Canadian Journal of Bioethics
Revue canadienne de bioéthique

Canadian Journal of Bioethics
Revue Canadienne de Bioéthique

The Hidden Realities of Discrimination from Patients: A Scoping Review of Healthcare Workers' Experiences

Claudia Barned, Akosua Nwafor and Melanie Anderson

Volume 8, Number 1-2, 2025

Numéro hors-thème & Leçons tirées de la COVID
Open Issue & Lessons from COVID

URI: https://id.erudit.org/iderudit/1117871ar
DOI: https://doi.org/10.7202/1117871ar

See table of contents

Publisher(s)

Programmes de bioéthique, École de santé publique de l'Université de Montréal

ISSN

2561-4665 (digital)

Explore this journal

Cite this article

Barned, C., Nwafor, A. & Anderson, M. (2025). The Hidden Realities of Discrimination from Patients: A Scoping Review of Healthcare Workers' Experiences. *Canadian Journal of Bioethics / Revue canadienne de bioéthique*, *8*(1-2), 74–106. https://doi.org/10.7202/1117871ar

Article abstract

Discrimination in healthcare settings is a burgeoning area of applied inquiry and intervention. Existing research has focused on the experiences of patients as the targets of discrimination with less attention paid to patients as the source of discrimination. The main objective of this scoping review is to identify, explore and map the literature on the experiences of healthcare workers (HCWs) as targets of discrimination from patients and/or their family members. A scoping review of articles indexed in Ovid Medline, Ovid Embase, Ovid Emcare, and Web of Science Core Collection was conducted between March 2022 and June 2023. The results were summarized, coded and thematically categorized according to the aim. The review identified 173 articles that highlighted various forms of discrimination manifesting in a multitude of ways, including requests for, and refusals of specific HCWs based on social identity markers. The results suggest that there are significant barriers that prevent HCWs from reporting and responding to these incidents in efficient ways, resulting in an array of negative psychological ramifications. This review highlights core areas in need of greater attention in order to better support HCWs during challenging interactions with discriminatory patients. Institutional recommendations aimed at research and education efforts, learner experiences, policy writing, documenting and reporting, institutional culture, resources and support as well as the role of professional bodies, were identified. Evidence-informed work is needed in this area to ensure that policy-level changes are informed by the lived experiences of those enduring these incidents.

Canadian Journal of Bioethics
Revue Canadienne de Bioéthique

ARTICLE (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

The Hidden Realities of Discrimination from Patients: A Scoping Review of Healthcare Workers' Experiences

Claudia Barned[a,b,c], Akosua Nwafor[a,d], Melanie Anderson[b,e]

Résumé
La discrimination dans les établissements de soins de santé est un domaine de recherche appliquée et d'intervention en plein essor. Les recherches existantes se sont concentrées sur les expériences des patients en tant que cibles de la discrimination et ont accordé moins d'attention aux patients en tant que sources de discrimination. L'objectif principal de cette étude exploratoire est d'identifier, d'explorer et de cartographier la littérature sur les expériences du personnel de santé en tant que cible de la discrimination de la part des patients ou des membres de leur famille. Une revue exploratoire des articles indexés dans Ovid Medline, Ovid Embase, Ovid Emcare et Web of Science Core Collection a été réalisée entre mars 2022 et juin 2023. Les résultats ont été résumés, codés et classés par catégories thématiques en fonction de l'objectif. L'analyse a permis d'identifier 173 articles mettant en évidence diverses formes de discrimination se manifestant de multiples façons, y compris des demandes et des refus de travailleurs de la santé spécifiques fondés sur des marqueurs d'identité sociale. Les résultats suggèrent qu'il existe des obstacles importants qui empêchent les professionnels de la santé de signaler ces incidents et d'y répondre de manière efficace, ce qui entraîne toute une série de ramifications psychologiques négatives. Cette étude met en évidence les principaux domaines nécessitant une attention accrue afin de mieux soutenir les professionnels de la santé lors d'interactions difficiles avec des patients victimes de discrimination. Des recommandations institutionnelles visant les efforts de recherche et d'éducation, les expériences des apprenants, la rédaction de politiques, la documentation et les rapports, la culture institutionnelle, les ressources et le soutien, ainsi que le rôle des organismes professionnels, ont été identifiées. Des travaux fondés sur des données probantes sont nécessaires dans ce domaine afin de garantir que les changements au niveau des politiques s'appuient sur les expériences vécues par les personnes confrontées à ces incidents.

Mots-clés
discrimination, bioéthique, politique de santé, patients biaisés, expériences des professionnels de santé, formation

Abstract
Discrimination in healthcare settings is a burgeoning area of applied inquiry and intervention. Existing research has focused on the experiences of patients as the targets of discrimination with less attention paid to patients as the source of discrimination. The main objective of this scoping review is to identify, explore and map the literature on the experiences of healthcare workers (HCWs) as targets of discrimination from patients and/or their family members. A scoping review of articles indexed in Ovid Medline, Ovid Embase, Ovid Emcare, and Web of Science Core Collection was conducted between March 2022 and June 2023. The results were summarized, coded and thematically categorized according to the aim. The review identified 173 articles that highlighted various forms of discrimination manifesting in a multitude of ways, including requests for, and refusals of specific HCWs based on social identity markers. The results suggest that there are significant barriers that prevent HCWs from reporting and responding to these incidents in efficient ways, resulting in an array of negative psychological ramifications. This review highlights core areas in need of greater attention in order to better support HCWs during challenging interactions with discriminatory patients. Institutional recommendations aimed at research and education efforts, learner experiences, policy writing, documenting and reporting, institutional culture, resources and support as well as the role of professional bodies, were identified. Evidence-informed work is needed in this area to ensure that policy-level changes are informed by the lived experiences of those enduring these incidents.

Keywords
discrimination, bioethics, health policy, biased patients, healthcare professional experiences, education

Affiliations
[a] Department of Clinical and Organizational Ethics, University Health Network, Toronto, Ontario, Canada
[b] The Institute for Education Research (TIER), University Health Network, Toronto, Ontario, Canada
[c] Joint Centre for Bioethics, Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada
[d] Ethics Department, Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario, Canada
[e] Library and Information Services, University Health Network, Toronto, Ontario, Canada

Correspondance / Correspondence: Claudia Barned, claudia.barned@uhn.ca

INTRODUCTION

Discrimination in healthcare settings is a burgeoning area of academic and applied inquiry due to the detrimental effects on patient care, health outcomes and interventions promoting health equity. Despite the multidirectional nature of discrimination, the academic literature on the topic predominantly examines the experiences of patients as the targets of discrimination. A relatively small area of the literature, however, now explores patients as the source of discrimination due to increasing accounts of healthcare workers' (HCWs') experiences of racism, sexism, islamophobia and other forms of prejudice. Discrimination from patients poses a profound challenge to the fundamental principles of equity, respect, and justice. In caring professions where the ethos revolves around compassionate treatment and unbiased care, discrimination disrupts the ethical equilibrium. Bound by codes of ethics and an oath to prioritize the well-being of their patients, HCWs find themselves in an ethical conundrum

ISSN 2561-4665

when faced with discriminatory behaviours from their patients. A dilemma arises from their obligation to uphold patient autonomy and professionalism while simultaneously preserving dignity when responding to discriminatory patients.

Requests for Specific Healthcare Workers

There is a growing body of literature on racist requests for alternate care providers (1-4), and refusals of care providers (5) with a focus on requests from patients themselves (6), or their family members in the case of paediatric patients (2). Some studies have focused on migrant HCWs experiences with discriminatory patients (7-12), physician experiences with microaggressions (13,14), discrimination against Muslim HCWs (4,15), and requests for concordant care (16). In addition to this body of work, a growing number of studies have explored the issue from a policy lens, noting key recommendations for institutional guidelines and practices (17-23) that prevent patient discrimination while also balancing patient rights.

Despite the variation in the focus of these studies, the narratives represented are predominantly those of physicians and physician learners, with a smaller subgroup of articles documenting the experiences of nurses, particularly international/migrant nurses. An obvious gap in this scholarship is information about or an examination of the experiences of the multidisciplinary healthcare team. Very little is known about the experiences of social workers, physiotherapists, occupational therapists, or respiratory therapists, to name a few (17). What we do know, however, is that HCWs report harrowing experiences of physical violence, racially-motivated assaults and sexual harassment from patients and their families on a daily basis (1,7,24-31). Recollected accounts include, for example, a Filipina nurse being called “a fucking whore” and a “slut” by a patient’s family (24, p.4). Black physicians have described refusals phrased as “don’t want no nigger doctor” (25, p.1084) and being told that death would be more favourable than being “touched by a filthy Black doctor” (1, p.6). Others described refusals rooted in Arab identity (30), Jewish identity (31) and gender identity (1,26,27). Whereas some narratives solely describe verbal assaults and discriminatory refusals of care providers, others also include physical acts of violence and aggression, such as being punched (28,30) and spat at (7,28,29).

When patients refuse care providers due to their identity characteristics, this raises complex ethical, legal and clinical issues. From an ethics perspective, this topic tends to be explored in relation to the limits to autonomous decision-making, including who provides and is involved in care (18) – specifically, balancing the tension between promoting patient-centred care, establishing necessary boundaries to patient choice, and honouring the duty to care (1,18). While it is important to acknowledge and promote the values, wishes and beliefs of patients, this must be balanced against any potential consequences or harms to 1) staff who are the targets of biased refusals, and 2) other patients who might overhear or witness discriminatory statements or behaviour that may or may not be coupled with violence.

Refusals of care providers occur along a spectrum and can be rooted in reasons other than bigotry or prejudice. Paul-Emile et al. (6) argue that rejecting a provider based on identity characteristics is not always negative in nature and could be rooted in a request for identity concordance. Several studies have noted positive health outcomes for patients assigned to concordant care providers (32-34). In fact, positive clinical outcomes (e.g., increased patient-provider communication, patient satisfaction, and better health outcomes) have been attributed to concordant care relationships (32-34), particularly for groups/persons that have been historically marginalized or harmed by the medical system. Requests for concordant care providers could also be due to religious or cultural reasons, or they might be rooted in an individual’s trauma history (1,3,16,18). These types of requests are not inherently discriminatory and are therefore less ethically problematic.

In addition to the ethical dimension, refusals of care providers raise many legal questions, as the rights of the patient must be situated in relation to the rights of the healthcare worker. In Ontario, Canada, as employees or contractors of hospitals, clinics, or care facilities, HCWs are protected under the Ontario Human Rights Code (35) – they have the right to a workplace free from discrimination based on age, race, ethnicity, sex, disability, gender identity, and sexual orientation, whether this is from patients, family members or fellow staff/colleagues. Organizations that accommodate a patient’s discriminatory request or compel employees to acquiesce to a patient’s request for reassignment based on any of the 14 protected grounds may violate Ontario’s Human Rights Code. Despite an organization’s commitment to patient needs, HCWs have employment rights and protections that must be balanced against patients’ rights and requests.

The Current Study

There is a lack of published work that synthesizes how HCWs and institutions more broadly have responded to discriminatory behaviour from patients, their family or visitors; even less attention has been focused explicitly on the recommendations for institutions and teams regarding best practices in responding to such behaviour. The objective of this scoping review is thus to identify, explore and map the literature on HCWs’ experiences as the target of discrimination from patients and their family members, as well as identify knowledge and practice gaps.

METHOD

This review was conducted in accordance with Arksey and O’Malley’s (36) 5-step methodology for scoping reviews: 1) identifying the research question, 2) identifying relevant studies, 3) study selection, 4) charting the data and 5) collating, summarizing and reporting the results. The first author (CB) and the third author (MA, a health sciences librarian) developed and designed the search strategies employed in this study. Ovid Medline, Embase and Emcare, and Web of Science Core Collection were consulted, and for each a specific search strategy was used that matched the platform’s command language, controlled vocabulary and respective search fields.

Identifying the research question

This review was guided by the research question, “What does the literature tell us about HCWs’ experiences of discrimination from patients?” In addition to unearthing the general content on studies that examine discrimination from patients in healthcare settings, this review also sought to map how discriminatory requests or refusals of specific care providers have been managed within healthcare contexts, and any recommendations for change. Based on the research question and these broader aims, a scoping review was ideally suited as it is a type of research synthesis that maps the literature on a topic or area of study and provides opportunities to identify gaps and inform future research (37,38).

Identifying relevant studies

For our initial search, we started with a list of keywords and headings focused on racial discrimination from patients, however, our searches expanded to include additional terminology that covered discrimination from patients more broadly. Appropriate subject headings and keywords for each concept (e.g., discrimination, bias, treatment refusal, and policy) were used when searching the following databases: Ovid Medline, Ovid Embase, Ovid Emcare, and Web of Science Core Collection (see Appendix). The initial search was run on February 8, 2022, with additional searches on March 15, 2022, and May 6, 2022. An updated search was run on June 9, 2023 to capture any publications released between May 6, 2022 and June 9 2023. The results from the updated searches were added on June 9, 2023. To limit duplicate results during the additional searches and the updated search, date limits from the previous search to the date of the current search were applied. No starting date limitation was applied for the initial search. All citations were imported into Covidence web-based literature review software where duplicate citations were immediately removed. Although Covidence screens for duplicates upon uploading into the software, several duplicates were found during the screening process and were manually removed.

Study selection: eligibility criteria and screening

Five members of the research team (CB, AN and 3 additional reviewers) contributed to the screening process during the various stages of the search and screening cycles. Title and abstract screening were conducted using the Covidence software to eliminate articles that did not meet the inclusion criteria in Table 1.

Conference materials, dissertations, theses, books, book chapters and in-progress research were excluded. Only studies with the full text available in English were considered. The following were identified as the primary content related reasons for exclusion: ineligible population (bias experienced by patients or perpetuated by colleagues, aspects of the patient-provider relationship unrelated to discrimination), ineligible setting (bias experienced by providers not in a clinical or healthcare context), ineligible context (studies focused on discrimination or bias in the context of a health topic, for example, bias among patients in cancer care or concordance in relation to patient satisfaction). Other reasons for exclusion were: inability to retrieve full text and text not in English.

Table 1. Study inclusion criteria

Participants	• Studies focused on HCWs, residents, learners on the receiving end of prejudice, discrimination or micro-aggressions from patients.
Intervention/Exposure	• Articles on interactions with patients and HCWs on bias directed towards the healthcare worker (HCW) based on their identity (gender, race, religion, ethnicity, sexual orientation).
Comparator/Control	• Not applicable
Study designs	• Theoretical papers, opinion articles, commentaries, case studies, policy reports, and empirical studies that explore the mechanisms of responding to prejudiced patients or discrimination against HCWs based on identity factors. • Studies that focus on institutional recommendations, policy recommendations or training recommendations for learners, educators or institutions. • Studies that explore what healthcare systems, hospitals, care homes, clinics, academic teaching hospitals should do to respond [policies/strategies to protect workers / accommodations based on patient context].
Context	• Articles examining requests for concordance (healthcare interactions whereby the patient refuses care from specific healthcare providers). • Articles examining a request from a patient for concordant care and the institutional, supervisory or collegial response.
Outcomes	• Identify types of discrimination experienced, types of concordance requested, all policy recommendations, institutional guidelines, and departmental/unit strategies developed in response to discriminatory requests from patients/family/visitors.

