

“This happens all the time”: a Qualitative Study of General Internists’ Experiences with Discriminatory Patients



Amarette Filut, PhD¹, Lacey Alexander, PhD, RN-BC¹, Alexis Ray, BA²,
Kristen Pecanac, PhD, RN³, and Molly Carnes, MD, MS^{1,3} 

¹Center for Women’s Health Research, University of Wisconsin-Madison, Madison, WI, USA; ²School of Medicine and Public Health, University of Wisconsin-Madison, Madison, WI, USA; ³Departments of Medicine, Psychiatry, and Industrial Engineering, University of Wisconsin-Madison, Madison, WI, USA.

BACKGROUND: Workplace discrimination negatively affects physicians of color personally and professionally. Although the occurrence of discrimination from patients has been visible in social media, popular press, and personal essays, scant research exists on patients as a source of discrimination directed at physicians of color.

OBJECTIVE: To explore practicing general internists’ experiences observing or interacting with patients exhibiting discriminatory behavior directed at physicians of color.

DESIGN: A qualitative study with in-depth, semi-structured, one-on-one telephone interviews conducted and recorded between May and September 2019.

PARTICIPANTS: A purposive sample of 24 general internists practicing at 12 academic health centers in the USA: 14 self-identified as White and 10 as a physician of color, which included Asian, Black, Native American, and self-identified other race.

APPROACH: Four coders analyzed the transcribed and verified interview text; thematic analysis was used to inductively identify cohesive themes and subthemes.

KEY RESULTS: Analyses revealed four major themes: (1) assumption that a legitimate doctor is White, male, and able-bodied; (2) legacy of the Black experience; (3) working through the struggle of discrimination; and (4) ethical dilemma of providing care to discriminatory patients. In addition to discrimination from patients based on a physician’s race or ethnicity, participants described experiencing or observing discrimination based on a physician’s gender and disability status. Participants generally expressed a need for greater support from colleagues and more guidance from institutional policies.

CONCLUSIONS: General internists practicing in academic settings reported observing or experiencing discrimination from patients based on the physician’s race, ethnicity, gender (or their intersection), and disability status and the ethical dilemma of providing care to such patients. These results contribute to growing evidence of the need for institutions to better support an increasingly diverse physician workforce with policies and specific guidance to help physicians respond to discrimination from patients while still providing quality care.

KEY WORDS: physician-patient interaction; discrimination; academic medicine; qualitative research.

J Gen Intern Med 36(6):1553–60
DOI: 10.1007/s11606-021-06696-7
© Society of General Internal Medicine 2021

INTRODUCTION

Currently, 11.2% of physicians (vs. 33.4% of the US population) identify as a member of a historically underrepresented ethnic or racial group (Black or African American, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, or Hispanic or Latinx), and 17.1% of physicians (vs. 5.9% of the US population) identify as Asian (which includes multiple subgroups of cultures and languages).^{1, 2} International medical graduates (IMGs) comprise 25% of the physician workforce—the majority from countries without predominantly European heritage.³ In this paper, we refer to “physicians of color” (POC) as either US medical school graduates who are members of ethnic or racial minority groups historically underrepresented in the USA⁴ or who have other non-European heritage (e.g., Middle Eastern or Asian), or IMGs who come from countries without predominantly European heritage.³ POC are more likely to encounter workplace discrimination than their White counterparts and report negative impacts of such discrimination on career advancement, work satisfaction, and health which are accompanied by higher rates of job turnover, changing specialties, and leaving medicine altogether.^{5–9} The cumulative burden of discrimination toward POC has been termed a “minority tax¹⁰” and described as “racial fatigue.¹¹”

Research has identified colleagues, leaders, and evaluation practices as sources of workplace discrimination for POC, largely overlooking the patient as a potential source.⁵ In a systematic review,⁵ we identified only one survey study of POC that inquired about discrimination from patients with a single question about patients refusing care.¹¹ Given the paucity of research on this important issue, we explored experiences with and observations of discrimination from patients toward POC.

Molly Carnes and Kristen Pecanac contributed equally as senior authors.

