jurisdiction of the United States shall have the same right...to make and enforce contracts...as is enjoyed by white citizens" (25). In 2016, a United States District Court held reassignments based on race constitute an adverse employment action "because such assignments affect the terms and conditions of employment" violating 42 U.S.C. §1981 (26). Therefore, satisfying patients' biased requests for exclusively white healthcare is invalid under federal statute. In the 2019 case of *Teoka Williams v. Beaumont Health System*, a supervisor reassigned a black nurse moments after the patient complained he did not want a black nurse (27). The court held "a reasonable jury could conclude that 'unlawful discrimination was at least a motivating factor in the employer's actions'" and the evidence was "sufficient to show that [the nurse] suffered an adverse employment action."

5. Recommendations

COVID-19 has already impacted the healthcare system in unique, long-lasting ways, and it is not unlikely more pandemics will arise in the future. Now is the best time to reform how the healthcare system deals with discriminatory patients. Since 2017, more and more institutions have been incorporating anti-discrimination policies (6). Penn State has launched a policy that protects personal traits from disrespectful patient interactions. NYU Langone Health also launched an anti-discrimination policy that does not accept racist behavior or language from patients. At Mayo Clinic, a 5-step policy for addressing patient bias is changing the patient-doctor interaction for the better. Joselle Cook, a trainee born in Trinidad, noted, "There's not just a shoving of it under the carpet...In the past year and a half, my co-fellows are reporting

incidents more and more. You also see many leaders reaching out” (6). Cook even suggested patients are behaving better, “They see this is the policy, and they need to keep to it” (6). The United Kingdom also has plans to institute a zero-tolerance discrimination policy in the near future (28). More significant health institutions in the United States can and need to support this movement. For example, organizations like the American Public Health Association, American College of Healthcare Executives, Society of Medical Decision Making, or large providers such as Kaiser Permanente and Mercy can make a huge difference. Governments and civil rights organizations should also push for change by contacting stakeholders, spreading awareness through their networks, and encouraging law enforcement to track abusive patients.

The following general *step-by-step procedure* should be implemented in all healthcare institutions to empower racial minority employees. Healthcare professionals will follow this procedure, in a non-emergency situation, when faced with a patient refusing care on the basis of race. This procedure can help alleviate confusion and provide concrete steps for the employee to take when faced with a difficult, racially charged situation. This procedure also addresses the high concerns over “lack of patient respect,” “feeling like a cog,” and “lack of control” (15). In a situation where the patient demeans the employee out of sheer prejudice, this procedure protects the minority worker and gives them some autonomy. This policy also respects the patients’ choice to seek healthcare elsewhere, but still upholds emergency treatment if the patient is unstable. Though each institution should take feedback from their employees and patients, the policy should contain the following essential elements: primary evaluations of stability, thorough recording, introduction of another party if possible, clear communication, and the right to turn away the repeating offender.



Publicization of the above policy and an anti-discrimination stance should take place in-person and online to promote awareness. The statements should be in forms, posters, and brochures in physical locations where healthcare is offered. They must be visible to all patients and visitors in waiting rooms, elevators, restrooms, and by entrances or exits. The policy should also be posted on all relevant websites and social media accounts. All healthcare workers should explain this policy to the patient carefully and proactively.

Collaboration of multiple groups should occur. First, all healthcare institutions should implement training and workshops among all levels of healthcare workers (nursing assistant, nurse, scribe, medical resident, physician, etc.) to encourage unity against patient bias and prevent bystander effect. Second, healthcare institutions, local governments, civil rights organizations, and local media should collaborate to spread awareness about patient bias, xenophobia, and racism. Third, health administrations must assure their employees that they are legally protected from racially discriminatory requests and that all employees will be backed by their employers. However, abusing this policy will result in punishment. Fourth, staff consultants trained in ethics and de-escalation should be present in all healthcare settings to assist. Lastly, medical schools should consider incorporating education on these policies into their curriculum. Classes addressing physician bias can easily incorporate discourse on patient bias as well.

Support resources such as counseling, diversity workshops, and feedback systems should specifically deal with incidences of patient bias and racism. Minority healthcare workers need to know they have resources to fall back on and spaces to voice their concerns without fear. Anonymous reporting systems, monthly discussion groups, and peer counseling are a few options that could foster solidarity.

It is important to note this paper and the following recommendations were created before the publication of Kimani Paul-Emile's article *Addressing Patient Bias Towards Health Care Workers* on July 14, 2020 (29). This paper was nearing finalization before discovery of Paul-Emile's article. There is some similarity in the recommendation section. For example, Paul-Emile also encourages policies that explicitly address patient bias, a supportive team for staff, better recording, nuanced approaches for various situations (such as a female patient requesting a female nurse), and support resources. These were elements originally included in this paper's recommendations.