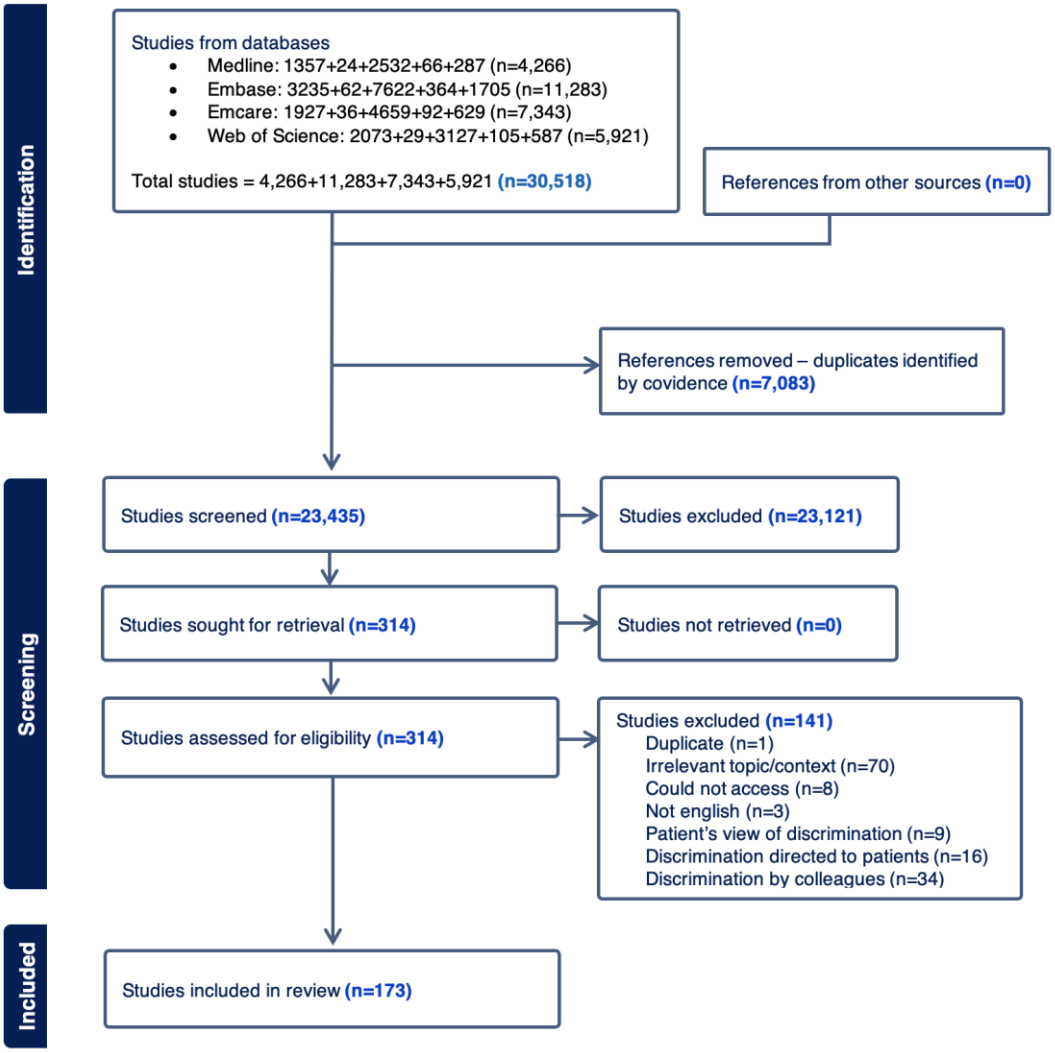
Two reviewers – the first author and a second reviewer (research team member 1) – conducted the first round of screening after the initial search on February 8, 2022. Each reviewer screened 50 articles independently, then met to discuss their reasons for inclusion and exclusion. This was done to ensure for reliability amongst the reviewers. The reviewers also discussed and deliberated over articles that were considered ‘conflicts’, i.e., cases where one reviewer voted to include, while the other voted to exclude. For these articles, we discussed how we arrived at our decision and matched against the inclusion criteria. Where consensus could not be reached, we searched the full text article to examine whether it included material relevant to the inclusion criteria and the overall aims of the review. This process was done with each new member of the

research team that contributed to the screening process (including the second author and research team members 2 and 3). As the research team grew, we scheduled regular meetings to discuss the conflicts. The aim of these meetings was to work through the disagreements and any nuances identified by discussing all assumptions made. We independently noted our reasons and final decision on the article, reviewed the full text as a group, and then shared our decision. This was done until we worked through all the conflicts and arrived at a consensus on the outcome of the article.

Charting the data

After title and abstract screening, all citations in the inclusion folder were subjected to full-text screening for data extraction purposes. Full text articles were obtained through institutional holdings available to the research team. For articles that could not be accessed, we solicited the third author's help in attaining them through interlibrary loans. After reading the full text of each article, the following information was extracted and entered into an Excel data charting form for characterization and analysis: author, year of publication, title, location (state and country), journal, study design, study setting/medical context, sample size (of empirical studies), type of concordance requested, type of refusal/assault/bias experienced, details about the refusal/assault/bias experienced, who the bias was perpetrated against, personal approach to the situation, who was involved in responding to the situation, what was the reaction of the team/supervisor/unit member involved, impact on the healthcare worker involved, whether the incident was reported, barriers to reporting (if any), type of approach implemented, institutional recommendations for addressing patient bias, team/unit recommendations for addressing patient bias, and institutional barriers. Studies were also excluded at this stage if they were not found to meet the eligibility criteria. See Figure 1 for a PRISMA flowchart illustrating data screening and characterization process.

Figure 1. PRISMA flow diagram illustrating the various stages of the review



Collating, summarizing and reporting the results

For each article included, we aimed to standardize the approach to which we extracted and charted relevant information. Reliability measures similar to those described in the screening process were also performed during this stage of the process.

Each member of the review team was assigned the same 10 articles to review and extract independently. We then met to discuss the content extracted and the level of detail retained in the extraction document. This was done to ensure that each reviewer was extracting similar material and including the same depth and breadth of coverage. Once each member was independently extracting the same type of material from each article, the articles were divided and distributed amongst a subset of reviewers for extraction. The first author routinely reviewed the extraction sheet of each reviewer to ensure that the material extracted was correct, and that sufficient detail was provided. Despite these reliability checks, it is often difficult to extract all relevant information where original research has failed to include the specificities of the nuances in question (39). In these instances, we entered 'not applicable' or 'not reported' into the data extraction table. The information presented in this review was collated, summarized and reported in accordance with PRISMA-ScR standards (40).

RESULTS

Descriptive findings: characteristics of the articles included

The literature search yielded 30,518 relevant papers for review. Removal of duplicates as well as title and abstract screening left 314 for full-text screening. Of these 314 articles, 141 did not meet eligibility criteria. This review presents the findings from 173 articles, primarily from the United States (n=111) (1,3,6,7,10,14,19,20-23,25-27,29,31,41-135), United Kingdom (n=25) (2,28,136-158), Canada (n=14) (18,159-171); with 4 from Israel (30,172-174), 3 from Australia (175-177), 2 each from Germany (8,178), Ghana (140,179), and Turkey (180,181), and 1 each from Belgium (180), Brazil (182), China (183), Eswatini (184), Netherlands (24), New Zealand (185), Norway (186), Poland (187), Portugal (180), the Republic of Korea (188), Singapore (189), Spain (180), Sweden (190), and Uganda (192). These articles focused on one of the following five core areas: 1) discriminatory language or behaviour from patients, 2) refusals of care providers, 3) HCW experiences of bias or discrimination, 4) HCW experiences of sexual harassment and 5) responding to discriminatory patients.

The majority of articles were empirical in nature (n=80), including qualitative (n=51), quantitative (n=21) and mixed methods studies (n=8). This was followed by commentaries (n=54), case studies (n=12), review papers (n=11), essays (n=3), letters (n=3), editorials (n=2), narratives (n=2), policy/guidelines (n=2), ethics rounds (n=1), perspectives (n=1), workshops (n=1), and virtual listening sessions (n=1). See Appendix B Table 1 for study design references. As observed in Figure 2, the oldest article included in this review was published in 1980, which means that no article (found through our search process + met the inclusion criteria) addressing the nuances of this issue was published prior to this date.

Figure 2. Number of published articles on the topic since 1980

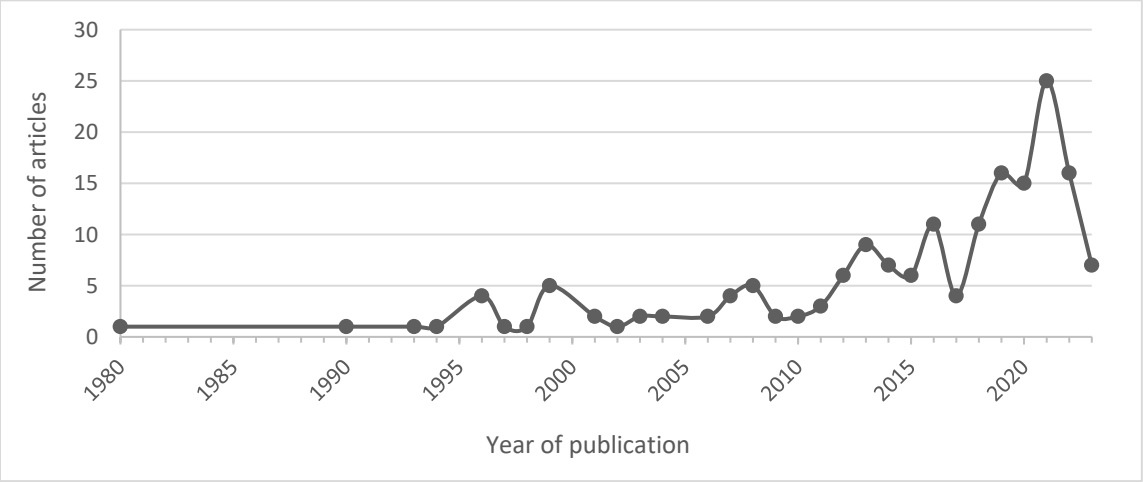


Figure 2 showcases a 10-year gap between the first and second article published on the topic (1980-1990), followed by a modest increase in articles published in 1996 (n=4). The graph shows a steady increase in publications on the topic from 2002 to 2016, with a significant increase noted between 2017 and 2021. The majority of these articles were published in medical journals (n=85), followed closely by nursing journals (n=42). Articles were also distributed across broadly defined health journals (n=22), ethics journals (n=13), pediatric journals (n=3), psychology journals (n=2), occupational therapy journals (n=2), and journals focused on law (n=1), social work (n=1), pharmacy (n=1) and physiotherapy (n=1). The journals most frequently published in were: *The Journal of the American Medical Associatio*n (n=11), *British Medical Journal* (n=9), *Annals of Internal Medicine* (n=8), *Academic Medicine* (n=7), *AMA Journal of Ethics* (n=6), *Journal of General Internal Medicine* (n=6), and the *Canadian Medical Association Journal* (CMAJ) (n=5). See Appendix B Tables 2 and 3 for journal references.

Of the 173 articles included in this review, the majority described patient bias/discrimination occurring in a hospital setting (n=121). This category included various types of hospitals, such as: academic hospitals (n=64), public hospitals (n=4) and non-specific hospital type (n=53). Residential care facilities were the second most cited care setting (n=14), including: nursing homes (n=7), long term care (n=3), residential/home care (n=2) and hospice settings (n=2). Other settings included

community care (n=5), rural healthcare facilities (n=1), medical centres (n=1) and public and private health services (n=1). Furthermore, some articles specified the clinical context within these settings where instances of patient bias occurred frequently. These included: nursing contexts (n=14), emergency departments/urgent care (n=13), primary health care (n=8), pediatrics (n=6), internal medicine (n=6), surgery (n=6), orthopedics (n=4), medicine (n=3), oncology (n=3), and obstetrics and gynecology (n=3). Other less cited clinical settings include pharmacy (n=2), mental health (n=6), occupational therapy (n=2), rural health (n=1), ICU (n=1), dermatology (n=1) cardiology (n=1). See Appendix B Tables 4 & 5 for study setting and clinical context references.

Target and Type of Discrimination, Harassment, and Assault Experienced

Target of Discrimination, Harassment, and Assault

The majority of the articles reviewed focused on the experiences of physicians and nurses as the primary targets of discrimination, harassment and assault (n=158) from patients and/or their family members. A total of 102 articles examined the experiences of physicians, whereas 56 examined the experiences of nurses. Other groups targeted include psychotherapists (n=3), physiotherapists (n=2), occupational therapists (n=2), pharmacists (n=1), and HCWs broadly defined (n=8). Of the 102 articles examining physicians as the target, 50 focused exclusively on the experiences of medical learners, i.e., residents, interns, trainees, and medical students. Similarly, of the 56 articles examining the experiences of nurses, 10 noted the experiences of nursing students exclusively. See Appendix B Tables 6 and 7 for target references.

In addition to the role/profession of the healthcare worker, some articles specified the social identity marker/characteristic that the patient targeted. For example, of the articles that focused on physician experiences, 21 noted the racial background of the physician, 9 noted the gender identity, 7 the religious identity, 1 the sexual orientation, and 3 noted the ethnicity. Similarly, the articles that examined the experiences of nurses noted a predominant focus on the racial identity of the nurse (n=24), followed by the nurse's ethnicity (n=9), gender identity (n=7), sexual orientation and religion (n=2).

Of the articles that examined medical residents as the target of discrimination, harassment or assault, 16 mentioned the racial background of the resident, 3 noted their gender identity, and 2 noted their religious background. Some of these articles referred to the multiple intersecting identities of the HCW, for example, an "Asian Male Resident Physician" (168) or "Sikh Male Medical Student" (14). Similarly, of the articles that focused on medical students (n=11), 3 noted the racial background of the student, 5 noted gender identity, and 1 noted religious background. Of the trainees (n=5) and interns (n=3), 3 articles mentioned racial background, 1 mentioned gender identity, and 1 mentioned religious identity.

Type of Discrimination, Harassment, and Assault Experienced

Varying forms of discrimination and abuse were noted amongst the articles reviewed (see Table 2 for examples). These included cases of refusals of specific care providers (n=60), requests for specific care providers (n=27), discriminatory comments (n=98), sexual harassment (n=25), physical assault (n=14), and inappropriate comments (n=13). The discriminatory request, refusal or comment was often in relation to a particular identity category of the healthcare provider. These included: racial background (n=96), gender (n=35), age (n=8), accent (n=10), disability (n=3), nationality (n=16), religion (n=17), language (n=3), status as a learner (n=1), sexual orientation (n=10), ethnicity (n=20), weight (n=2), political views (n=2), and training location (n=1). See Appendix B Tables 7, 8a and 8b for references.

Table 2. Examples of types of discrimination experienced

Category	Identity Characteristic	Example
Discriminatory Comment	Race	"Dr. Nwando Olayiwola, a Black female physician at San Francisco General Hospital, recounts her experience caring for a patient who explicitly stated, 'You didn't tell me I was going to see a Black doctor. And not just a Black doctor, but a Black woman!'. This same physician had experiences as a resident with a patient who told her 'All Black, Hispanic, Asian, and Jewish doctors should be burned alive,' and another who said she would 'rather die than be touched by a filthy Black doctor.'" (1)
	Gender	"I remember so often patients mistaking me for the nurse. I remember being the senior doctor in the room telling a patient his diagnosis and plan and that same patient looking to the male members to make sure they agreed with my plan – to validate me." (90)
	Accent	"Nurses described how their competency was questioned and how they felt the need to defend or to prove themselves not only to fellow nurses, but to doctors and patients as well. They also described experiencing more scrutiny than majority nurses, with those who spoke English with an accent reporting feeling even more scrutinized than those without accents, especially by patients." (10)
	Age	"A resident discusses dialysis with her elderly patient, who later says 'You look too young and pretty to be a doctor!'" (55)
	Ethnicity	An Arab American nurse shared "My worst experience was that a child was dying, and I wanted to clean the child. The father heard my accent and asked me where I was from. I said, 'I'm Lebanese,' and he told me not to touch his kid." (93)
	Sexual orientation	Survey respondents who would refuse to see a gay, lesbian or bisexual (GLB) physician provided various reasons. "Over half gave the reason that a homosexual physician would be incompetent. Fewer subjects were afraid of being sexually harassed or contracting a disease. Among 'other' reasons the most common was feeling 'uncomfortable' with homosexuals. Other reasons included the belief that a homosexual physician would be 'bizarre' or 'not normal', the respondent's upbringing, the belief that a homosexual physician is somehow a threat to children and dislike of homosexuals." (160)

	Religion	"…consider the experience of Dr. Bernard Sussman, a Jewish internist caring for Mr. W. During one visit, Mr. W revealed that he had served in the armed forces of Nazi Germany in Hitler's personal honor guard. Pressed further, he grew angry, claiming that the 'Jews were responsible for everything that happened to them.'" (1)
	Weight	"A lot of patients ask if I'm pregnant because I have a prominent belly. We have overweight white female attendings and I've never seen them ask if they're pregnant. So, I don't know if my minority played into patients asking if I'm pregnant, but it happens a lot." (156)
	Language	"Participants said that some patients feel uncomfortable seeing nurses speaking to other patients in another language. One participant stated: 'I recall one patient who was making comments and later pulled the curtains while I was speaking to an elderly Asian woman with her language' (Nurse 7). Another participant recalled: 'one patient saying to us, if you can't speak English, then go outside and speak to each other whatever you like' (Nurse 2)." (156) A migrant nurse described their experience: "The family was asking for an English nurse to update them with their patient's medical information although I know I can speak English clearly and fluently." (145)
	Disability	"As a person with a disability... patients have a hard time believing that I was the supervising physician on the team." (43) A deaf therapist encountered clients who could not fathom how she could be a competent therapist: "They have it in their mind that Deaf don't speak and Deaf definitively don't work as a health care professional." (139)
	Nationality	"At one point in my training, I was on rotation in a wealthy suburb of a metropolitan area, working with an attending in his clinic. I went to see a follow-up patient with a chief complaint of intermittent shortness of breath. I was unable to get through even a few questions without the patient interrupting with effusive praise of my attending. 'He is the best doctor I have ever known.... When will he be coming in? I trust him with my life.' I obtained a history and performed a physical, and then prepped the patient's nose for a laryngoscopy. I told the patient that I would return with the attending to perform the procedure and exited the clinic room. As I stood outside of the room waiting to present the patient's case to my attending, I discovered that the clinic door was not soundproof. The patient and his wife (both White) were discussing whether or not they could trust me, and whether I should be involved in the laryngoscopy. 'She seemed nice. But I don't know if I want a foreign doctor doing my scope. Her English was pretty decent, and at least I could understand her accent.'" (72)
	Country of training	A Jewish patient said "Over the past few years ... the number of Arab doctors increased dramatically. Do I appreciate them equally? No. It depends where they studied. That is, an Arab doctor who attended the Hebrew University [a prestigious university in Israel] is as good as a Jewish doctor who studied there. But there are certain places in the world in which medical training is of less value." (173)
Refusal of care providers	Gender	"A male medical student on his obstetrics-gynecology clerkship is assigned a 35-year-old female patient in the outpatient clinic who comes in for a routine well-woman exam, including a pelvic examination and Pap test, clinical breast examination, and discussion about contraception management. The student enters the examination room and introduces himself, but the patient straightforwardly tells him that she would prefer a woman student." (27)
	Race	A patient's relative said "Excuse me nurse, I don't want my mother to be nursed by a black person...in our family we don't do that; we don't associate with them." (175) "Early in Dr. Cornelia Wieman's career as a psychiatrist, a patient refused to see her because she was Indigenous. 'I tried to talk to them, to explain I was qualified, but the patient was adamant,' she says." (162)
	Religion	"A trainee in my clinical division had cared for a teenage girl for several years, dating from her diagnosis of acute leukemia. The family, and especially the patient, had developed a very strong and trusting bond with her. … the patient and her parents came for her regularly scheduled clinic visit only to find out that her favorite doctor was not there. The staff apologized profusely for failing to reschedule the appointment, but Dr. X was not there that day because it was Yom Kippur, one of the Jewish High Holy days, and she had taken the day off to be with her family and attend services at her local temple. The family was shocked to discover that Dr. X was Jewish. After discussing it amongst themselves for a few minutes they announced that they did not want her taking care of their daughter anymore, and demanded that a Christian physician be appointed to take over the case." (31)
	Ethnicity	"The first time it happened was when I went into this patient's room and her son was there. Upon seeing me, seeing my hijab, he refused to have me as his nurse. When I asked him why, his exact answer was that he felt threatened by me because I wear the hijab, that the way I look made him think of all the violence that is happening in the Middle East." (171)