Prior Presentations None. Received May 20, 2020

Accepted March 2, 2021

Published online March 29, 2021

METHODS

Study Design

In this qualitative study, we conducted and recorded in-depth, semi-structured, one-on-one telephone interviews of practicing general internists at academic medical centers about their experiences with and observations of patients exhibiting discriminatory behavior toward POC. Interviews occurred between May and September 2019. We used thematic analysis to inductively generate themes from transcribed interviews. We followed the Consolidated Criteria for Reporting Qualitative Research (COREQ).¹² The University of Wisconsin-Madison institutional review board approved the study.

Participants

We recruited a national, purposive sample of academic general internists.^{13, 14} To obtain rich, qualitative data from a wide range of participants who have experience with the phenomenon of interest, we recruited participants by randomly selecting both private and public institutions accredited by the Association of American Medical Colleges (AAMC) across the four US geographic regions.^{15, 16} Historically Black Colleges or Universities (HBCUs) were grouped separately ($n=3$).

We collected physicians' names, email addresses, and demographics online from institutional websites¹⁷ and randomly selected 5 physicians from each of 4 demographic groups (White-male, White-female, POC-male, POC-female) from each randomly selected institution. Once all POC from an institution received invitations, we randomly selected a new institution from that group (e.g., private, Northeastern institution) to continue our recruitment of physicians from the four demographic groups. We invited participants via email and verified demographics with a pre-interview questionnaire. We expanded recruitment with snowball sampling.¹⁸ Recruitment and data collection continued until no new ideas emerged (thematic saturation).¹⁹ In total, we sent 955 email invitations including 529 POC over 8 rounds of recruitment, with rounds 7 and 8 only recruiting POC (48 and 56 individuals, respectively). At some institutions, we invited all POC on their list of internists. Of the 44 who responded to our email invitation, 16 participated. We invited 21 additional physicians via snowball referrals; 8 participated. In our final sample of 24 participants, 14 participants self-identified as White and 10 as a physician of color, which included Asian, Black, Native American, and self-identified other race. The physician who identified as Native American also identified as Hispanic/Latinx. No physician from an HBCU volunteered to participate in our study. One physician indicated that they were an IMG (Table 1).

Data Collection

A.F., L.A., or A.R. audio-recorded one-on-one phone interviews from a private office with participants in their preferred location. A.F. is a researcher with a PhD, L.A. is a nurse

researcher with a PhD, and A.R. was a medical student with a BA. A.F. and L.A. identify as White, A.R. identifies as African American, and all three identify as female. All had training in qualitative methods. Interviewers introduced themselves at the start of the call and explained their role in the study. Some participants knew M.C. through her research.

We developed a semi-structured interview script of questions to ask all participants, pilot tested at a single site (Appendix, Table 3). Interviewers took field notes to facilitate the interview process; these notes were not included in analyses. Based on analysis of the first few interviews, we added two questions relevant to the phenomenon of interest to the interview script. We did not conduct repeat interviews.

Data Analysis

We sent verbatim transcripts of interviews to participants for verification. Of the 17 who responded, one participant sent back grammatical edits; others confirmed the accuracy of the text. Using thematic analysis,²⁰ four authors (A.F., L.A., A.R., K.P.) independently coded 10 transcribed interviews line-by-line, meeting to discuss codes, and build our codebook. A.F. and L.A. then coded all the interviews using the established codebook. Facilitated by QSR NVivo 12 software,²¹ A.F. and L.A. grouped codes into potential themes and subthemes, refining them through an iterative process. We sent descriptions of our themes to all study participants for verification (member checking).²² Six participants responded and confirmed that our findings reflected their experiences. The labels applied to the themes were adjusted until the authors were satisfied that they accurately captured the theme. Triangulation of all authors' perspectives and member checking helped ensure that the themes reflected the full range and depth of the data.²³ From the finalized themes and subthemes, we created a thematic map.