However, the two papers have inherent differences. For example, in terms of recommendations, Paul-Emile emphasizes institutions should create procedures specific to trainees, nurses, and clinicians' roles. She suggests healthcare institutions exempt trainees and students from providing care to biased patients. Doing so will prevent stress on their professional development and ensure they do not carry traumatic experiences into their future work. Nurses should also have flexibility and autonomy because of their extensive interaction with patients. Reassignment can occur, but only with the consent of the employee. Whether these varying approaches will actually be enforced or effective in reality is uncertain. Nevertheless, Paul-Emile

shares a helpful, nuanced perspective because it acknowledges not all healthcare workers have the same skillset, shift lengths, or positions in their careers.

Another difference is that Paul-Emile states, “In the highly unusual scenario where the clinician does not consent [to bias-based reassignment] and the patient does not modify their behavior, institutions should seek legal advice.” (29). It is not completely clear what “seeking legal advice” entails. For instance, some institutions may be rural or serve low-income populations. They may not be able to afford having an ethics or legal consultant on hand constantly or even at all, but this does not mean clinicians in such areas are free to suffer abuse either. Even in a typical institution, a consultant may not be available on weekends or at late hours. This unavailability should not paralyze clinicians. With simple training on examples of discriminatory versus non-discriminatory behavior, such as those presented earlier under 3.1, most healthcare workers could grasp when they can or cannot refuse a patient right in the moment. Furthermore, this paper has explained healthcare institutions’ legal capacity and obligation to implement such policy. Seeking legal advice can certainly be done in the process of forming the policy, but it makes little sense to attempt it as the situation is occurring. Again, the policy is not meant to eradicate racism everywhere for everyone. The main purpose is to support racial minority healthcare professionals trying to perform their duties and avoid perpetuating harmful patient bias in critical moments.

Conclusion

After years of working as an emergency physician and tolerating racist behavior, Uche Blackstock finally challenged the status quo. In 2018, NYU Langone Health launched its anti-discrimination policy. Shortly after, Blackstock witnessed one of her own emergency medicine residents, a Muslim, experiencing patient bias. The patient rudely insisted he could not be assigned a Muslim doctor. Instead of feeling paralyzed and worrying how to respond, Blackstock and the resident took immediate action: they checked for the patient’s stability, informed him such behavior and language were not acceptable, then told him he would have to leave if he continued. The patient left. That day, Blackstock’s resident did not have to endure the powerlessness, invalidation, or isolation that Blackstock had to endure in the past. Instead, they both had support. “It makes a huge difference knowing that your institution backs you up. It can be so empowering,” Blackstock said (6).

Accommodation of racially biased requests should no longer have a place in medical culture. Healthcare institutions may not be able to stop patients from expressing bias, but they can choose to support their minority workers by challenging racialization of illnesses, implementing effective patient bias policies, and collaborating with civil rights organizations or government institutions. They can make a powerful difference socially, ethically, and legally. Ultimately, the healthcare system, its patients, and society can all benefit from this positive change. If minority healthcare workers are to care for their patients, then healthcare institutions need to care for their workers.