Requests for specific care providers	Gender	“The patient was uncomfortable about being assigned a male nurse from the beginning and requested a switch. Male nurses were occasionally regarded as ‘men’ rather than as ‘nurses’.” (188)
	Race	“Nurse NG (AA) remembered when a white patient’s fiancée only wanted the Caucasian nurses and she was like ‘this one is so sweet, can I have this one?’ and every day she would request and then we saw a pattern.” (121) "While on a trauma service during my intern year, I was subject to a more overt display of racism. One of our patients was a middle-aged Latino man who had been stabbed during an altercation with a black man. After we stabilized him, he acquired a systemic bloodborne infection and was being monitored on the floor. He had antagonized several staff members using expletives and was intermittently refusing treatment. After a particularly harsh exchange, his nurse, a black woman, paged me requesting I draw blood for cultures. The nurse had been unable to convince him to cooperate, and the patient, after becoming agitated and increasingly rude, asked for a physician to draw the blood instead. Upon entering the room and explaining I had arrived to take a sample of blood, he became agitated, shouted racial slurs at me, and demanded another physician. ‘Get me a white doctor,’ he exclaimed.” (91)
	Nationality	“Examples included derogatory comments and threats against care workers, complaints to supervisors or co-workers, exaggerated suspicion and reactions of fear during visits, refusals to be attended by ethnic minority staff in nursing homes, refusals to let ethnic minority staff into the apartment/house, and requests to replace staff with ‘someone Swedish’.” (190)
	Religion	“If I can choose between a Jewish or Arab doctor, of course I’ll select the Jewish one ... only because he is a Jew ... If the Jewish and the Arab doctors are both excellent professionals, then I would go to the Jewish one out of loyalty. We share the same religion, the same state, the Jewish state ... He is one of my people. (Jewish man)” (173)
Sexual Harassment		A female trainee reported that a male patient grabbed her crotch during a physical exam. (1) A medical student described his experience with a patient: “I was on a team and the patient was an older gay man and every time I came in, he would ask me to sleep with him. I was stunned...” (14)
Inappropriate comment		“One Filipino nurse encountered a white patient who asked whether he could bring her home as a maid with a sexual overtone and profound ignorance that the Philippines was so backward that the entire country was connected by dirt roads.” (7)
Physical Assault		“I’ve been assaulted by a patient, she was confused because of her illness and she spit in my face, she was a HIV patient, it’s normal for us.” (182)

Barriers to Reporting

Most articles (n=131) made no reference to reporting or escalating the incident for further review. A small subset noted whether the incident was or was not reported/escalated (n=42). Of this subset, a total of 16 articles explicitly mentioned that experiences of patient bias were not reported. Whereas 26 articles noted that experiences of patient bias were reported to a supervisor, manager or attending. Of the 26 articles that described reporting, 9 included cases where some but not all instances were reported. When instances of patient bias were reported, it was typically done by: a) physician learners to their supervisors/attendings (n=7), b) nurses to their managers (n=5), and c) other clinical learners (doctoral student therapists and physical therapists) reporting to their supervisors/clinical instructors (n=2).

Multiple barriers to reporting were described in the literature, most commonly: a fear of retaliation, repercussion or retribution (n=17); an assumption that the experience would be dismissed, ignored or unaddressed (n=9); and a lack of support from management (n=6). Others described the culture of silence and submission given the hierarchical medical structure, the prioritization of patient care, feeling disempowered to raise issues of racism in the workplace, and concerns about creating conflict in the workplace as key barriers to reporting discriminatory experiences/assaults. Less cited barriers include feeling the need to handle these issues alone, downplaying incidents as not serious enough to report, normalizing experiences of harassment and feeling pessimistic about the likelihood of such situations changing. Others highlighted being too busy with other responsibilities, feeling dissuaded by cumbersome reporting processes, not knowing where or how to report particularly when senior staff are unavailable, and a lack of policy or standardized protocol as impeding the likelihood or willingness to report. See Appendix B Tables 9a and 9b for references.

Impact of Discrimination

The literature shows that HCWs are deeply affected by these experiences, which have an impact on their emotional and psychological wellbeing, their self-perception, job satisfaction, and how they perform their roles. Table 3 below displays the varying effects of discriminatory experiences on HCWs.

Table 3. Ways in which discriminatory experiences negatively affect healthcare workers

Impact on the HCW	Descriptions
Emotional & psychological responses	• Felt dumbfounded/taken aback (6,75,82,84,91,124,134) • Felt hurt (50,125,174,184,189,190) • Felt sad/disheartened (44,138,171,185) • Felt disappointed (138,188) • Felt devastated (31) • Felt beaten down (121) • Felt defeated (25) • Suppressed their feelings and denied the pain (120) • Felt an added sense of responsibility and concern for the wellbeing of other minority staff (25) • Felt uncomfortable (61,84,88,108,168,180,188) • Felt embarrassed (1,99,108,184) • Felt disrespected (6,86,189) • Felt powerless (1,141,159,181,185) • Felt invalidated (51) • Felt intimidated and unsafe to perform duties (44,75,108,184) • Emotionally/Psychologically traumatized (50,60,86,105,181) • Anger, fear (1,28,67,69,86,88,98,99,108,113,114,138,139,145,181,185) • Frustration and confusion (27,98,145,139,185,188,189) • Emotionally and mentally exhausted (79,98) • Felt terrified (75,91) • Felt shocked (1,24,75,107,138,171) • Felt stressed (60,75,185) • Felt humiliated (1,7,99,162,174,181) • Felt unwelcomed (175,179) • Felt anxious or worried about future incidents (28,84,108,135,153,190) • Felt isolated, alone, invisible (10,43,68,139,153) • Experienced racial fatigue (43,68,79,176)
Negative impact on self-perception	• Engaged in self-loathing for not having thicker skin (125) • Hyperawareness of self-identity (123) • Felt they couldn't be themselves/had to hide identity (85) • Demoralizing (81,98) • Doubted abilities (44,98,166) • Contributed to low self-esteem (157,184,189) • Confidence was lowered (43,62) • Felt inadequate (55) • Ego was damaged (62)
Changed their performance/how they practiced	• Affected ability to focus on learning or training or developing into a better clinician (98) • Affected ability to perform at work (1,44,56,61,185) • Felt a need to prove competency (7,10,56,164,189) • Developed thick skin/got used to it (14,43,147,149) • Doubted whether they could continue caring for the patient (1,67,108,114) • Negatively affected relationship with the patient (1,56,83,86,138) • Questioned duty to care (28) • Silenced oneself due to the interaction (1) • Felt under intense scrutiny/ surveillance (159)
Negative impact on job satisfaction	• Questioned why they would continue to work hard if not appreciated (185) • Considered leaving the job (43,83,149) • Felt dissatisfied with the job (86) • Experienced lower job satisfaction and burnout (56,68) • Contributed to unhappiness with career (8,44,56,86,152) • Threatened job and mental health (175) • Questioned their experiences at work due to their gender (42,188) • No longer felt joy from the job (42,93)

Response to Discrimination

The literature also shows that HCWs respond to these incidents in varying ways. Table 4 highlights the 16 core approaches used, while Table 5 showcases the responses of the supervisor, and/or team/unit.

Table 4. Individual responses to instances of discrimination from patients

Individual Responses	Details of the response
De-escalation	• Walked away/left the room (6,20,25,27,41,43,91,94,119,121,133,134,149) • Distanced themselves from the patient [physically] (44,185) • Responded with humour (7,43,77,108,121,139) • Tried to calm patient down (133) • Kept a cool composure (128,135) • Tried to be as present as possible (75) • Offered empathy/support to the patient (75,77,132) • Attempted to understand the patient's concerns (132)
Transferred Care	• Requested a change to the unit assigned (121) • Switched patients with another HCW (1,30,91,108,159,162) • Asked to be reassigned (127,135) • Changed the shift (121) • Left the position (121) • Suggested other providers for patients (175) • Withdrew from clinical role with specific patient (98,137)
Direct Confrontation	• Talked to patient/family about their behaviour (14,122,138,139,147,159) • Asked the patient to leave (1,125) • Re-asserted their clinical role (25,98) • Reintroduced themselves and their role (25) • Answered patients intrusive and biased questions with direct answers (46,108,124,169) • Remained firm with the patient when stating that their behaviour will not be accepted (43) • Informed the patient of the importance of a respectful environment (91,108) • Intentionally challenged race-related issues/conflicts (79)
Accessed Support from Others	• Relied on colleagues for support (159,185) • Sought support from ethnic minority colleagues (159,166) • Debriefed with colleagues (110,128,132,159,181) • Vented to family/friends (110,128,133,159,166,181)
Relied on Institutional Guidance	• Followed hospital protocols (159) • Applied scripted procedures (159) • Reported the incident (20,27,61,65,80,84,91,94,121,133,135,138,153)
Boundary Setting with Patient	• Role clarification (42) • Asked patient to leave (1,125) • Corrected the misidentification (168,169) • Tried to explain, show, and prove competency to patient (46,50,57,59,91,121,132,162,170) • Described training background and experience that qualifies them for care provision (59,162) • Provided the patient with multiple sources of proof of their credentials (91) • Introduced themselves as doctor instead of using full name (86) • Explained the limits of refusals of care due to staffing (30,137) • Explained the consequences of continuous refusals (i.e., being moved to another institution or delays in care) (98,137) • Explained to patient that they are the most senior clinician [attending] and that they can see a white male intern physician, but the attending would still be involved in their care (177) • Outlined acceptable behaviour guidelines to proceed with care (92) • Taught the patient the correct terms and language to refer to people of colour (102,108) • Told the patient some things are better left unsaid in response to racist comments (108) • Practiced limit setting (110)
Reciprocated Negative Behaviours	• Matched patient's inappropriateness with a comparable inappropriate response (swearing back to patient, giving a sassy response) (122,125) • Became physical with patient (put hand over patient's mouth) (29) • Chased after the patient (107)

Normalized Patient's Behaviour	• "Explained away" the behaviour as due to a medical condition (63,65,102,121,145,146,182) • Assumed the role the patient ascribed to them (192) • Became accustomed to problematic behaviour/accepted bias (10,24,30,98,149,183) • Accommodated the patient's request despite inappropriate rationale (106,116)
Persuasion/Negotiation Tactics	• Persuaded patients to accept care (190) • Worked on a compromise for the patient (112,150)
Used Different Forms of Processing	• Practiced journaling as an avenue to process the behaviour/comments (43) • Engaged in active listening/tried to be present (75) • Became more aware of appearance and surroundings (85)
Reliance on Enforcement Groups	• Called police/security (30, 169)
Masked Aspects of their Identity	• Put up a shield in preparation for the day – changed how they present at work (85) • Masked feminine traits to de-gender the role of a physician (44) • Put on an androgynous front (44) • Altered behaviour after experiencing microaggressions (56,86)
Avoidance	• Ignored/didn't acknowledge the comment (1,24,43,67,99,105,113,114,132,135,138,176) • Ignored behaviour, stayed silent, didn't address (1,65,67,75,79-81,84,90,98,99,113,114,121, 138,141,148,153,166,185,186,190) • Smiled nervously (141) • Unsure how to respond (75,81,124) • Shut down/dissociated (75)
Trauma-informed Disclosures of Identity	• Disclosed sexuality with straight male patients who have been abused by men before providing care, especially intimate care (148)
Reframed the Behaviour	• Relied on personal values to ignore the behaviour (121) • Blamed the external world (society) (121) • Relied on religious beliefs to guide actions and responses (121, 159) • Chose not to internalize the discrimination (121)

Table 5. Responses from the supervisor, team or unit towards the incident

Response	Details of the response
Boundary Setting	• Warned the patient about potential discharge if respect isn't shown/abusive behaviour continues (159) • Informed the patient that services will no longer be provided if discriminatory attitudes continue (94) • Informed the patient that his/his family's behaviour was unacceptable (93,133) • Enforced a non-discriminatory environment by not accommodating biased refusal (175) • Requested that the patient keep the conversation professional and reestablished the role of the targeted individual (51) • Described the institution's anti-discrimination policy, staffing levels and assured patient of the clinician's competence (29,92) • Assured the patient of clinician's compassion and competency (106)
Avoidance/Lack of Action	• Lack of intervention from coworkers and attendings (42,84) • General silence from colleagues (43,44,68,153,168) • Attendings didn't correct the patient or address the incident privately (1) • Team/supervisor ignored the patient's comments (113,174) • Team/supervisor froze/were immobilized by the witnessed incident (25,107,176)
Lack of Support	• Lack of support from some coworkers (81,169,172) • Colleagues laughed at the patient's inappropriate comment/behaviour (44,176) • Supervisor denied targeted clinicians request to be reassigned (135)
Dismissed the Behaviour & Impact of the Behaviour	• Blamed the patient's behaviour on mental state or diagnosis (146,147,190) • Told targeted individual not to take it personally (44,146,179) • Supervisors did not believe that discrimination towards HCWs is still a problem (190) • Discriminatory comments/behaviour were brushed aside, ignored or not taken seriously (138) • Dismissed impact of verbal racial assault on clinician by asking targeted clinician to calm the patient down (93) • Dismissed impact on the clinician by telling them that regardless of the patient's comments/behaviours, they still have to fulfill the role of a physician (127)

Empathy/ Support	• Issued blanket apology (61) • Apologized for their experience and inquired how best to support (14) • Expressed concern over patient's inappropriate comment and provided a path forward (44) • Tried to make light of the irony/hypocrisy of the patient's comments (46,125) • Expressed sympathy, concern and support to the targeted individual over the patient's comments (19,91,113,140,143,165,171,182) • Expressed embarrassment and sadness that a biased request was accommodated (31) • Engaged affected clinician one on one to discuss the situation (186) • Provided guidance on how to handle future encounters (75,98,108)
Redirection	• Redirected inappropriate comment to focus on the patient's care (14) • Changed the topic following the patient's inappropriate comment (113)
Addressed the Bias	• Tried to persuade patients to be accepting of all HCWs (190) • Reassigned the targeted individual to another case (27,46,174) • Care was provided by another clinician (27,97,108,158) • Reported the patient to director of nursing (29) • Changed the layout/how patients were clustered to protect other patients from the biased patient (142) • Defended the targeted individual in response to the discriminatory comments (123)
Enabled Discrimination	• Supervisor condoned biased refusal by telling staff not to provide care to certain patients because of their racial preferences (179) • Accommodated patient's discriminatory request (2,29,31,49,53,79,97,106)

Barriers to Addressing Bias and Discrimination

Different types of barriers were noted throughout the literature. In addition to the various barriers to reporting or documenting an experience, there were also barriers to addressing the incident in the moment or after it happened. Several different barriers to addressing bias and discrimination were raised, most of which spanned varying domains, including: personal (n=15), clinical (n=5), educational (n=33), fear of reprisal (n=14), legal (n=2), professional (n=16), policy (n=20), and institutional (n=125) barriers. See Appendix B Table 10 for references.

Personal Barriers

Personal barriers to addressing patient bias included: low clinician capability, comfort and confidence in responding; desensitization, normalization and diminishment of one's experience of mistreatment from patients, their family members or visitors; perceived ineffectiveness of responding; a desire to maintain patient-clinician rapport and concern that confronting a patient would be too time consuming or would further inflame the situation.