Table 1 Characteristics of General Internists ($n=24$) Participating in a Qualitative Study on Physicians' Experiences With Discriminatory Patients

| | <i>N</i> (% of participants) |
|--|------------------------------|
| Sex | |
| Female | 15 (62%) |
| Self-reported race/ethnicity | |
| White | 14 (58%) |
| Asian | 5 (21%) |
| Black | 3 (13%) |
| Native American | 1 (4%) |
| Other (no racial or ethnic details provided) | 1 (4%) |
| Hispanic/Latinx | 1 (4%) |
| Female White | 7 (29%) |
| Female POC | 8 (33%) |
| IMG | 1 (4%) |
| Geographic region | |
| Northeast | 6 (24%) |
| Midwest | 10 (42%) |
| South | 3 (13%) |
| West | 5 (21%) |
| Type of institution | |
| Public | 9 (38%) |
| Private | 15 (62%) |
| HBCU | 0 (0%) |

RESULTS

The 24 interviews lasted 10–52 min (median=37 min); in the interview that lasted 10 min, the participant chose to skip over questions. Overall, White participants reflected on what they have observed while POC focused on both their lived experiences and observations. Although our focus was on discrimination directed at POC, physicians with other identities described experiencing discrimination from patients. We included these experiences in our analyses.

Four major themes emerged (Fig. 1): (1) assumption that a legitimate doctor is White, male, and able-bodied; (2) legacy of the Black experience; (3) working through the struggle of discrimination; and (4) ethical dilemma of providing care to discriminatory patients. These major themes and their sub-themes are described in the following sections. Table 2 provides representative quotes with participants' self-described demographics and assigned number.

Themes and Subthemes

Assumption That a Legitimate Doctor Is White, Male, and Able-bodied. Male and female POC, White female physicians, and a physician with a disability reported how patients challenge their role as a physician from outright refusal of care to unintentional microaggressions. These experiences sent the message to our participants that patients assume doctors are White, male, and able-bodied, often prompting the need to assert their physician status.

Refusal of Care. Some physicians described patients who exhibited explicit prejudice by refusing care from their physician. For example, a participant witnessed a patient refusing care from an Asian physician colleague because he

was “not even an American” (American Indian, female, P274). Another physician had a patient that “just started yelling saying ‘I am not going to see her, she’s a terrorist’” to a colleague (White, female, P272). This refusal of care was driven by both gender and race: “the patient specifically wanted to see a White, male doctor” (White, female, P263).

Microaggressions. As described by a White, male physician (P213), microaggressions may be “meant in a positive way”; for example, “a patient, in an effort to be kind, said to an African American resident, ‘it’s good to see more of you people in medicine.’” Other patients assumed a POC was in a lower status role without being overtly discriminatory: “predominantly Black or Latino colleagues...have been asked by patients, ‘when are you gonna come by and clean our room,’ thinking they were housekeeping staff” (Asian, female, P240). Female physicians reported being mistaken for a nurse which was usually gender-based but intersected with race: “people are still calling me nurse after I introduce myself as a doctor” (Black, female, P292). Having a disability also led patients to question a physician’s role: “as a person with a disability...patients have a hard time believing that I was the supervising physician on the team” (White, male, P211).

Indicating Physician Status. Participants described both verbal and non-verbal ways to establish their physician status. Because discrimination “adds to that insecurity of ‘Oh...I’m not really this authority figure that I’m trying to be right now’” (White, female, P229) some “women physicians are much more likely to wear white coats with their names on them” (White, male, P288). One physician described it as, “‘doctoring up’...to be able to