References

1. **Corley J.** Boston doctor becomes victim of COVID-19 racism. Forbes. 14 April 2020. Accessed at <https://www.forbes.com/sites/jacquelyncorley/2020/04/14/boston-doctor-becomes-victim-of-covid-19-racism-here-is-how-we-should-respond/> on 11 August 2020.
2. **Young R.** Trump's racial slurs to describe coronavirus put health care workers, patients at risk. WBUR. 25 June 2020. Accessed at <https://www.wbur.org/hereandnow/2020/06/25/trump-racial-slurs-coronavirus> on 11 August 2020.
3. **U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis.** Sex, race, and ethnic diversity of U.S. health occupations. August 2017. Accessed at <https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/diversityushealthoccupations.pdf> on 11 August 2020.
4. **Paul-Emile K.** Patient racial preferences and the medical culture of accommodation. UCLA Law Rev. 2012:468.
5. **Weeks L.** When the patient is racist, how should the doctor respond? STAT. 12 June 2017. Accessed at <https://www.statnews.com/2017/06/12/racism-bias-patients-doctors/> on 11 August 2020.
6. **Weiner S.** Pushing back against patient bias. AAMC. 17 January 2020. Accessed at <https://www.aamc.org/news-insights/pushing-back-against-patient-bias> on 11 August 2020.
7. **Web MD, Medscape.** 2017 Medscape patient/physician bias survey. Medscape. 2017. Accessed at https://img.webmd.com/dtmcms/live/webmd/consumer_assets/site_images/article_thumbnails/news/2017/10_2017/patient_prejudice/2017_patient_prejudice_professional_survey_results.pdf on 11 August 2020.
8. **Watson S.** Credentials don't shield doctors, nurses from bias. WebMD. 18 October 2017. Accessed at <https://www.webmd.com/a-to-z-guides/news/20171018/survey-patient-bias-toward-doctors-nurses> on 11 August 2020.
9. **Serafini K, Coyer C, Brown JB, et al.** Racism as experienced by physicians of color in the health care setting. Family Medicine. 2020;52:282-287. [PMID: 32267524] doi:10.22454/FamMed.2020.384384
10. **Reynolds KL, Cowden JD, Brosco JP, et al.** When a family requests a white doctor. Pediatrics. 2015;136:381-386 [PMID: 26169433] doi:10.1542/peds.2014-2092
11. **Natividad I.** Racist harassment of Asian health care workers won't cure coronavirus. UC Berkeley News. 9 April 2020. Accessed at <https://news.berkeley.edu/2020/04/09/racist-harassment-of-asian-health-care-workers-wont-cure-coronavirus/> on 11 August 2020.
12. **Byyny RL.** The joy in caring. The Pharos. 2018 Spring. Accessed at <https://alphaomegaalpha.org/pharos/2018/Spring/2018-2-Byyny.pdf> on 11 August 2020.
13. **Maslach C, Leiter MP.** The truth about burnout: How organizations cause personal stress and what to do about it. Jossey-Bass. 1997.

14. **Shanafelt TD, Boone S, Tan L, et al.** Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*. 2012;172:1377-1385. [PMID: 22911330] doi:10.1001/archinternmed.2012.3199
15. **Kane L.** Medscape national physician burnout & suicide report 2020: The generational divide. Medscape. 15 January 2020. Accessed at <https://www.medscape.com/slideshow/2020-lifestyle-burnout-6012460#1> on 11 August 2020.
16. **Occupational Health & Safety.** Healthcare workers suffer from PTSD and burnout during COVID-19. Occupational Health & Safety. 19 May 2020. Accessed at <https://ohsonline.com/Articles/2020/05/19/Healthcare-Workers-Suffer-from-PTSD-and-Burnout-During-COVID19.aspx?Page=1> on 11 August 2020.
17. **Han S, Shanafelt T, Sinsky C, et al.** Estimating the attributable cost of physician burnout in the United States. *Annals of Internal Medicine*. 2019;170:784-790. [PMID: 31132791] doi:10.7325/M18-1422
18. **Hoppe T.** “Spanish flu”: When infectious disease names blur origins and stigmatize those infected. *American Journal of Public Health*. 2018;108:1462-1464. [PMID: 30252513] doi:10.2105/AJPH.2018.305645
19. **Louie P, Wilkes R.** Representations of race and skin tone in medical textbook imagery. *Social Science & Medicine*. 2018;202. doi:10.1016/j.socscimed.2018.02.023
20. **Health Sciences Library.** The Hippocratic Oath and others. McMaster University. 26 April 2019. Accessed at <https://hslmcmaster.libguides.com/c.php?g=306726&p=2044095> on 11 August 2020.
21. **Shmerling RH.** The myth of the Hippocratic Oath. Harvard Health Blog. 28 November 2015. Accessed at <https://www.health.harvard.edu/blog/the-myth-of-the-hippocratic-oath-201511258447> on 11 August 2020.
22. **Garran AM, Rasmussen, BM.** How should organizations respond to racism against health care workers? *American Medical Association Journal of Ethics*. 2019;21:499-504. [PMID: 31204990] doi:10.1001/amajethics.2019.499
23. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990)
24. 42 U.S.C. § 2000e-2
25. 42 U.S.C. §1981
26. *McCrary v. Oakwood Healthcare, Inc.*, 170 F. Supp. 3d 981 (E.D. Mich. 2016)
27. *Williams v. Beaumont Health Sys.*, Case No. 18-12522 (E.D. Mich. Aug. 26, 2019)
28. **North Bristol NHS Trust.** North Bristol hands red card to racism. NHS. 4 November 2019. Accessed at <https://www.nbt.nhs.uk/news-media/latest-news/north-bristol-hands-red-card-racism> on 11 August 2020.
29. **Paul-Emile K.** Addressing patient bias toward health care workers: Recommendations for Medical Centers. *Annals of Internal Medicine*. 14 July 2020. [PMID: 32658573] doi:10.7326/M20-0176