Clinical Barriers

The primary clinical barriers that prevented HCWs from addressing instances of bias were identified as the clinical context as well as the speciality. Some clinical contexts leave little time to establish a therapeutic relationship (e.g., emergency departments) which can dissuade clinicians from confronting discriminatory patients. Additionally, different specialties have varied levels of tolerance for verbal abuse or problematic patient behaviour; in mental health specialties, for example, verbal abuse may be expected or tolerated to various degrees based on the diagnosis in question. However, on general medicine floors/wards, similar behaviours may be seen as surprising and warranting further intervention. The unique position of clinical trainees was reported as a barrier to disclosing experiences; more specifically, team hierarchies and the associated power differentials were identified as barriers that prevented trainees from speaking up about their experiences.

Educational Barriers

The lack of training material or guidance on how to address patient bias, as well as the general lack of discussion in health professions education programs about discrimination and racism generally were the main educational barriers noted in the literature.

Fear of Reprisal

Concerns regarding acts of reprisal and retaliation were described as barriers for both reporting and addressing patient bias. More specifically, fear of legal action against HCWs who terminate the patient-clinician relationship, fear of reprisal on patient-satisfaction scores for terminating the patient-provider relationship, fear of reinforcing the patient's prejudice or ignorance, fear of job loss or punishment, and fear of intervening and becoming a target prevented HCWs from addressing patient bias. Trainees had an additional fear of their instructors' reactions and fear that their evaluations would be affected if they addressed problematic patient behaviour.

Legal Barriers

Other articles explicitly attended to legal barriers that place restrictions on if, when, and how HCWs might respond to instances of patient bias. The legal barriers included restrictions on what can be done to address patient bias in certain situations. For example, the Emergency Medical Treatment and Labor Act (EMTALA) in the United States prohibits hospitals from denying

emergency care. As such, in some contexts, it may be necessary to accommodate or ignore discriminatory behaviours, requests/refusals of care providers. The hiring conditions/employment nuances under which one works was also identified as a barrier; more specifically, a physician's status as an independent contractor as opposed to an employee of the hospital limits the types of rights and protections available. For example, independent contractors in the US are not protected by all sections of the Civil Rights Act, which grants the right to a workplace free of discrimination.

Professional Barriers

Several studies cited the lack of diversity within the health professions as a barrier that prevented underrepresented HCWs from speaking up about and addressing patient bias directly. Other articles noted that regulatory college mandates affected how complaints were handled, and the permissibility of refusing to care for abusive patients. Furthermore, expectations of objective/neutral professionalism in all situations was referenced as a key barrier that prevented HCWs from directly responding to or addressing patient bias. It was also noted that the professional code of ethics lacked proper guidance on mistreatment from patients and thus failed to equip HCWs with the requisite knowledge, skill and training to adequately respond to abusive, disrespectful or discriminatory patients.

Policy Barriers

Some articles noted the role that a lack of policy or an inadequately developed policy plays in hindering how one might want to respond to patient bias (n=10). It was often the case that HCWs were unaware of the institution's policy on the matter, or that the policy itself lacked the necessary levers to make it a supportive policy when faced with bias and discrimination from patients. Some articles identified policies that fail to provide sufficient practical guidance or flexibility as a barrier to responding to these encounters.

Institutional Barriers

A lack of action and follow-up on reports (n=28), as well as a lack of support from management and colleagues in dealing with conflict (n=26) were the two main institutional barriers noted. Other institutional barriers included institutional prioritization of patients over staff; HCWs feeling undervalued, devalued and disempowered; general silence or lack of discussion on bias and discrimination in the workplace; institutional racism; and ingrained gender biases relating to the composition of the healthcare workforce (e.g., that only women can be nurses) that make it difficult to enact change. Institutional culture at times impeded a clinician's ability to feel like they could safely address patient bias. Barriers related to this include not taking issues of racism seriously, refusal to call out acts of discrimination, and a lack of diversity in leadership positions. Other notable barriers included: a lack of inclusion of racism in considerations of workplace violence; a lack of data collection on patient interactions; a lack of staff awareness of institutional reporting mechanisms or resources; customer service models of healthcare, resulting in overprioritizing patient's needs; and, a limited presence of staff with seniority or authority to implement consequences, requiring interns or nurses to respond to biased patients.

Recommendations for Responding to Discrimination

Table 6 below outlines core recommendations for addressing discriminatory behaviour, requests, and refusals across various roles.

Table 6. Individual, team and unit recommendations for addressing patient bias and discrimination

Role	Summarized recommendations

Targeted HCW	**Recommendations on how to respond in the moment**
	• Assess reason for biased patient language, behaviour or request (1,6,19,27,47,51,52,59,66,69,75,80,91,96,124,147)
	• Set clear and explicit boundaries when problematic behaviour or language arises (6,25,69,73,81,91,135,141-144)
	  ○ Inform patient/family about any zero tolerance policies regarding acts of bigotry, discrimination, violence and abuse (52,59,66,81,142,143,177)
	  ○ Inform patient/family that all employees are capable and competent (47,53,55)
	  ○ Make it clear that services can be withdrawn if the abuse persists, and that the patient has the option of seeking care with another clinician or facility (59,66,81,124,142,151-153)
	  ○ If feeling unsafe, physically distance oneself or exit/end the clinical encounter (1,29,67,81,114,116,131,177)
	• Address the comment in real time – avoid silence, minimizing and banter (2,51,55,81,162)
	  ○ Address the behaviour to protect other patients who are also affected by the biased behaviour, language or request (142,144)
	  ○ Engage in open communication with the person (99,119,173)
	• Remain composed/professional when responding and be as compassionate as possible (27,52,57,66,67,69,71,81,88,107,128,130,142,154)
	  ○ Ignore the biased comment (41,75,88)
	  ○ Avoid negative emotion and frame the conversation as positively as possible (82,107,154)
	  ○ Respect cultural differences and individual needs (52,65,139,150)
	• Seek advice from colleagues, supervisors and seniors (47,49,67,177)
	• Assess clinical stability and decisional capacity (6,55,66,108,130)
	  ○ First, treat and stabilize the patient (6)
	  ○ If the patient lacks decision-making capacity, persuade and negotiate (6)
	  ○ If the patient has decisional capacity, inform them that they can leave the care setting and seek care elsewhere (66)
	• Assess the nuances of the case and where necessary, negotiate to establish mutually acceptable conditions for providing care (1,6,150)
	• Clarify roles and challenge stereotypes (27,51,55,88)
	• Report to management (28,29,81,141,142,177)
	• Document the interaction with the patient (114,135,177)
	• Consider if the request is clinically indicated/feasible to a reasonable degree (1,18,47,59)
	• Inform security about any dangerous behaviour, physical attack or verbal abuse/threats (28,47)
	• Share individual perspective on the biased comment/behaviour with the patient (51,55,57,80)
	• Discuss with minority staff (or targeted provider) their preference in responding, i.e., continue providing care or opt out (47)
	• Involve a neutral party or chaperone in interactions with patient/family/visitor (119,150)
	• Acknowledge and assess one's own privileges, biases, prejudices, and potential for harm (10,52,54,61,71,139,146,177,188)

Colleagues, peers and bystanders	• Demonstrate allyship – support the targeted colleague when witnessing racist incidents (105,106,133,165,175,177,190) • Bystanders observing should directly or indirectly intervene, if safe (1,14,105,177) • Peers should speak up and advocate for their colleagues (106,133, 165) • Collectively advocate for an inclusive, equitable environment (164) • Make room for underrepresented colleagues (122,133,166,156,170)

Unit or team	• Check-in and debrief as a unit after each incident (19,20,25,80,98,105,106,117,186)
	• Collaborate to create a team plan to protect targeted individuals and/or debrief the incidents (98,135)
	• In a debrief, cover the following: what went well, challenges experienced, ways to improve and ways to ensure team safety (41,55,82)
	• Isolate the abusive patient/family/visitor from other patients if/when necessary (66,141,142)
	• Promote respectful, professional dialogue to ensure proper treatment of staff and increase diversity (68,79,149)
	• Discuss the experience of abuse with colleagues, and supervisors for reflection (51,55,63)
	• Call for an ethics consult, if/when necessary (116,134)
	• Assess team culture and create a safe space where everyone has the opportunity to process and validate their feelings (14,92,120,133,166)
	• Leaders ought to facilitate reflective dialogue on sensitive topics (including racism and diversity) (1,67,98,114,121,166,171,177)
	  ○ Create an open environment for dialogue where sharing on experiences of racism is understood as acceptable and reportable (121,171)
	  ○ Ensure that white nurses develop the racial stamina to be able to hear the experiences of nurses of colour and engage in authentic cross-racial discussions (120)

Learners	• Report incidents to supervisors (3,25,27,41,163) • Learners have the option to suggest another resident continue with the patient's care (41)

Preceptors	• Debrief with affected trainee immediately after the incident (1,19,25,27,61,73,131)
	  ○ Provide support to the learner, especially in identifying and addressing bias, discrimination and abuse (27,161,166)
	  ○ Involve trainees when determining response to the patient and planning next steps (73)
	• Reaffirm the trainee's role and competence (1,19,27,59,61,73)
	• Provide learners with opportunities to practice responding to potential patient bias scenarios that might arise with patients (75)
	• Acknowledge and address harmful comments from patients, and the impact on trainees (1,3,19,61,73,83,131)
	• Set expectations and discuss protocols for responding to biased patients at the start of the relationship with trainees (1,3,73,163)
	• Create caring and accepting learning environments (3,27,71,80,87)
	• Preceptors should model appropriate behaviour (3,27,71,80,87)
	• Faculty should halt the problematic patient behaviour through a calm, professional response or interruption (19,73)
	• Inform patients that discriminatory behaviour is impermissible and will not be tolerated (3,19,73)
	• Alert patients in advance/make them aware of the presence of medical students and learners (55,61)
	• Temporarily remove learners from the biased interaction (55)
	• Empower learners to remove themselves from discriminatory encounters, if necessary (61,117)

Supervisors and managers	• Assert targeted clinician's competency and role (18,134,174) • Set expectations that everyone is treated with respect, and that discrimination is not tolerated (18,131,143) • Provide support and debrief with the targeted clinician (18,105,115,134) • Explore reasons for the patient's request, including speaking with the family (18,134) • Reassign and/or transfer harmful patients and explain the transfer of care (105,135,174) • Model effective and supportive leadership by calling out harmful patient behaviour (14,177)

Table 7. Institutional recommendations to address discriminatory behaviour

Recommendation theme	High-level recommendation	Detailed explanation
Education	Implement training on how to address discrimination and harassment	• Implement bystander training to teach staff how to support their colleagues should they be targets of patient bias, discrimination and/or harassment (42,65,67,71,78,83,87,105,110,131,161) • Provide staff with the necessary skills/education required to address/challenge racism, racial discrimination and racial prejudice (1,2,3,43,55,62,103,108,152,176,179) • Provide education on how to respond to biased or discriminatory requests/refusals (1,7,55,76,87,98,99,110,115,116,117,131,132,157,162) • Build content on discrimination, and the various forms it may take into pre-clerkship curricula (1,55) • Educate clinicians on their rights and responsibilities as employees/care providers (1,56,81) • Provide training on self-defense to aid in situations of violence and aggression (28)
	Embed equity, diversity and inclusion (EDI) training across the institution	• Embed anti-racism, anti-discrimination and EDI training and education into core institutional trainings (61,71,73,76,103,145,160,164,167,177,188) • Provide cultural diversity, cultural competency, and cultural safety training (7,50,67,76,96,117,118,122,170,180) • Update curricula to be more EDI oriented (1,55,165) • Provide diversity management training for those in leadership roles (97) • Institute ongoing/longitudinal and mandatory EDI training for all (1,50) • Provide targeted training for migrant minority nurses to facilitate integration into the new work country (7,8,50,189)
Learners	Implement specialized training for learners to prepare them for incidents of patient bias	• Preceptors should set expectations and prepare learners for potential discriminatory events (20,55,62,67,117,157) • Residency program directors should be proactive about developing formal methods to monitor and address instances of bias or discrimination experienced by residents (85) • Physiotherapy programs should include anti-racist resources and education programs to aid learners (166) • Institutions ought to ensure that trainees are provided with resources, supports and guidance on how to address microaggressions from patients (56,83)

	Implement measures to ensure for diversity in healthcare education	• Implement efforts to increase diversity within trainee programs (85,96,166) • Nursing education should integrate decolonizing approaches that bring together diverse stories to inform the values and structures embedded in nursing curricula, teaching methodologies and professional development (171) • Nursing programs need to adopt strategies that best fit students' needs and provide resources for the success of minority students in clinical education practice (58) • Faculty should set the tone for patients and families by demonstrating respect and the use of proper titles for trainees once patient encounters/interactions begin (87) • Education programs should recognize and address inequalities experienced by learners as a result of longstanding systemic factors (164)
	Prioritize exemptions for students/ learners based on their needs in the moment	• Students should be exempted from providing further care to biased patients but should also be given the option to continue providing care/not be removed, should they wish to stay (3) • Academic programs to foster a welcoming environment of diversity, equity and inclusion (51,58,75,83,96,131,132,161,166,177)
Accommodation	Understand the conditions for accommodating requests for specific providers	• Accommodate culturally or religiously appropriate requests (1) • Accommodate clinically indicated concordances (3) • Accommodate or work towards mutually acceptable conditions for patients who are prone to biased behaviour as a result of psychiatric illnesses or cognitive impairment (70,151) • Competent patients have the right to refuse care, including care from an unwanted clinician and should be treated in a compassionate and respectful manner, even if the clinician feels hurt or unfairly stereotyped by the patient's request (27)
	Acknowledge obligations to care and to accommodate	• Hospitals are under no obligation to provide additional physicians on account of patient prejudice (65) • The decision to accommodate racist demands for a particular provider or to exclude particular providers is at the discretion of the treating institution (70) • Processes to ensure continuity of care for patients needing transfer when they refuse to be treated by the team are needed (117) • In smaller communities, where there are fewer choices, the obligation is greater to make the physician-patient relationship work because patients do not have alternative sources of care (124)
	Establish limits and boundary-set against accommodation	• There is a duty to challenge patients who do not wish to be seen by particular health professionals or staff because of their ethnicity (151) • Institutions should not accommodate patients in stable condition who persist with reassignment requests based on bigotry (6) • Accommodating racist demands says that the institution believes complying is more important than respecting the dignity of their staff and the majority of patients (70,151) • Healthcare institutions should not accommodate discrimination (93) • If a patient persists in racist language or behaviours following a verbal reminder about a code of conduct, the care team should assess the individual's ability to be discharged (105) • If a racist and disruptive patient does not have a medical condition requiring emergency stabilization and could otherwise be treated as an outpatient, discharging the patient is acceptable (105)
Professional Bodies	Acknowledge the problem and establish anti-abuse policies	• Professional bodies should issue statements and guidelines that address discrimination, including discriminatory requests for providers and the intersectional nature of discrimination that many women of color experience (65,155) • Leading nursing organizations should release position statements regarding racial and ethnic discrimination experienced by minority migrant nurses (97) • Professional bodies should develop position statements that addresses race-based physician requests (134) • Medical regulators should address racism in anti-abuse policies to give clinicians guidance on how to respond (157,162)
	Embed cultural competence and de-escalation strategies into professional standards of practice & codes of ethics	• Cultural competence and the de-escalation of conflicts should be integrated into professional standards of direct care practice (159) • Codes of professional ethics should provide guidance on how to respond to patients who engage in disrespectful behaviour (64,142)
	Generate discussion within the profession to support individual institutions and clinicians	• Professional bodies should start broader dialogue about the influence of racism in the healthcare workplace and the importance of increasing workplace diversity (79) • Greater crosstalk needed between organizations and professional bodies; organizations need to have an understanding of the available guidance from associations, legislation and professional colleges to develop consistent responses to discriminatory care provider preferences (18)