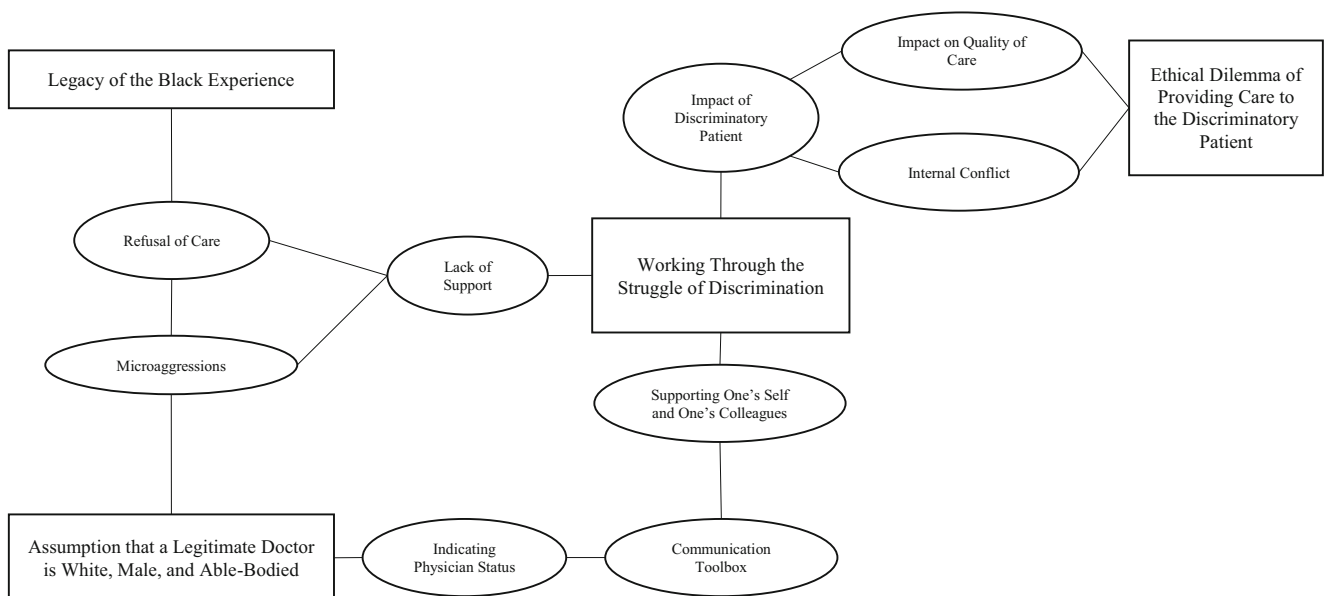


Figure 1 Thematic map of practicing general internists' observations of or interactions with patients exhibiting discriminatory behavior toward their physician illustrating the relationship between themes (rectangles) and subthemes (ovals) identified in the data.