Research	Policy on the topic must be informed by research on lived experiences	• Research that explores the lived experiences of LGBT nurses is necessary to establish fair and effective policies for managing conflicts (67,114) • Future research exploring discrimination against clinicians from nonvisible and visible minorities is needed (160) • Future work should focus on the experiences of residents and consider the impact of these events on the individual and the training environment (161) • The experiences of nursing staff should be assessed to determine whether sexual harassment is an issue within the organization (181) • Research on sexism in healthcare and how the hierarchy of medical professionals affects the way patients view doctors and nurses is needed (169) • Research related to nursing students' experiences of racism is needed (157)
	Research to inform evidence-based interventions is needed	• Research agendas on the topic is necessary to combat racial discrimination in the workplace (61,68) • Research on microaggressions from patients is essential to establish evidence-based processes and policy protocols on how to handle these incidents (67) • Future research should explore and evaluate the effectiveness of interventions i) targeting racism, ii) decreasing misidentification of women physicians, and iii) that prevent and combat violence in the workplace of health professionals (86,177,182) • Research on how institutions should support HCWs experiencing abuse from patients (30)
Institutional resources and supports	Provide communication tools to aid discussions	• Provide communication scripts for use with discriminatory patients (25,43,56,73,82,105,106,112,117) • Integrate communication tools (i.e., intake questionnaires or scripts) to ask about gender-based preferences regarding care providers (150)
	Consider patient contracts or care plans	• Use patient contracts to address biased or discriminatory behaviour with clear consequences for repeated violence (3,105,129) • Integrate contracts or care plans for repeat offenders of racist verbal aggression clearly outlining behavioural expectations when receiving emergency and hospital-based care (105)
	Create and distribute signage across the institution	• Post notices that all patients are welcome, that hospital staff are diverse, and that care will be administered by an available provider; a medically unstable patient can be stabilized and diverted to another facility if unable to accept this policy (31,66) • Post signage to reinforce values of mutual respect in the clinical encounter (73,105)
	Create multidisciplinary action committees to help adjudicate	• Create a diversity action committee or an equity task force (which has power equal to other units in the organization reporting directly to leadership) that examines local contexts and implements solutions raised by oppressed groups (71,164) • Build a multidisciplinary taskforce to spearhead education initiatives addressing discriminatory patients (117) • Implement an interdisciplinary committee to address discriminatory patient behaviour (129) • Use Coordinated Care Review Boards to identify: i) problematic/negative behaviours, ii) limit negative behaviors, and iii) promote a culture where mutual respect is valued and practiced (129)
	Offer targeted resources and support based on need	• Invest in security and provide resources and training for self-defense (28) • Establish a well-advertised sexual harassment office whose role extends to the hospital setting (161,167) • Offer confidential counselling (167) • Institutions should have an ombudsman for staff to turn to when they face abuse (161,167) • Contact information for ethics consultation service should be made available (91) • Additional funding and supports are needed to strengthen the mental health of long-term care facility staff, including those that address mental health consequences of discrimination that staff encounter from residents while performing their job (65) • Explore legal recourse for physicians of colour if healthcare organizations tie their pay to patient satisfaction scores (68) • Consider public investments in safety measures to contain and treat cases of assault (182) • Hold interventions between nursing home residents and staff (102)
	Embed existing legislation and protocols, where appropriate	• Incorporate relevant legislation when responding to patient bias (e.g. The Race Relations Act 1979 and Race Relations (Amendment) Act 2000; The Commission for Equality and Human Rights in the U.S) (158) • Incorporate relevant guidelines or protocols available in the literature (e.g., use of UHN's caregiver preference protocol while accounting for contextual adaptations for specific countries). Additionally, ethnicity of the practitioner, hierarchical level of power as well as the political climate should be considered (174)

	Create professional development opportunities and support groups	• Create program-specific women's professional development groups for support and broader interventions on gender bias (42) • Create a mentorship program for residents to feel comfortable and to help obtain advice when reporting incidents of discrimination (26) • Implement various leadership initiatives to build and foster necessary leadership skills (122,164) • Programs and departments could encourage and sponsor underrepresented individuals to pursue leadership positions (122,164) • Create mentorship and sponsorship programs for historically excluded peoples (122,170) • Create ways for BIPOC staff/students to share experiences of racism or trauma, strategize ways of coping, and connect with others (10,60,79,165,166,167) • Support the integration of immigrant and migrant nurses (7,50,97,179)
Policy	Recommended types of policies for addressing patient bias	• Policies ought to embed zero tolerance to discrimination and abuse towards HCWs (26,66,83,93,105,105,118,151,153,174,175,180) • Institutions should enforce anti-discrimination, anti-racism and anti-abuse policies from all levels (53,60,61,63,68,113,137,159,169,171) • Policy needs to address discriminatory patients in a way that protects HCWs (20,31,43,61,80,87,93,117,128,141,142,144,190) • Institutions should issue policies on human rights and sexual harassment (155,167,181,188,192) • Institutions should create patient and visitor codes of conduct that outline acceptable behaviours towards HCWs (26,105,106,115,135,162) • Institutions should develop trainee/learner specific policies (3) • A Practitioner's Rights Law complementary to the Israeli Patient's Rights Law should be established to delineate the rights and obligations of practitioners as well as provide legal and perhaps, moral grounds for handling various incidents of racism in healthcare organizations (174)
	Policy considerations to embed	• Policies on the topic need to explicitly address patient bias (3) • Policies should recognize patients' past experiences (including discrimination in the healthcare system) (3) • Anti-discrimination prevention efforts need to be multimodal (including individual efforts, workplace policies and the promotion of tolerance and respect across various levels of society) (185) • Policy drafting should involve multiple disciplines with expertise in conflict resolution and counselling, educational leadership and union representation (3) • Reassignment requests should be addressed separately to guidelines on patients' biased conduct (3) • Policies must be infused with follow-up and accountability procedures (60,108,122) • Policies should have transparent processes for reporting discriminatory behaviour and other potential biases (121,171) • Policy should use language that incites an active and systemic response (25) • Policies should include pathways to documenting microaggressions and being transparent about the frequency of such events and approaches to addressing them (101) • Policies should identify antiracist actions with measurable goals, objectives and timelines (60) • Policies should review and strengthen existing antidiscrimination and EDI policies (2,50,89,177,190) • Policies should be posted publicly so that patients and visitors know what to expect before going to the hospital (81) • Policies need to recognize patient vulnerabilities and rights as well as the rights and responsibilities of staff (3,29,79,93) • Policies should include formal processes that embed discussions with the affected healthcare worker and discussions with the team to share and learn from such experiences (186) • Policies should recognize the impact of such incidents on bystanders/onlookers (19)

Institutional Culture	Address the lack of diversity in the workforce	• Increase diversity at the senior management levels (82,83,85,96,122,123,165,170,180,190) • Address the hiring practices to ensure for a diverse workforce (96,103)
	Set transparent expectations for patient conduct	• Organizations need to make choices about whether and how to communicate the existence of care provider preference guidelines to their patients (18) • Patients should be made aware that there are consequences for abusive or discriminatory behaviours towards HCWs (26,81) • Proactive communication about values, equity, diversity & inclusion, and intolerance for biased or harmful patient conduct towards staff should be made clear (1) • Leadership should enforce accountability at the individual and group levels (71)
	Challenge problematic internal culture	• Institutions should challenge and change institutional, systemic, cultural and societal policies and practices that manifest and support racism (84,164) • Institutions should name and recognize issues of prejudice and discrimination (43,179) • Institutions should immediately confront racism (2) • Institutions should recognize that racism permeates all levels of society (177) • Institutions should incorporate mechanisms that enforce/support a safe and inclusive workplace (19,68,84,118,140,147,186) • Healthcare culture must be respectful and civil for patients to be expected to behave respectfully toward staff (64) • Institutions should foster a culture of transparency that includes open communication (81,99,105) • Institutions should create cultures where workers feel secure to voice their concerns about racism and know that they will be taken seriously (19,147) • Implement cultural safety to address issues of bias and discrimination (10)
Documenting & Reporting	Standardized methods of reporting and tracking	• Create a standard way to report and address discrimination from patients (3,6,21,25,26,45,60,65,73,74,85,105) • Create tracking and data collection mechanisms and procedures (3,6,19,25,85,105,123,163) • Implement confidential annual mistreatment surveys for longitudinal tracking and intervention (117)
	Culture of reporting and accountability	• Improve institutional attitudes towards reporting (19,26,110,113,164) • Create cultures of reporting without fear of reprisal or retaliation (19,26,110,113,164)

Sociopolitical Context – Geopolitical Influences

Of the 173 articles, 20 articles referred to a broader sociopolitical context in which they were written. This includes civil litigations brought forward by racialized HCWs in the US in response to hospital accommodations of racist patient requests (n=3), most notably, the Smith v CNA Financial Corporation (49) and the Chaney v Plainfield Health Care Center (31) cases in 2010, as well as the Battle v Hurley Medical Center (70) case in 2012. Similarly, public cases of physician advocacy/speaking up about experiences with patient bias/discriminatory requests/refusals in the media (154) were also noted in the literature. Other articles referenced highly publicized instances of police brutality, most notably, the 1993 Stephen Lawrence Inquiry and resulting Macpherson report in the UK (2,151) and the 2020 murder of George Floyd in the US (84,120). Sociopolitical changes in various geographical areas (e.g., the US and Sweden) were also contextualized in some articles on patient bias (25,107,190). For example, some authors situated their experiences within the context of an increase in white nationalism in the US once the Trump administration was sworn into office (25,107), whereas others pointed to the increased xenophobia associated with the increasing rates of immigration in Sweden (190). Other significant geopolitical events referenced as affecting preferences for specific HCWs were the Iraq war (57,118), COVID-19 pandemic (28,87,187) and the ongoing conflict between Israel and Palestine (30,172,174), which were also significant events affecting patient bias and preferences for specific providers/refusals of others.

DISCUSSION

The aim of this scoping review was to identify predominant themes, experiences and recommendations for HCWs when navigating discrimination from patients, their family members and visitors. To our knowledge, this is the first scoping review that reviews English qualitative, quantitative and review articles examining all types of discrimination from patients towards HCWs, with an exclusive focus on generating both individual and institutional level recommendations for change. While other scoping reviews have explored racism in healthcare, with some examining the experiences of HCWs (192,193), the topic of focus tends to be on how racism is discussed/produced in healthcare settings (193,194), or the various anti-racism interventions currently at play (195). The current study expands upon the available literature by describing the variation in the types of discrimination experienced; who is most targeted; the impact of the discriminatory experience(s); responses to the discriminatory incident, including whether or not it is reported; barriers to addressing the incident and to reporting; and most notably, recommendations for change at both individual and institutional levels.

As with other studies, our review identified that discussions on discrimination in healthcare are largely situated within the US context (193,194) with smaller pockets in the UK and Canada. Our findings confirm earlier remarks that the experiences of physicians and physician learners dominate the literature in this area (17). This is closely followed by the experiences of nurses and nursing learners. The predominant focus on physician and nurse experiences puts into context the article distribution across mainly medical and nursing journals. Our review also focused on the social identity of the targeted healthcare worker, noting the significance of intersectionality and the predominance of anti-Black racism. Several of the discrimination experiences noted focused on multiple aspects of the healthcare worker's identity as opposed to a singular focus (for example, a Black, Muslim, female doctor experiencing discrimination on account of her racial background, gender identity, and religious affiliation). Evidence of anti-Black racism was particularly clear in the US context, where there were more precise descriptors used to capture the specific racial background of the healthcare worker (14,20,55,61,82,94,117) as opposed to the UK/European based studies, which tended to focus more on the experiences of "ethnic minority" HCWs (151,152,180).

Given our broadened focus on experiences of all types of discrimination, our review highlights the breadth and depth of discriminatory experiences in an array of healthcare settings. While our findings reveal an overwhelming focus on experiences of racism, particularly, anti-Black racism, there are also several examples of sexism (26,42), homophobia (75,160,110), islamophobia (171), anti-Semitism (31) and xenophobia (190), as well as experiences of discrimination on account of a person's status as a learner (59), their political views (81), the training location (173), their accent (10,62,179), age (82,159), disability (14,139), nationality (85,105,138) and language (145,156). The impact of such experiences is profound; the literature notes that repeated exposure to such experiences takes an emotional toll on HCWs, often leading to feelings of demoralization, stress and burnout (25,43,60,68,75,79,121,176,185). Table 3 confirms the significance of these experiences for HCWs, most notably, how it impacts their emotional and psychological wellbeing, job performance, and job satisfaction.

We identified numerous individual strategies employed when responding to discriminatory experiences. These included de-escalation strategies, care transfers, confrontation-based and avoidant-based strategies, among other tactics. Interestingly, strategies employed in response to these incidents varied according to role and were often associated with specific responsibilities (e.g., if a preceptor witnessed a discriminatory experience endured by a learner, there were often specific supervisory responsibilities for escalation associated with the role). Despite this, variances in responses and strategies employed supports the need for carefully curated standards, guidelines and protocols for navigating these issues in a uniformed way.

Our results suggest that various barriers operating in the clinical environment prevent HCWs from reporting and responding to these incidents in effective ways. How one responds, and to whom one escalates an incident, has direct implications on how the incident is triaged, but also affects future reactions and responses. While some have written about the need for effective policy on the issue (17-23), the creation of such policies is just now gaining traction. This review sets the stage for further research on the experiences of HCWs, particularly as it relates to evaluating responses to discriminatory requests/behaviour, and removing barriers that prevent proper responding, reporting and escalating. Our findings provide the foundations for evidence-based mobilization on this issue. The recommendations identified in Tables 7 and 8 provide instructions for institutional efforts to establish anti-discrimination policies and set organizational standards on addressing discriminatory behaviour, and requests/refusals of care providers. Given the predominant focus on the experiences of physicians and nurses, we caution that the recommendations provided are largely situated within the medical and nursing dimensions. We therefore note that future research needs to go beyond these two professions and consider the usefulness of these recommendations for the health professions more generally.

Our findings are situated within contentious sociopolitical and geopolitical contexts (e.g., the murder of unarmed Black men, Israel-Palestine conflict, COVID-19, white nationalism). These observations remind us that the frequency and focus on who is targeted/who experiences discrimination cannot be separated from the larger context of who comprises the healthcare workforce (i.e., the contemporary diversification of the healthcare workforce globally). This is significant given the historical exclusion and segregation of Black and other racialized people from medical and nursing schools in the US and Canada, which had a direct effect on who accessed the profession and when (196-198). Many of these schools enforced strict racial quotas or outright bans on Black applicants, effectively excluding them from these professions (e.g., McGill University and Queens University, in Canada). In fact, it wasn't until 2018 that Queens University officially repealed the 1918 ban against Black applicants, with its formal removal in 2019 (196,199). The discussion on discrimination from patients must be contextualized within this history of systemic racism, segregation, and exclusion as it provides insight on the social dynamics and contemporary trends observed within healthcare leadership, and healthcare systems, more generally.

Addressing discrimination in healthcare requires a multifaceted approach. Firstly, healthcare organizations must prioritize creating work environments that denounce discrimination of all kinds. This involves implementing zero tolerance policies and protocols that effectively address instances of discrimination and provide HCWs with necessary support and protection. These policies must be rooted in evidence-informed interventions that actually protect HCWs and provide the necessary supports and resources to address the situation. Additionally, effective training and education on the topic must be provided to HCWs and patients, ensuring that healthcare spaces remain inclusive for all involved in the provision and receipt of care. Lastly, as the healthcare workforce continues to make strides in reflecting the global majority, individual organisations must make concerted efforts to retain their staff, as continued exposure to these experiences will contribute to many leaving the healthcare field in droves, thus further exacerbating existing staffing shortages in particular fields.

LIMITATIONS

This study is limited to English language articles identified through the 4 databases searched. This means engagement in this topic in other languages and outside of the disciplinary domains explored is not captured in our analysis. Additionally, while the use of multiple independent reviewers and extractors supports the reliability of the selection process, this could have introduced some level of discrepancy throughout the process. We attempted to correct for this by holding regular meetings to go through any discrepancies noted, and to also do joint screenings and extractions. Lastly, the lack of disciplinary diversity in our findings is a significant limitation in that there may be nuances specific to some disciplines less commonly represented in the literature that might make them more or less susceptible to particular types of experiences and interactions with patients. For example, the manner in which physiotherapists or occupational therapists interact with patients might call for a unique response to discriminatory comments or aggressive behaviour not reflected in the identified recommendations.

CONCLUSION

This scoping review mapped the state of the literature on healthcare workers' experiences of discrimination from patients, their families and visitors. Our review highlights the need for concrete guidance and protections from employers, professional bodies and health systems more broadly, especially in light of the clear tensions in obligations to patients and HCWs. Good quality patient care can only be truly optimized in spaces where HCWs are physically and psychologically safe to perform their duties. This calls for broader acknowledgement of the multidirectional nature of discrimination in healthcare, especially when considering policy-related interventions aimed at addressing violence and behavioural issues in clinical work environments. Additionally, further research on the experiences of HCWs across the health professions and at various stages of training would bolster the academic literature in this area, especially if supplemented with jurisdiction-specific legislation on employer obligations to prevent harassment and provide a discrimination-free work environment.

Reçu/Received: 20/06/2024

Publié/Published: 28/04/2025

Remerciements
Nous remercions Sun Drews, Nasra Tahlil et Julia McCann-Pepe pour leur contribution au processus de sélection et d'extraction. Ann Heesters pour les ressources et le soutien qu'elle a apportés à la réalisation de cette étude et du projet plus vaste dont elle découle.

Acknowledgements
We are grateful to Sun Drews, Nasra Tahlil, and Julia McCann-Pepe for their contributions to the screening and extraction process. Additionally, we would like to thank Dr. Ann Heesters for the resources and support to conduct this study and the larger project from which it derives.

Conflits d'intérêts
Aucun à déclarer

Conflicts of Interest
None to declare

Édition/Editors: Aliya Affdal

Les éditeurs suivent les recommandations et les procédures décrites dans le Core Practices de COPE. Plus précisément, ils travaillent pour s'assurer des plus hautes normes éthiques de la publication, y compris l'identification et la gestion des conflits d'intérêts (pour les éditeurs et pour les auteurs), la juste évaluation des manuscrits et la publication de manuscrits qui répondent aux normes d'excellence de la revue.

The editors follow the recommendations and procedures outlined in the COPE Core Practices. Specifically, the editors will work to ensure the highest ethical standards of publication, including: the identification and management of conflicts of interest (for editors and for authors), the fair evaluation of manuscripts, and the publication of manuscripts that meet the journal's standards of excellence.

Évaluation/Peer-Review: Nadeem Moghal & Rachel Horton

Les recommandations des évaluateurs externes sont prises en considération de façon sérieuse par les éditeurs et les auteurs dans la préparation des manuscrits pour publication. Toutefois, être nommé comme évaluateurs n'indique pas nécessairement l'approbation de ce manuscrit. Les éditeurs de la *Revue canadienne de bioéthique* assument la responsabilité entière de l'acceptation finale et de la publication d'un article.

Reviewer evaluations are given serious consideration by the editors and authors in the preparation of manuscripts for publication. Nonetheless, being named as a reviewer does not necessarily denote approval of a manuscript; the editors of *Canadian Journal of Bioethics* take full responsibility for final acceptance and publication of an article.

REFERENCES

1. Chandrashekar P, Jain SH. Addressing patient bias and discrimination against clinicians of diverse backgrounds. Academic Medicine. 2020;95(12S):S33-43.
2. Moghal N. Allowing patients to choose the ethnicity of attending doctors is institutional racism. BMJ. 2014;348:g265.
3. Paul-Emile K, Critchfield JM, Wheeler M, de Bourmont S, Fernandez A. Addressing patient bias toward health care workers: Recommendations for medical centers. Annals of Internal Medicine. 2020;173(6):468-73.
4. Popper-Giveon A, Keshet Y. The secret drama at the patient's bedside—refusal of treatment because of the practitioner's ethnic identity: the medical staff's point of view. Qualitative Health Research. 2018;28(5):711-20.
5. Hennein R, Tineo P, Bonumwezi J, Gorman H, Nguemeni Tiako MJ, Lowe SR. "They wanted to talk to a 'real doctor'": predictors, perpetrators, and experiences of racial and ethnic discrimination among healthcare workers. Journal of General Internal Medicine. 2022;37(6):1475-83.
6. Paul-Emile K, Smith AK, Lo B, Fernández A. Dealing with racist patients. New England Journal of Medicine. 2016;8(374):708-11.

7. Xu Y. Strangers in strange lands: a metasynthesis of lived experiences of immigrant asian nurses working in Western countries. Advances in Nursing Science. 2007;30(3):246-65.
8. Klingler C, Marckmann G. Difficulties experienced by migrant physicians working in German hospitals: a qualitative interview study. Human Resources for Health. 2016;14:57.
9. Hagey R, Choudhry U, Guruge S, Turrittin J, Collins E, Lee R. Immigrant nurses' experience of racism. Journal of Nursing Scholarship. 2001;33(4):389-94.
10. Moceri JT. Hispanic nurses' experiences of bias in the workplace. Journal of Transcultural Nursing. 2013;25(1):15-22.
11. Okougha M, Tilki M. Experience of overseas nurses: the potential for misunderstanding. British Journal of Nursing. 2010;19(2):102-6.
12. Allan HT, Cowie H, Smith P. Overseas nurses' experiences of discrimination: a case of racist bullying? Journal of Nursing Management. 2009;17(7):898-906.
13. Ahmad SR, Ahmad TR, Balasubramanian V, Facente S, Kin C, Girod S. Are you really the doctor? Physician experiences with gendered microaggressions from patients. Journal of Women's Health. 2021;31(4):521-32.
14. Bullock JL, O'Brien MT, Minhas PK, Fernandez A, Lupton KL, Hauer KE. No one size fits all: a qualitative study of clerkship medical students' perceptions of ideal supervisor responses to microaggressions. Academic Medicine. 2021;96(11S):S71-80.
15. Martin MB. Perceived discrimination of Muslims in health care. Journal of Muslim Mental Health. 2015;9(2):41-69.
16. Jang Y, Yoon H, Kim MT, Park NS, Chiriboga DA. Preference for patient–provider ethnic concordance in Asian Americans. Ethnicity & Health. 2021;26(3):448-59.
17. Drews S, Barned C. Who protects clinical learners in Canada? Ethical considerations for institutional policy on patient bias. Canadian Journal of Bioethics / Revue canadienne de bioéthique. 2023;6(3-4):33-43.
18. Anstey K, Wright L. Responding to discriminatory requests for a different healthcare provider. Nursing Ethics. 2013;21(1):86-96.
19. Paul-Emile K. How should organizations support trainees in the face of patient bias? AMA Journal of Ethics. 2019;21(6):E513-20.
20. Mitchell CD. How should clinicians and trainees respond to each other and to patients whose views or behaviors are offensive? AMA Journal of Ethics. 2019;21(6):E480-4.
21. Mustapha T, Ho Y, Andrews JS, Cullen MJ. See no evil, hear no evil, stop no evil: institutional-level tracking to combat mistreatment of residents and fellows. Journal of Graduate Medical Education. 2019;11(5):601-5.
22. Walker VP, Hodges L, Monica PM, Sim M, Harris C. Taking the VITALS to interrupt microaggressions. MedEdPORTAL. 2024;18:11202.
23. Warner NS, Njathi-Ori CW, O'Brien EK. The GRIT (Gather, Restate, Inquire, Talk It Out) Framework for addressing microaggressions. JAMA Surgery. 2020;155(2):178-9.
24. Cottingham MD, Andringa L. "My color doesn't lie": race, gender, and nativism among nurses in the Netherlands. Global Qualitative Nursing Research. 2020;7:2333393620972958.
25. Williams JC, Rohrbaugh RM. Confronting racial violence: resident, unit, and institutional responses. Academic Medicine. 2019;94(8):1084-88.
26. Pendleton AA, McKinley SK, Pendleton VE, et al. A multi-institutional study of patient-derived gender-based discrimination experienced by resident physicians. The American Journal of Surgery. 2021;221(2):309-14.
27. Peek M, Lo B, Fernandez A. How should physicians respond when patients distrust them because of their gender? AMA Journal of Ethics. 2017;19(4):332-9.
28. Oxtoby K. Another epidemic: abuse and violence towards doctors from patients and the public. BMJ. 2021;372:n739.
29. Taylor-Walton C, Anema MG. Manager's dilemma: dealing with a patient's prejudices. Nursing. 1990;6(20):32DD-32FF.
30. Keshet Y, Popper-Giveon A. Race-based experiences of ethnic minority health professionals: Arab physicians and nurses in Israeli public healthcare organizations. Ethnicity & Health. 2018;23(4):442-59.
31. Rosoff PM. Making sausage. Narrative Inquiry in Bioethics. 2016;6(1):31-3.
32. Otte S V. Improved patient experience and outcomes: is patient–provider concordance the key? Journal of Patient Experience. 2022;9:23743735221103033.
33. Saddler N, Adams S, Robinson LA, Okafor I. Taking initiative in addressing diversity in medicine. Canadian Journal of Science, Mathematics and Technology Education. 2021;21(2):309-20.
34. Wallis CJD, Jerath A, Coburn N, et al. Association of surgeon-patient sex concordance with postoperative outcomes. JAMA Surgery. 2022;157(2):146-56.
35. Human Rights Code, R.S.O. 1990, c. H.19.
36. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. International Journal of Social Research Methodology. 2007;8(1):19-32.
37. Daudt HML, van Mossel C, Scott SJ. Enhancing the scoping study methodology: a large, inter-professional team's experience with Arksey and O'Malley's framework. BMC Medical Research Methodology. 2013;13:48.
38. 38.Pham MT, Rajić A, Greig JD, Sargeant JM, Papadopoulos A, McEwen SA. A scoping review of scoping reviews: advancing the approach and enhancing the consistency. Research Synthesis Methods. 2014;5(4):371-85.
39. Badger D, Nursten J, Williams P, Woodward M. Should all literature reviews be systematic? Evaluation & Research in Education. 2000;14(3-4):220-30.
40. Tricco AC, Lillie E, Zarin W, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): checklist and explanation. Annals of Internal Medicine. 2018;169(7):467-73.

41. Chakrabarty A. "Don't you have any American doctors?": international medical graduates and patient prejudice. AMA Journal of Ethics. 2012;14(4):310-11.
42. Stavely T, Salhi BA, Lall MD, Zeidan A. "I just assume they don't know that I'm the doctor": Gender bias and professional identity development of women residents. AEM Education and Training. 2022;6(2):e10735.
43. Filut A, Alexander L, Ray A, Pecanac K, Carnes M. "This happens all the time": a qualitative study of general internists' experiences with discriminatory patients. Journal of General Internal Medicine. 2021;36(6):1553-60.
44. Babaria P, Abedin S, Berg D, Nunez-Smith M. "I'm too used to it": A longitudinal qualitative study of third year female medical students' experiences of gendered encounters in medical education. Social Science & Medicine. 2012;74(7):1013-20.
45. Hennein R, Tineo P, Bonumwezi J, Gorman H, Nguemeni Tiako MJ, Lowe SR. "They wanted to talk to a 'real doctor'": predictors, perpetrators, and experiences of racial and ethnic discrimination among healthcare workers. Journal of General Internal Medicine. 2022;37(6):1475-83.
46. Jagsi R. How deep the bias. JAMA. 2008;299(3):259-60.
47. Martorella C, Beglinger J. A prejudiced patient. Hospitals and Health Networks. 2003;77(12):28.
48. DeWane ME, Mattessich S, Wu R, Whitaker-Worth D. A survey study of resident experiences of sexual harassment during dermatology training. Journal of the American Academy of Dermatology. 2020;83(2):594-6.
49. Lane-Fall M. Accommodating bigotry. JAMA. 2014;311(2):139-40.
50. Xu Y, Gutierrez A, Kim SH. Adaptation and transformation through (un)learning: lived experiences of immigrant Chinese nurses in US healthcare environment. Advances in Nursing Science. 2008;31(2):E33-47.
51. Sheffield V, Fraley L, Warrier G. Addressing biased patient behavior: a teachable moment. JAMA Internal Medicine. 2021;181(12):1631-2.
52. Bartoli E, Pyati A. Addressing clients' racism and racial prejudice in individual psychotherapy: Therapeutic considerations. Psychotherapy: Theory, Research, Practice, Training. 2009;46(2):145-57.
53. Rakatansky H. Addressing patient biases toward physicians. Rhode Island Medical Journal. 2017;100(12):11-2.
54. Calhoun AJ, Martin A, Adigun A, et al. Anti-Black racism in clinical supervision: asynchronous simulated encounters facilitate reflective practice. MedEdPublish. 2023;13:4.
55. Shankar M, Albert T, Yee N, Overland M. Approaches for residents to address problematic patient behavior: before, during, and after the clinical encounter. Journal of Graduate Medical Education. 2019;11(4):371-4.
56. Ahmad SR, Ahmad TR, Balasubramanian V, Facente S, Kin C, Girod S. Are you really the doctor? Physician experiences with gendered microaggressions from patients. Journal of Women's Health. 2022;31(4):521-32.
57. Kheirbek RE. At the VA, healing the doctor-patient relationship. Health Affairs. 2017;36(10):1848-51.
58. Graham CL, Phillips SM, Newman SD, Atz TW. Baccalaureate minority nursing students perceived barriers and facilitators to clinical education practices: an integrative review. Nursing Education Perspectives. 2016;37(3):130-7.
59. Beer DA, Macklin R, Robinson W, Wang P. Bad night in the ER -- patients' preferences and reasonable accommodation. Ethics & Behavior. 1996;6(4):371-83.
60. Salvant S, Kleine EA, Gibbs VD. Be heard—we're listening: emerging issues and potential solutions from the voices of BIPOC occupational therapy students, practitioners, and educators. American Journal of Occupational Therapy. 2021;75(6):7506347010.
61. Premkumar A, Whetstone S, Jackson A v. Beyond silence and inaction: changing the response to experiences of racism in the health care workforce. Obstetrics & Gynecology. 2018;132(4):820-7.
62. Helberg JM. Bias against the nurse. Nurse Educator. 1993;18(5):3.
63. Xiao C, Winstead V, Townsend C, Jablonski RA. Certified nursing assistants' perceived workplace violence in long-term care facilities: a qualitative analysis. Workplace health & safety. 2021;69(8):366-74.
64. Cooper LA, Beach MC, Williams DR. Confronting bias and discrimination in health care-when silence is not golden. JAMA Internal Medicine. 2019;179(12):1686-7.
65. Perone AK. Constructing discrimination rights: comparisons among staff in long-term care health facilities. The Gerontologist. 2023;63(5):900-9.
66. Capozzi JD, Rhodes R. Coping with racism in a patient. The Journal of Bone & Joint Surgery. 2006;88(11):2543-4.
67. Lim FA, Borski DB. Defusing bigotry at the bedside. Nursing. 2015;45(10):40-4.
68. Filut A, Alvarez M, Carnes M. Discrimination toward physicians of color: a systematic review. Journal of the National Medical Association. 2020;112(2):117-40.
69. Alfandre D, Geppert C. Discriminatory and sexually inappropriate remarks from patients and their challenge to professionalism. The American Journal of Medicine. 2019;132(11):1251-3.
70. Rosoff PM. Discriminatory demands by patients. Hastings Center Report. 2018;48(4):7-11.
71. Samora JB, Denning J, Haralabatos S, Luong M, Poon S. Do women experience microaggressions in orthopaedic surgery? Current state and future directions from a survey of women orthopaedists. Current Orthopaedic Practice. 2020;31(5):503-7.
72. Danan D. Eracism. Academic Medicine. 2021;96(12):1701.
73. Goldenberg MN, Cyrus KD, Wilkins KM. ERASE: a new framework for faculty to manage patient mistreatment of trainees. Academic Psychiatry. 2019;43(4):396-9.
74. Schlick CJR, Ellis RJ, Etkin CD, et al. Experiences of gender discrimination and sexual harassment among residents in general surgery programs across the US. JAMA Surgery. 2021;156(10):942-52.
75. Ahn LH, Yee SE, Dixon KM, Kase CA, Sharma R, Hill CE. Feeling offended by clients: The experiences of doctoral student therapists. Journal of Counseling Psychology. 2021;68(2):125-38.

76. Wang LJ, Tanious A, Go C, et al. Gender-based discrimination is prevalent in the integrated vascular trainee experience and serves as a predictor of burnout. Journal of Vascular Surgery. 2020;71(1):220-7.
77. Forrest L. How one nurse came to terms with her patients' prejudice. 'Get your black hands off me!' RN. 1980;43(8):54-5.
78. Stokes F, Iskander R. Human rights and bioethical considerations of global nurse migration. Journal of Bioethical Inquiry. 2021;18(3):429-39.
79. Nunez-Smith M, Curry LA, Bigby J, Berg D, Krumholz HM, Bradley EH. Impact of race on the professional lives of physicians of African descent. Annals of Internal Medicine. 2007;146(1):45-51.
80. Valdez P, Kendrick-Allwood S, Williams TS, Spinks-Franklin A, Nyp SS. Let me spell it out: the impact of microaggression on the health care professional. Journal of Developmental and Behavioral Pediatrics. 43(5):303-6.
81. Warsame RM, Hayes SN. Mayo Clinic's 5-Step policy for responding to bias incidents. AMA Journal of Ethics. 2019;21(6):E521-29.
82. Turner J, Higgins R, Childs E. Microaggression and implicit bias. The American Surgeon. 2021;87(11):1727-31.
83. Alimi Y, Bevilacqua LA, Snyder RA, et al. Microaggressions and implicit bias in surgical training: an undocumented but pervasive phenomenon. Annals of Surgery. 2023;277(1):e192-6.
84. Steinkamp L. Microaggressions: underrepresented minority physical therapist student experiences while on clinical internships. Wisconsin Medical Journal. 2021;120(S1):S61-5.
85. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority resident physicians' views on the role of race/ethnicity in their training experiences in the workplace. JAMA Network Open. 2018;1(5):e182723.
86. Berwick S, Calev H, Matthews A, et al. Mistaken identity: frequency and effects of gender-based professional misidentification of resident physicians. Academic Medicine. 2021;96(6):869-75.
87. Richmond NL, Goitein L. Mistreatment experienced by internal medicine residents-the more things change, the more they stay the same. JAMA Internal Medicine. 2022;182(4):450-2.
88. Shahriari N, Lakdawala N, Grant-Kels JM. Multiculturalism and diversity: How to ethically care for a prejudiced patient. Journal of the American Academy of Dermatology. 2016;75(1):234-6.
89. Padela AI, Azam L, Murrar S, Baqai B. Muslim American physicians' experiences with, and views on, religious discrimination and accommodation in academic medicine. Health Services Research. 2023;58(3):733-43.
90. Aggarwal M. My voice. JACC: Case Reports. 2019;1(1):81-2.
91. Pean CA, Hart D. One resident's recommendations for responding to unjust patient bias. AMA Journal of Ethics. 2019;21(6):E530-35.
92. Shuman AG. Operating through hatred. Narrative Inquiry in Bioethics. 2015;5(1):20-2.
93. Saadi A, Taleghani S, Dillard A, Ryan G, Heilemann M, Eisenman D. Original research: nurses' experiences with racial, ethnic, cultural, and religious discrimination in the workplace: a qualitative study. The American Journal of Nursing. 2023;123(5):24-34.
94. Fischbach RL, Hunt M. Part II. Educating for diversity: a decade of experience (1989-1999). Journal of Women's Health & Gender-Based Medicine. 1999;8(10):1249-56.
95. Padela AI, Schneider SM, He H, Ali Z, Richardson TM. Patient choice of provider type in the emergency department: perceptions and factors relating to accommodation of requests for care providers. Emergency Medicine Journal. 2010;27(6):465-9.
96. Paul-Emile K. Patient racial preferences and the medical culture of accommodation. UCLA Law Review. 2012;60:462-504.
97. Tuttas CA. Perceived racial and ethnic prejudice and discrimination experiences of minority migrant nurses: a literature review. Journal of Transcultural Nursing. 2015;26(5):514-20.
98. Wheeler M, de Bourmont S, Paul-Emile K, et al. Physician and trainee experiences with patient bias. JAMA Internal Medicine. 2019;179(12):1678-85.
99. Charlot M. Power in our hands: addressing racism in the workplace. Journal of Clinical Oncology. 2020;38(34):4118-9.
100. Sobel L, O'Rourke-Suchoff D, Holland E, et al. Pregnancy and childbirth after sexual trauma: patient perspectives and care preferences. Obstetrics and Gynecology. 2018;132(6):1461-8.
101. Ehie O, Muse I, Hill L, Bastien A. Professionalism: microaggression in the healthcare setting. Current Opinion in Anaesthesiology. 2021;34(2):131-6.
102. Berdes C, Eckert JM. Race relations and caregiving relationships. Research on Aging. 2001;23(1):109-26.
103. Nunez-Smith M, Pilgrim N, Wynia M, et al. Race/ethnicity and workplace discrimination: results of a national survey of physicians. Journal of General Internal Medicine. 2009;24(11):1198-204.
104. Baldwin DC, Daugherty SR, Rowley BD. Racial and ethnic discrimination during residency: results of a national survey. Academic Medicine. 1994;69(10 Suppl):S19-21.
105. Chary AN, Fofana MO, Kohli HS. Racial discrimination from patients: institutional strategies to establish respectful emergency department environments. The Western Journal of Emergency Medicine. 2021;22(4):898-902.
106. Fahey DM. Racial discrimination in patient care-preserving relationships with integrity. Journal of Hospice and Palliative Nursing. 2023;25(1):5-11.
107. Henderson D. Racial politics in the exam room. Family Medicine. 2016;48(8):647-8.
108. Schapira L, Gordon-Rowe L, Martignetti R, et al. Racism in the chemotherapy infusion unit: a nurse's story. The Oncologist. 2008;13(11):1177-80.
109. Baqai B, Azam L, Davila O, Murrar S, Padela AI. Religious identity discrimination in the physician workforce: insights from two national studies of Muslim clinicians in the US. Journal of General Internal Medicine. 2023;38(5):1167-74.