Table 2 Illustrative quotations from participants

| Theme: Assumption that a legitimate doctor is White, male, and able-bodied. | Participant (P) characteristics |
|--|---|
| <p><i>Subtheme and quotation</i> <i>Refusal of care</i> "I've definitely had patients who've said, 'I really don't want any women taking care of me.'" "The patient] made a comment that he was in the United States and he didn't want to be cared for by a brown person."</p> | P245 Asian female P202 |
| <p><i>Microaggressions</i> "A lot of patients will ask me where I'm from or where I [was] born." "Oh, you're so articulate or well-spoken or very intelligent' in a surprised way – that's a microaggression that physicians of color get."</p> | P202 P292 Black female |
| <p><i>Indicating physician status</i> "We assert ourselves in front of the patient... 'Oh the nurse is here'... so at that point I will say, 'No we're the doctors' or make a joke about it, 'It's 2019...women can be doctors too.'" "Patients] think I'm the person that's delivering their food... I just reinforce to them... 'I'm Dr. NAME. Thank you, but I'm not a nurse.' ...if they want to call me by my first name, I still reinforce that I'm a doctor, 'No, Dr. NAME is best.' I do this to make sure we have that set in place."</p> | P218 Black female P292 Black female |
| <p>Theme: Legacy of the Black experience. "Everywhere I turn there is...this aspect of my life...this is something that my colleagues don't have to deal with... and it's above and beyond the ordinary stressors of life...so this is not my first rodeo with [discriminatory] patients." "As a Black person, I've been a minority in medicine forever...now people have more covert ways of being discriminatory and people feel more empowered to be overtly discriminatory with the current political climate. I don't know if it's increased, but it might be more apparent...because...people feel they can discriminate against people openly."</p> | Participant (P) characteristics P278 Black female P292 Black female |
| <p>Theme: Working through the struggle of discrimination. <i>Subtheme and quotation</i> <i>Lack of support</i> "We do need to escalate these concerns to the higher-ups that have a policy about how you respond to [discriminatory patients]." "Oblivious...very unsupportive. He was like... 'I don't know why...you guys had that interaction. The patient likes me.'" <i>Impact of discriminatory patient</i> "It can be a very lonely place. I think we all experience some level of this type of discriminatory behavior and if you keep it inside it will eat you away...you try to compartmentalize it." "Makes us feel like we're not a part of the group or we're not accepted."</p> | Participant (P) characteristics P202 P292 Black female P240 Asian female P218 Black female |
| <p><i>Supporting one's self and one's colleagues</i> "I share a lot with my wife...she's a nurse, she's Latina, we can debrief with one another." "I definitely thought about how I could have or should have handled it, and it made me... more doubtful or insecure in the way that I handled it because I still don't know if I should have said to the patient, 'You should not call him Oriental, he is part of our medical group and he's great and we don't use that term anymore.'" <i>Communication toolbox</i> "If...they say, 'Oh when is the doctor coming in,' or if it's a patient I've seen previously and I come in and they so 'oh the nurse is here' I just have a prepared, 'oh remember Mr. So and So, I'm Dr. NAME, I saw you before, I'm your doctor taking care of you,' and that's my stock response." "Develop your stock responses...have something in your pocket you can put out, 'That is inappropriate for you to say that to me. When you say that to me it is hard for me to feel like you respect me as a doctor'...whatever phrase you are comfortable with."</p> | P232 other race male P247 Asian female P247 Asian female P272 White female |
| <p>Theme: Ethical dilemma of providing care to the discriminatory patient. <i>Subtheme and quotation</i> <i>Internal conflict</i> "You want to make very clear what you find morally reprehensible about what is being said, but you also want to make clear that regardless of all of that, you have an obligation to the patient." "I ignored it...I just kept working because a code had been called so he needed to be assessed." <i>Impact on quality of care</i> "It never helps the patient's cause...we try to...treat people equally or equitably, but things like this undoubtedly have an effect." "It would really impair my ability...to care for that person...change my obligation to or my attitude toward providing the best [care] I possibly can to them...it produces subconscious bias against this person that I would sort of have to think through."</p> | Participant (P) characteristics P210 White male P218 Black female P202 P210 White male |

give...that external symbol...of authority" (Asian, female, P245). Female physicians and POC reported that they introduce themselves using their title and "repeat [that they are the] 'doctor' a few times" (Asian, female, P247).

Legacy of the Black Experience. Black physicians shared some experiences with other POC, but given encounters with racism outside of medicine, their experiences were also unique. As described by an Asian, female physician: "speaking on behalf of my colleagues who are Black...I think they get it way more than I do" (P240). One Black, female physician (P218) shared that, "a patient...referred to me as the 'n' word." Even in situations that were not explicitly racist, one noted "it's always in the back of your mind as a Black physician that somebody's hatred or hostility towards you is partially due to [race]" (Black, female, P292). One White female physician (P272) noted that patients may make racist statements like "wow, it is so nice to see a smart, Black doctor." Some Black physicians described spending more of their "emotional and cognitive energy battling" discrimination every day (Black, female, P278), and perceived their experiences with discrimination as having a negative impact on their health: "I think I'm gonna have a stroke just having to work around racism and its impact on health...I'm increasing my cardiovascular risk" (Black, female, P278).

In addition to overt instances of discrimination, the frequency of microaggressions encountered by Black physicians led one physician to take the following position:

I've taken the attitude...to dismiss a lot of the microaggressions because they're my everyday life so I wish that there was more known about how best to combat this from an internal way and a social way. (Black, female, P292)

Black physicians sometimes described the need to be "resilient...let it roll off us without it affecting us too deeply" (Black, female, P278). One described how being trained at a highly regarded predominantly White medical school served as a form of protection from microaggressions:

Flash a [medical school] badge and...doors would open... Those credentials of goodness that can sort of cover you like White skin when you don't have the White skin...so it makes it extra challenging when you have Black skin and a Black school (Black, female, P278).