110. de Bourmont SS, Burra A, Nouri SS, et al. Resident physician experiences with and responses to biased patients. JAMA Network Open. 2020;3(11):e2021769.
111. Lo MCM, Bahar R. Resisting the colonization of the lifeworld? Immigrant patients' experiences with co-ethnic healthcare workers. Social Science & Medicine. 2013;87:68-76.
112. Moore R, Loe IM, Whitgob E, Cowden JD, Nyp SS. Responding to discriminatory patient requests. Journal of Developmental & Behavioral Pediatrics. 2021;42(5):429-31.
113. Killeen OJ, Bridges L. Solving the silence. JAMA. 2018;320(19):1979-80.
114. Lim FA, Borski DB. Supporting LGBT nurses. Nursing Management. 2016;47(8):48-52.
115. Williams KE, Baskin ML, Brito AL, Bae S, Willett LL. Supporting trainees by addressing inappropriate behaviors by patients. Southern Medical Journal. 2021;114(2):111-5.
116. Singh K, Sivasubramaniam P, Ghuman S, Mir HR. The dilemma of the racist patient. American Journal of Orthopedics. 2015;44(12):E477-9.
117. Whitgob EE, Blankenburg RL, Bogetz AL. The discriminatory patient and family: strategies to address discrimination towards trainees. Academic Medicine. 2016;91(11):S64-9.
118. Kulwicki A, Khalifa R, Moore G. The effects of September 11 on Arab American nurses in metropolitan Detroit. Journal of Transcultural Nursing. 2008;19(2):134-9.
119. Blasen L, Patton C, Green R. Dealing with prejudice in the ED. Advance for Nurse Practitioners. 2001;9(7):26.
120. Roberts DC. The elephant in the room. Nursing. 2020;50(12):42-6.
121. Wheeler RM, Foster JW, Hepburn KW. The experience of discrimination by US and Internationally educated nurses in hospital practice in the USA: a qualitative study. Journal of Advanced Nursing. 2014;70(2):350-9.
122. Wolf L, Delao A, Perhats C, et al. The experiences of United States emergency nurses related to witnessed and experienced bias: a mixed-methods study. Journal of Emergency Nursing. 2023;49(2):175-97.
123. Dellasega C, Aruma JF, Sood N, Andreae DA. The impact of patient prejudice on minoritized female physicians. Frontiers in Public Health. 2022;10:902294.
124. Powers BW, Jain SH. The prejudiced patient. The Virtual Mentor. 2014;16(6):434-9.
125. Jain SH. The racist patient. Annals of Internal Medicine. 2013;158(8):632.
126. Jain SH. The racist patient. Annals of Internal Medicine. 2013;159(3):227-8.
127. Galishoff M. The racist patient. Annals of Internal Medicine. 2013;159(3):227.
128. Sahai SK. The racist patient. Annals of Internal Medicine. 2013;159(3):227.
129. Nardone DA. The racist patient. Annals of Internal Medicine. 2013;159(3):227.
130. Nakao M. The racist patient. Annals of Internal Medicine. 2013;159(3):227.
131. Wheeler DJ, Zapata J, Davis D, Chou C. Twelve tips for responding to microaggressions and overt discrimination: When the patient offends the learner. Medical Teacher. 2019;41(10):1112-7.
132. Eisenberg EH, Kieffer KA. Use of simulated patient encounters to teach residents to respond to patients who discriminate against health care workers. Journal of General Internal Medicine. 2019;34(5):764-8.
133. Bonsu JM. What's important: addressing racism in patient encounters. Journal of Bone and Joint Surgery. 2021;103(15):1462-3.
134. Reynolds KL, Cowden JD, Brosco JP, Lantos JD. When a family requests a white doctor. Pediatrics. 2015;136(2):381-6.
135. Miles A, Awong L. When the patient is a racist. The American Journal of Nursing. 1997;97(8):72.
136. Lewis LS. A case for "reasonable discrimination". BMJ. 2014;348:g1717.
137. Badger F, Clarke L, Pumphrey R, Clifford C. A survey of issues of ethnicity and culture in nursing homes in an English region: nurse managers' perspectives. Journal of Clinical Nursing. 2012;21(11-12):1726-35.
138. De D. Are international nursing students disadvantaged by UK patients? British Journal of Nursing. 19(20):1299-305.
139. Beagan BL, Chacala A. culture and diversity among occupational therapists in Ireland: when the therapist is the 'diverse' one. British Journal of Occupational Therapy. 2012;75(3):144-51.
140. Larsen JA. Embodiment of discrimination and overseas nurses' career progression. Journal of Clinical Nursing. 2007;16(12):2187-95.
141. Easmon C. Ethical dilemma: dealing with racist patients. Commentary: isolate the problem. BMJ. 1999;318(7191):1130.
142. Selby M, Neuberger J, Easmon C, Gough P. Ethical dilemma: dealing with racist patients. BMJ. 1999;318(7191):1129-31.
143. Neuberger J. Ethical dilemma: dealing with racist patients. Commentary: a role for personal values . . . and management. BMJ. 1999;318(7191):1130.
144. Gough P. Ethical dilemma: dealing with racist patients. Commentary: courteous containment is not enough. BMJ. 1999;318(7191):1131.
145. Estacio EV, Saidy-Khan S. Experiences of racial microaggression among migrant nurses in the United Kingdom. Global qualitative nursing research. 2014;1:2333393614532618.
146. Miller E, Nambiar-Greenwood G. Exploring the lived experience of student nurses perspective of racism within education and clinical practice: Utilizing the flipped classroom. Nurse Education Today. 2022;119:105581.
147. Deacon M. How should nurses deal with patients' personal racism? Learning from practice. Journal of Psychiatric and Mental Health Nursing. 2011;18(6):493-500.
148. Riordan DC. Interaction strategies of lesbian, gay, and bisexual healthcare practitioners in the clinical examination of patients: qualitative study. BMJ. 2004;328(7450):1227-9.

149. Tuffour I. It is like "judging a book by its cover": An exploration of the lived experiences of Black African mental health nurses in England. Nursing Inquiry. 2022;29(1):e12436.
150. Padela AI, Rodriguez del Pozo P. Muslim patients and cross-gender interactions in medicine: an Islamic bioethical perspective. Journal of Medical Ethics. 2011;37(1):40-4.
151. de Wildt G, Gill P, Chudley S, Heath I. Racism and general practice--time to grasp the nettle. The British Journal of General Practice. 2003;53(488):180-2.
152. Duffin C. Racism in NHS is driving out ethnic minority nurses. Nursing Standard. 2002;16(29):4.
153. Purves R. 'Racist abuse ruined my life'. Nursing Times. 100(32):24-5.
154. Mathew R. Rammya Mathew: we need to rise above racist abuse and challenge attitudes. BMJ. 2019;367:l6474.
155. Viglianti EM, Oliverio AL, Meeks LM. Sexual harassment and abuse: when the patient is the perpetrator. Lancet. 2018;392(10145):368-70.
156. Ali PA, Johnson S. Speaking my patient's language: bilingual nurses' perspective about provision of language concordant care to patients with limited English proficiency. Journal of Advanced Nursing. 2017;73(2):421-32.
157. Ferns T, Meerabeau L. Verbal abuse experienced by nursing students. Journal of Advanced Nursing. 2008;61(4):436-44.
158. Dimond B. What is the law if a patient refuses treatment based on the nurse's race? British Journal of Nursing. 15(19):1077-8.
159. Boateng GO, Brown KK. "Go back to your country": Exploring nurses' experiences of workplace conflict involving patients and patients' family members in two Canadian cities. Nursing Inquiry. 2022;29(1):e12444.
160. Druzin P, Shrier I, Yacowar M, Rossignol M. Discrimination against gay, lesbian and bisexual family physicians by patients. CMAJ. 1998;158(5):593-7.
161. VanIneveld CH, Cook DJ, Kane SL, King D. Discrimination and abuse in internal medicine residency. Journal of General Internal Medicine. 1996;11(7):401-5.
162. Vogel L. Doctors on their own when dealing with racism from patients. CMAJ. 2018;190(37):E1118-9.
163. Crutcher RA, Szafran O, Woloschuk W, Chatur F, Hansen C. Family medicine graduates' perceptions of intimidation, harassment, and discrimination during residency training. BMC Medical Education. 2011;11:88.
164. Brown A, Bonneville G, Glaze S. Nevertheless, they persisted: how women experience gender-based discrimination during postgraduate surgical training. Journal of Surgical Education. 2021;78(1):17-34.
165. Ewers NP, Khashmelmous R, Hamilton-Hinch BA. "Oh, you're my health care provider?" Recounting the experiences of people of African descent in Nova Scotia pursuing or working in health professions. CMAJ. 2022;194(42):E1429-36.
166. Vazir S, Newman K, Kispal L, et al. Perspectives of racialized physiotherapists in Canada on their experiences with racism in the physiotherapy profession. Physiotherapy Canada. 2019;71(4):335-45.
167. Cook DJ, Liutkus JF, Risdon CL, Griffith LE, Guyatt GH, Walter SD. Residents' experiences of abuse, discrimination and sexual harassment during residency training. McMaster University Residency Training Programs. CMAJ. 1996;154(11):1657-65.
168. Yeung EYH. Sexism and racism in medical care: It depends on the context. CMAJ. 2020;192(12):E323.
169. Neiterman E, Bourgeault IL. The shield of professional status: Comparing internationally educated nurses' and international medical graduates' experiences of discrimination. Health. 2015;19(6):615-34.
170. Vukic A, Jesty C, Mathews SV, Etowa J. Understanding race and racism in nursing: insights from aboriginal nurses. ISRN Nursing. 2012;2012:196437.
171. Saleh N, Clark N, Bruce A, Moosa-Mitha M. Using narrative inquiry to understand anti-Muslim racism in Canadian nursing. The Canadian Journal of Nursing Research. 2023;55(3):292-304.
172. Keshet Y, Popper-Giveon A. Neutrality in medicine and health professionals from ethnic minority groups: The case of Arab health professionals in Israel. Social Science & Medicine (1982). 2017;174:35-42.
173. Popper-Giveon A. Preferring patient-physician concordance: the ambiguity of implicit ethnic bias. Ethnicity & Health. 2021;26(7):1065-81.
174. Popper-Giveon A, Keshet Y. The secret drama at the patient's bedside-refusal of treatment because of the practitioner's ethnic identity: the medical staff 's point of view. Qualitative Health Research. 2018;28(5):711-20.
175. Dywilli S, O'Brien L, Anderson J. "It's only the skin colour, otherwise we are all people": the changing face of the Australian nurse. Australian Journal of Advanced Nursing. 2021;38(2).
176. Stone TE, Ajayi C. "There comes a time when silence is betrayal": racism and nursing. Nursing & Health Sciences. 2013;15(4):407-9.
177. Foong LH. Anti-racism in the emergency department: Navigating clinician experiences of racism. Emergency Medicine Australasia. 2022;34(1):116-9.
178. Yolci A, Schenk L, Sonntag PT, Peppler L, Schouler-Ocak M, Schneider A. Observed and personally experienced discrimination: findings of a cross-sectional survey of physicians and nursing staff. Human Resources for Health. 2022;20:83.
179. Bayuo J, Abboah-Offei M, Duodu PA, Salifu Y. A meta-synthesis of the transitioning experiences and career progression of migrant African nurses. BMC Nursing. 2023;22:104.
180. Antón-Solanas I, Rodríguez-Roca B, Vanceulebroeck V, et al. Migrant and ethnic minority nurses' experience of working in European health services: a qualitative study. Revista da Escola de Enfermagem da USP. 2022;56:e20220104.
181. Kisa A, Dziegielewski SF. Sexual harassment of female nurses in a hospital in Turkey. Health Services Management Research. 1996;9(4):243-53.

182. Pai DD, Sturbelle ICS, Santos C dos, Tavares JP, Lautert L. Physical and psychological violence in the workplace of healthcare professionals. Texto & Contexto Enfermagem. 2018;27(1).
183. Song Y, Nassur AM, Rupasinghe V, et al. Factors associated with residents' responsive behaviors toward staff in long-term care homes: a systematic review. The Gerontologist. 2023;63(4):674-89.
184. Zwane PG, Shongwe MC, Shabalala FS. Challenges faced by mental health nurses working with people living with mental illness in Eswatini: A qualitative study. International Journal of Africa Nursing Sciences. 2022;17:100475.
185. Chun L de, Ye R, Wilby KJ. Exploring discrimination towards pharmacists in practice settings. Pharmacy Practice. 2020;18(3):1966.
186. Debesay J, Arora S, Fougner M. Organisational culture and ethnic diversity in nursing homes: a qualitative study of healthcare workers' and ward nurses' experiences. BMC Health Services Research. 2022;22:843.
187. Rzymski P, Nowicki M. COVID-19-related prejudice toward Asian medical students: A consequence of SARS-CoV-2 fears in Poland. Journal of Infection and Public Health. 2020;13(6):873-6.
188. Chang HE, Jeong S. Male nurses' experiences of workplace gender discrimination and sexual harassment in South Korea: a qualitative study. Asian Nursing Research. 2021;15(5):303-9.
189. Pung LX, Goh YS. Challenges faced by international nurses when migrating: an integrative literature review. International Nursing Review. 2017;64(1):146-65.
190. Jönson H. Is it racism? Skepticism and resistance towards ethnic minority care workers among older care recipients. Journal of Gerontological Social Work. 2007;49(4):79-96.
191. Achora S. Conflicting image: Experience of male nurses in a Uganda's hospital. International Journal of Africa Nursing Sciences. 2016;5:24-8.
192. Wittkower LD, Bryan JL, Asghar-Ali AA. A scoping review of recommendations and training to respond to patient microaggressions. Academic Psychiatry. 2022;46(5):627-39.
193. Hamed S, Bradby H, Ahlberg BM, Thapar-Björkert S. Racism in healthcare: a scoping review. BMC Public Health. 2022;22:988.
194. Merz S, Aksakal T, Hibtay A, et al. Racism against healthcare users in inpatient care: a scoping review. International Journal for Equity in Health. 2024;23:89.
195. Hassen N, Lofters A, Michael S, Mall A, Pinto AD, Rackal J. Implementing anti-racism interventions in healthcare settings: a scoping review. International Journal of Environmental Research and Public Health. 2021;18(6):2993.
196. Vogel L. Queen's to redress harms of historic ban on black medical students. CMAJ. 2019;191(26):E746.
197. Campbell KM, Corral I, Infante Linares JL, Tumin D. Projected estimates of African American medical graduates of closed historically Black medical schools. JAMA Network Open. 2020;3(8):e2015220.
198. Jefferies K, States C, MacLennan V, et al. Black nurses in the nursing profession in Canada: a scoping review. International Journal for Equity in Health. 2022;21:102.
199. de Bruin T. Black Canadians. The Canadian Encyclopedia. 2013.

APPENDIX A

Search strategy: Ovid MEDLINE(R) ALL 1946 to June 08, 2023

#	Searches	Results
1	microaggression/	114
2	(microaggression* or micro-aggression*).mp.	714
3	*racism/	5194
4	exp *prejudice/	21405
5	exp *bias/	7183
6	*Discrimination, Psychological/ [discrimination, psychological/ appears to be an inappropriate subject heading that has been applied to at least 1 key paper, therefore including it]	9137
7	exp *social discrimination/	9375
8	social marginalization/	585
9	*stereotyping/	5684
10	racis?.mp.	12160
11	(sexis? or misogyn*).mp.	4720
12	(homophob* or transphob* or biphob* or aphob* or panphob* or lesphob* or lesbiphob*).mp.	2412
13	prejudice*.mp.	30770
14	bias??.ti,kf,hw.	71463
15	discriminat*.mp.	316900
16	(hate or hateful* or hatred).mp.	1985
17	or/1-16	427951
18	organizational policy/	14523
19	(pc or lj).fs.	1684997
20	exp Policy Making/	28219
21	institutional practice/	1257
22	professional practice/	17112
23	exp Ethics/ and (practic* or guid* or respons* or react* or address* or respond* or dilemma*).mp.	55108
24	addressing.ti,kf.	12926
25	recommendation?.mp.	340852
26	guideline?.mp.	596778
27	((practitioner* or clinician* or doctor* or nurse* or "hcp's" or provider* or staff or resident* or intern? or therapist* or physiotherapist* or allied health or health profession*) adj2 (race or ethnic* or religio* or cultur* or languag*)).mp.	5776
28	(policy or policies or policymaking).mp.	439192
29	framework*.mp.	397825
30	((professional or institutional or organizational) adj3 practices).mp.	2940
31	organization??.mp.	1013911
32	institution??.mp.	372974
33	process??.mp.	2503388
34	(ethic* adj6 (practic* or guid* or respons* or react* or address* or respond* or dilemma*)).mp.	28366
35	((structural or institutional or organizational) adj2 competen*).mp.	505
36	(action? or inaction?).mp.	1062953
37	or/18-36	7049709
38	exp Professional-Patient Relations/	148342
39	exp treatment refusal/	13744
40	(professional adj1 patient).mp.	43001
41	(doctor adj1 patient).mp.	9303
42	(nurse adj1 patient).mp.	37759
43	(practitioner adj1 patient).mp.	733
44	(patient? adj4 relations).mp.	150702
45	(patient adj3 satisf*).mp.	121053
46	((treat* or care or healthcare) adj4 refusal?).mp.	16330
47	((treat* or care or healthcare) adj4 accept*).mp.	79245
48	((practitioner* or clinician* or doctor* or nurse* or "hcp's" or provider* or staff or resident* or intern? or therapist* or physiotherapist* or allied health or health profession*) adj4 experien*).mp.	47420
49	(patient* adj4 (choose or chose? or choice?)).mp.	34046
50	(preferen* adj4 (patient* or famil*)).mp.	34725
51	(prefer??? adj4 (patient* or famil*)).mp.	13823
52	(concordan* and (race or ethnic* or religio* or cultur* or languag* or gender*)).mp.	9651
53	or/38-52	480027
54	17 and 37 and 53	4032
55	(202205* or 202206* or 202207* or 202208* or 202209* or 20221* or 2023*).dt,ez,da.	1994978
56	54 and 55	287

APPENDIX B

Table B.1. Study design references

Study Design	References
Empirical	
Qualitative	8,14,24,30,42-45,50,54,63,65,75,79,84,85,89,93,98,100,102,111,117,121,123,138-140,145-149,156,159,160,165,166,169-175,180,181,184,186,190,191
Quantitative	21,22,26,48,71,74,76,83,86,95,103,104,109,110,115,137,161,163,167,178,187
Mixed Methods	10,56,118,122,157,164,182,185
Commentaries	2,3,28,31,41,46,49,51,55,61,62,64,65,67,69,72,73,77,80,87,88,90,94,96,99,107,114,119,120,124-130,133-135,141-144,150,152-155,176,177,188
Case studies	18,20,27,29,47,59,66,92,106,112,131,158
Review papers	1,7,58,68,78,97,101,116,179,183,189
Essays	52,57,70
Letters	23,136,168
Editorials	105,151
Narratives	91,162
Policy/guidelines	19,81
Ethics rounds	108
Perspectives	6
Workshops	132
Virtual listening sessions	60

Table B.2. Journal type

Type of Journals	References
Medical	1-3,6,14,21-23,25,26,28,36,42,43,45,46,48,49,51,53-55,64,66,68,69,71-74,76,79,82-88,90,94,95,98,99-101,103-105,107-110,113,115-117,125-133,136,141-145,147,148,151,154,155,160-162,164,165,167,168,177
Nursing	7,10,18,24,29,50,58,62,67,77,93,97,106,114,118-122,135,137,138,140,145,146,149,152,153,156-159,170,171,175,176,179,180,184,188,189,191
Health	8,30,44,47,56,57,63,65,89,102,111,123,169,172-174,178,181-183,186,187
Ethics	19,20,27,31,41,59,70,78,81,91,92,124,150
Pediatrics	80,112,134
Psychology	52,75
Occupational therapy	60,139
Law	96
Social work	190
Pharmacy	185
Physiotherapy	166

Table B.3. Journals most frequently published in

Journal Name	References
The Journal of the American Medical Association	23,46,49,51,64,74,85,87,98,110,113
British Medical Journal	2,28,136,141-144,148,154
Annals of Internal Medicine	3,79,125-130
Academic Medicine	1,14,25,72,86,104,117
AMA Journal of Ethics	19,20,27,41,81,91
Journal of General Internal Medicine	43,45,103,109,132,161
Canadian Medical Association Journal	160,162,165,167,168

Table B.4. Study setting

Study Setting	References
Hospital settings	
Academic hospitals	1,14,18,20,21,22,25,26,27,31,41,42,43,44,45,46,48,51,55,56,61,66,72,73,74,76,81,83,86, 87,89,90,91,93,94,98,101,108,109,110,112,114,115,117,123,125,126,127,128,129,130, 132,133,142,151,155,157,161,164,167,168,181,187
Public hospitals	30,154,172,174
Non-specific hospital type	2,6,8,24,28,29,47,49,50,53,59,69-71,77,82,92,95-97,99,100,103,105,116,118,119,121,122,134,135,139,141,143-145,148-150,152,153,156, 159, 162,166,169,170,178,179,182,184,188,191
Residential care facilities	
Nursing homes	50,102,137,159,183,186,189
Long term care	63,65,189
Residential/home care	24,190
Hospice	106,189
Community care	75,118,139,158,170
Rural healthcare facilities	175
Medical centres	3
Public and private health services	180

Table B.5. Clinical context

Clinical Context	References
Nursing	7,10,50,67,78,120,140,147,159,171,176
Emergency departments/Urgent care	14,20,53,59,91,95,105,119,122,134,150,177,182
Primary health care	57,79,107,111,124,148,160,173
Pediatrics	2,56,80,117,123,153
Internal medicine	41,43,87,110,115,161
Surgery	74,76,83,92,123,135
Orthopedics	66,71,91,133
Medicine	23,64,121
Oncology	46,92,108
Obstetrics and gynecology	27,61,100
Pharmacy	168,185
Mental health	52,77,112,147,176
Occupational therapy	60,139
Rural health	191
ICU	53
Dermatology	48
Cardiology	90

Table B.6. Target of discrimination, harassment and assault

Target	References
Physicians	1,2,6,8,14,18-23,25-27,31,41-49,51-57,59,61,66,68-74,76,79,80,82,83,85-92,94-96,98,99,101,103-105,107,109-111,113,115,117,123-134,136,141-144,150,155,160-164,167-169,172-174,177,178,187
Medical learners	1,14,19,20,21,22,23,25- 27,41,42,44,46-48,51,53,55,56,59 61,66,72-74,76,83,86,91,94,101,104,110,113,115,117,123,125,131,133,134,142,161,163,164,168,177,187
Nurses	1,7,10,18,24,28-30,50,58,62,63,65,67,77,78,93,97,102,106,108,114,118-122,135,138,140,145,146,147,149,152,153,156-159,169-171,175,176,178-184,186,188,189,191
Nursing students	1,3,58,62,67,138,146,157,174,176
Psychotherapists	52,75,112
Physiotherapists	84,166
Occupational therapists	60,139
Pharmacists	185
Healthcare workers	116,148,149,151,154,165

Table B.7. Type of discrimination, harassment and assault

Type of discrimination, harassment and assault experienced	References
Physicians	
Racial identity	1,6,19,25,46,49,54,68,79,85,89,90,99,103,105,107,111,124,131,162,174
Gender identity	1,54,69,71,89,90,131-150,155
Religious identity	31,60,89,109,117,140,173,174
Sexual orientation	160
Ethnicity	103,173,174
Nurses	
Racial identity	7,10,24,28,50,77,91,93,108,119,120,121,135,140,147,149,152,153,158,169,175,176,179
Ethnicity	30,78,118,138,152,159,180,186,189
Gender identity	18,30,67,93,169,188,191
Sexual orientation and religion	93, 171
Medical residents	
Racial identity	1,46,55,66,82,85,91,94,117,125-127,129,130,158,168
Gender identity	42,113,168
Religious identity	1,53
Medical students	14,20,22,27,44,51,113,117,123,132,133
Racial identity	14,20,132
Gender identity	14,27,51,113,117,133
Religious background	14
Trainees and Interns	
Racial identity	61,72,177
Gender identity	61
Religious identity	1

Table B.8a. Type of discrimination, harassment and assault experienced

Type of discrimination, harassment and assault	References
Refusals of specific care providers	1,2,6,7,10,14,24-26,29,30,31,43,46,49,53,57,63,66,79,84,89,91,93,94,96,97,98,102,103,105,106,109,110,112,117-119,121,132-134,138-140,153,159,162,166,171-175,180,185,186,190
Requests for specific care providers	3,19,27,31,41,43,45,47,50,56,57,59,70,81,91,105,119,121,134,135,150,166,170,173,177,188,190
Discriminatory comments	1,3,6,8,10,19,20,25,26,28,30,41-44,46,48,49,50,55,60-63,65,67,68,71,72,74,76,77,79,80-85,89-93,5,97,99,101,102,105,107,108,110,112-115,119,121-123,125,127,131,133,135,138-141,146,147-149,152,156,157,159,160,161,163-169,171,173,176,183,186,187,189,190,191
Sexual harassment	1,7,14,21,26,44,48,56,65,74,98,110,113,157,159,161,163,164,167,177,181,183,184,185,188
Physical assault	21,28,29,30,133,138,147,157,161,167,169,182,183,191
Inappropriate comments	7,14,21,51,69,73-75,108,132,163,164,184

Table B.8b. Nature of the discriminatory request, refusal or comment

Identity characteristic of the HCW related to the discrimination	References
Racial background	1,2,6,7,10,14,19,20,24,25,28,29,43,45-47,49,50,53,55-57,60-63,65,66,68,70,72,77,79,81,82,83,84,91,93,94,96,98,99,101-103,105-108,110,112,115,117,119,121,122,123,125,131,133-135,137-141,145-147,149,152,153,157-159,161,163,165,166,168-171,175, 176,179,180,183,185-187,189,190
Gender	1,14,19,24,26,27,42-45,48,56,71,74,76,81-83,90,93,98,101,113,115,117,150,157,161,163,164,168,185,188,190,191
Age	1,42,45,55,56,81,82,159
Accent	10,62,81,112,121,159,168,169,179,186
Disability	14,43,139
Nationality	8,41,46,50,72,85,97,105,112,121,138-140,145,186,190
Religion	1,19,31,53,81,89,92,93,98,109,110,115,117,127,141,171,173
Language	58,145,156
Learner-status	59
Sexual orientation	19,67,81,82,110,114,148,160,161,167
Ethnicity	19,30,80,81,84,92,93,96-98,109,115,117-119,127,172-174,190
Weight	81,123
Political views	81,173
Training location	173

Table B.9a. Barriers to reporting – experiences of patient bias reported/not reported

Barriers to reporting	Reference
Patient bias not reported	24,25,30,43,63,77,85,86,102,110,122,139,149,166,167,175
Patient bias reported to a supervisor, manager or attending	20,26,27,29,48,53,61,75,76,80,83,84,89,91,93,94,106,108,125,127, 135,138,153,157,158,181
Some patient bias experiences reported but not all	26,48,53,76,83,138,153,157,181
Experiences reported by physician learners to their supervisors	20,27,61,91,94,125,127
Experiences reported by nurses to their managers	29,93,106,135,158
Experiences reported by clinical learners to their supervisors	75, 84

Table B.9b. Barriers to reporting – actual barriers faced

Barrier reported	Reference
Fear of retaliation, repercussion or retribution	1,53,65,67,68,76,78,89,139,149,163,166-168,180,181,183
Assumption that the experience would be dismissed, ignored or unaddressed	26,53,75,76,85,122,166,167,181
Lack of support from management	63,81,93,146,159,183
Culture of silence and submission	55,113
Prioritization of patient care	65,67,110
Feeling disempowered to raise issues of racism in the workplace	79,103,145,177
Concerns about creating conflict in the workplace as key barriers to reporting discriminatory experiences/assaults	26,79,85
Feeling the need to handle these issues alone	79,175
Downplaying incidents as not serious enough to report	48,63,75,102,167,175
Normalizing experiences of harassment	24,63,65,166,181
Feeling pessimistic about the likelihood of such situations changing	102
Being too busy with other responsibilities	26,76,85
Feeling dissuaded by cumbersome reporting processes	89
Not knowing where or how to report	26,73,174
Lack of policy or standardized protocol	3,30

B.10. Barriers to addressing bias and discrimination

Barrier Domains	Barrier Reported	Reference
Personal Barriers	Low clinician capability, comfort and confidence in responding	7,18,57,82
	Desensitization, normalization and diminishment of one's experience of mistreatment from patients, family members or visitors	24,63,65,73,164,181
	Perceived ineffectiveness of responding	98,110,117
	A desire to maintain patient-clinician rapport	51
	Concern that confronting a patient would be too time consuming	73
Clinical Barriers	Clinical context	96
	Speciality	170
	Clinical trainee status/hierarchy	89,160,165
Educational Barriers	Lack of training material/guidance	18,24,50,57,60,63,69,73,82,87,98,99,102,103,110,124, 134,150,152,170,176,183,185
	Lack of discussion in education programs	52,125,176
Fear of Reprisal	Concerns re reprisal and retaliation	19,168,180,181
	Fear of legal action	1
	Fear of reprisal on patient satisfaction scores	68,73,80
	Fear of reinforcing the patient's prejudice	154
	Fear of job loss or punishment	140,164
	Fear of becoming a target	122
	Trainees fear of their instructors' reactions	84,89
Legal Barriers	Legislative restrictions on what can be done to address patient bias	1
	hiring conditions/employment nuances	6
Professional Barriers	lack of diversity within the health professions	60,61,91,133,166
	Lack of clear instructions from regulatory colleges on the permissibility of refusing to care for abusive patients	159
	Lack of profession specific knowledge, skill and training to adequately respond	64
Policy Barriers	Lack of policy or an inadequately developed policy	3,30,31,91,98,99,135,156,162,174
	Hcws unaware of the institution's policy on the matter	98,147
	Policies that fail to provide sufficient practical guidance	69,156,185
Institutional Barriers	A lack of action and follow-up on reports	24,28,53,63,65,76,77,79,84,93,101,103,116,122,124, 134,138,139,141,149,152,153,159,169,179,182,183
	Lack of support from management and colleagues in dealing with conflict	29,43,50,60,63,76,81,84,85,93,98,135,137,140,152, 156,159,162,169,170,174,179,181,183,189
	Institutional prioritization of patients over staff	31,67,93,98,106,116,124,125,138,139,153,159
	Hcws feeling undervalued, devalued and disempowered	7,10,53,60,71,79,82,111,139,140,149,170,175,181,189
	General silence or lack of discussion on bias and discrimination in the workplace	3,60,62,79,81,85,93,97,102,103,114,120,122,139,141, 149,153,179,182
	Institutional racism	2,1050,89,111,133,174
	Ingrained gender biases relating to the composition of the healthcare workforce	71,123,164,188,192
	Not taking issues of racism seriously & refusal to call out acts of discrimination	25,137
	Lack of diversity in leadership positions	162,166
	Lack of inclusion of racism in considerations of workplace violence	25
	Lack of data collection on patient interactions	68
	Lack of staff awareness of institutional reporting mechanisms or resources	73,185
	Customer service models of healthcare, resulting in overprioritizing patient's needs	31,70
	Limited presence of staff with seniority or authority to implement consequences	174