Working Through the Struggle of Discrimination. Participants described variable support from colleagues, the long-term impact of encounters with discriminatory patients, and commonly used responses.

Lack of Support. The lack of support from colleagues when faced with a discriminatory patient was exemplified by one physician: "afterwards people were pretty quiet about it except for a pharmacist"; as a result, she has "never mentioned it to my boss or my chair" (Black, female, P218). Some wanted institutions to recognize discrimination from patients as an issue and provide support: "the institution could do a better job of (A) naming and talking about these issues and (B) educating providers about what kind of practical strategies could be used" (White, male, P210). A White, female physician (P297) felt the institution needed to be more explicit to discriminatory patients about the consequences of their behavior: "it should be clear to patients we are changing a provider because of the provider's mental health, not because you are a racist."

Impact of Discriminatory Patient. Interacting with a discriminatory patient made some physicians feel isolated, excluded, and alone. An Asian, male physician (P202) reflected on how being frequent targets of discrimination from patients may compel physicians to "quit medicine or make a change or leave the practice." Such interactions could contribute to the attrition of POC "because patients are being racist and they [POC] can't be a doctor because they're not being seen as a doctor" (Asian, female, P258). This wore POC "down; it makes [them] tired...and some days [they] don't even feel like coming to work" (Asian, female, P240). As perceived by a White, female physician (P272), interacting with discriminatory patients can have "a huge impact on wellness and confidence and...overall mental health."

Supporting One's Self and One's Colleagues. Some participants chose to confront a discriminatory patient: "if it's something more overt...taking a firm stance that this behavior is not going to be accepted" (Asian, male, P202), while others used "humor a little bit" (White, female, P287). Sometimes the target removed themselves: "I just left the room and I took the team with me" (White, female, P297). A White, male physician (P237) described how "we would need to support the [physician] in not being discriminated against."

Some physicians described means of coping with the aftermath of discriminatory patients. One chose to "journal and write things down to sort of process it" (Asian, female, P260). Another recommended that physicians "reach out to others in their social support network," including mentors, colleagues, friends, and family: "I still need other people to take care of me" (Black, female, P278).

Communication Toolbox. Participants described having a "communication toolbox" (Asian, female, P240) for responding to a discriminatory patient. One White, male physician (P237) will say, "it's interesting that you feel comfortable saying that, '... as a way of noting the language without...an accusation of its motivation or underlying bias.'" Physicians without a "toolbox" were curious "what other people have had ready in their

pocket" and noted their institutions need to "develop policies to address [discriminatory patients] in a way that protects healthcare providers" (White, male, P211).

Ethical Dilemma of Providing Care to Discriminatory Patients. When they encountered a discriminatory patient, physicians in our study were often torn between their aversion to the patient and their professional obligation to provide care, pondering the impact on the patient's quality of care.

Internal Conflict. Encountering a discriminatory patient affected the clinical interaction and physician-patient relationship. Physicians described an "ethical dilemma" (White, male, P210) between confronting the patient and an obligation to provide care. A White, male physician (P213) described that in working with a neo-Nazi patient with swastika tattoos, the physician team still wanted to stay "true to the professional code," and provide quality care.

Impact on Quality of Care. A discriminatory patient can jeopardize the quality of care they receive. A White, male physician (P210) questioned "how do you not let that affect your obligation to this person...if you find their beliefs morally reprehensible?" These situations could be draining and required physicians "to turn on some active energy to maintain...objectivity with the patient" (White, male, P213). These types of interactions may affect quality of care: "you might not be as willing to go as out of your way...may not go the extra mile for them" (Asian, male, P202). One physician expressed concern about a discriminatory patient's refusal to share relevant clinical information with a POC, "which makes the doctor visit take longer and makes the interaction get off to a bad start" (White, female, P258).

DISCUSSION

From microaggressions to refusal of care, physicians in our study described discrimination from patients based on the physician's race, gender, or disability status. Our physicians' responses to such discrimination ranged from ignoring what was said to direct confrontation, with the interaction leaving some feeling isolated and alone and others enduring some adverse effects. Some physicians felt torn between providing quality care and confronting the discriminatory patient. Both targets of and witnesses to discrimination from patients expressed a need for support from their colleagues and clearer institutional guidance.

The issue of encountering discriminatory patients has emerged in social media,²⁴⁻²⁶ the popular press,^{27, 28} and personal essays.²⁹⁻³² However, our systematic review of discrimination experienced by POC found little research on

patients as a source of discrimination.⁵ In the interim, a focus group study from Wheeler et al. explored this issue using a convenience sample of hospitalist physicians, residents, and medical students.³³ Despite differences from our study design and sampling, participants in both studies encountered similar types of discrimination from patients and identified lack of institutional support as a barrier for change.

Even in the absence of overt prejudice, our physicians encountered microaggressions.^{34, 35} This was sometimes in the form of "status leveling" where a person is assumed to belong to a group of lower status in a social hierarchy (e.g., a Black physician assumed to be housekeeping staff or a female physician assumed to be a nurse).³⁶⁻³⁸ Black physicians in particular experienced the well-described cumulative psycho-emotional impact of frequent microaggressions.³⁴ The current COVID-19 pandemic underscores the challenges and vulnerabilities of Black physicians practicing in the USA.³⁹

When faced with a discriminatory patient, the American Medical Association's Code of Ethics recommends transferring their care to another physician.⁴⁰ Mayo Clinic has developed policies to facilitate transfer of patient care in such situations taking into account the condition and mental state of the patient, the effect of transfer on the patient's health, and the provider's safety.⁴¹ While well-intended, it is not yet known whether having an institutional policy helps resolve the conflict our physicians voiced between their aversion to a discriminatory patient and their responsibility to care for that patient.

Arming physicians with stock phrases for use with discriminatory patients would appear to provide an area for immediate action. Analogous to the "communication toolbox," Mayo Clinic provides physician targets and bystanders with scripts to use with discriminatory patients.⁴¹ Mello and Jagsi provide scripts to address patients who exhibit sexual harassment or gender bias⁴² and Goldenberg et al. found that behavioral rehearsal of specific scripts in a workshop increased skills and confidence of physician faculty to intervene with patients exhibiting prejudice toward trainees.^{43, 44} In addition to training physicians to competently deliver appropriate scripts when experiencing or witnessing discrimination from patients,⁴¹⁻⁴⁵ health care organizations can implement bias literacy training so members of the organization have a common language⁴⁶ to more easily recognize, label, discuss, and address episodes of discrimination.^{47, 48} Organizations can develop and visibly display diversity and inclusion messages that emphasize a growth mindset for overcoming the influence of stereotypes⁴⁹ and look to social marketing research to construct messages directed at patients to reduce prejudice toward their physician.^{50, 51}

Our use of a national sample, authentication of transcripts and themes with participants, collection of data until thematic saturation was achieved, and convergence of findings with existing research strengthen the

trustworthiness of our data and transferability of our findings; however, our study has limitations.²² Our findings are limited to general internists in academic medical centers at predominantly White institutions, and although thematically consistent in their perceptions and experiences, our sample contained only three Black physicians and one Hispanic/Latinx physician. We have no information on reasons physicians did not participate which could have been numerous; e.g., the invitation went to “junk mail,” no experience with or observations of patients discriminating against POC, no interest in participating because of the topic or in a time-consuming interview, or racial fatigue of POC at having to constantly “tell their story.”³⁰

In conclusion, our findings contribute to a mounting body of evidence that physicians who do not match patients' mental model of a physician as White, male, and able-bodied can be targets of demeaning and belittling behaviors from patients. While achieving a respectful work environment for all physicians will require a cultural change, there are actions health care organizations can take immediately to work toward this goal.^{52, 53}

Supplementary Information The online version contains supplementary material available at <https://doi.org/10.1007/s11606-021-06696-7>.

Corresponding Author: Kristen Pecanac, PhD, RN; Departments of Medicine, Psychiatry, and Industrial Engineering, University of Wisconsin-Madison, Madison, WI, USA (e-mail: lund2@wisc.edu).

Funding This work received financial support from the National Institutes of Health grants UL1TR000427, TL1TR000429, TL1TR002375, and R35GM122557; the University of Wisconsin Department of Medicine; and University of Wisconsin School of Medicine and Public Health Shapiro Scholars Program.

REFERENCES

- AAMC. Diversity in Medicine: Facts and Figures 2019; AAMC; 2019.
- QuickFacts United States, Population estimates, July 1, 2019 (V2019). United States Census Bureau.; 2019. <https://www.census.gov/quickfacts/fact/table/US/PST045219>. Accessed November 3, 2020.
- Murphy B. How IMGs have changed the face of American medicine. 2020; <https://www.ama-assn.org/education/international-medical-education/how-imgs-have-changed-face-american-medicine>.
- AAMC. Underrepresented in Medicine Definition. 2004. <https://www.aamc.org/what-we-do/mission-areas/diversity-inclusion/underrepresented-in-medicine>.
- Filut A, Alvarez M, Carnes M. Discrimination toward physicians of color: A systematic review. *J Natl Med Assoc.* 2020; 112(2): 117-140. <https://doi.org/10.1016/j.jnma.2020.02.008>.
- Padela AI, Adam H, Ahmad M, Hosseinian Z, Curlin F. Religious identity and workplace discrimination: A national survey of American Muslim physicians. *AJOB Empir Bioeth.* 2016;7(3):149-159. <https://doi.org/10.1080/23294515.2015.1111271>.
- Bhatt W. The little brown woman: gender discrimination in American medicine. *Gender Soc.* 2013;27(5):659-680. <https://doi.org/10.1177/0891243213491140>.
- Chen PGC, Nunez-Smith M, Bernheim SM, Berg D, Gozu A, Curry LA. Professional experiences of international medical graduates practicing primary care in the United States. *J Gen Intern Med.* 2010;25(9):947-953. <https://doi.org/10.1007/s11606-010-1401-2>.
- Chen PG-C, Curry LA, Bernheim SM, Berg D, Gozu A, Nunez-Smith M. Professional challenges of non-US-born international medical graduates and recommendations for support during residency training. *Acad Med.* 2011;86(11):1383. <https://doi.org/10.1097/acm.0b013e31823035e1>.
- Hassouneh D, Lutz KF, Beckett AK, Junkins Jr EP, Horton LL. The experiences of underrepresented minority faculty in schools of medicine. *Med Educ Online.* 2014;19(1):24768. <https://doi.org/10.3402/meo.v19.24768>.
- Nunez-Smith M, Pilgrim N, Wynia M, et al. Race/ethnicity and workplace discrimination: results of a national survey of physicians. *J Gen Intern Med.* 2009;24(11):1198-1204. <https://doi.org/10.1007/s11606-009-1103-9>.
- Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care.* 2007;19(6):349-357. <https://doi.org/10.1093/intqhc/mzm042>.
- Morse JM. What's wrong with random selection?: Sage Publications Sage CA: Thousand Oaks; 1998.
- Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Adm Policy Ment Health.* 2015;42(5):533-544. <https://doi.org/10.1007/s10488-013-0528-y>.
- United States Census Bureau. Census Regions and Divisions of the United States. https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf.
- AAMC. AAMC Medical School Members. 2018; <https://members.aamc.org/eweb/DynamicPage.aspx?site=AAMC&webcode=AAMCOrgSearchResult&orgtype=Medical%20School>.
- Kaatz A, Magua W, Zimmerman DR, Carnes M. A quantitative linguistic analysis of National Institutes of Health R01 application critiques from investigators at one institution. *Acad Med.* 2015;90(1):69-75. <https://doi.org/10.1097/acm.0000000000000442>.
- Creswell JW. Qualitative inquiry and research design: Choosing among five traditions, Thousand Oaks: Sage; 1998.
- Guest G, Bunce A, Johnson L. How many interviews are enough? An experiment with data saturation and variability. *Field Methods.* 2006;18(1):59-82. <https://doi.org/10.1177/1525822X05279903>.
- Braun V, Clarke V. APA handbook of research methods in psychology. Cooper H, Thematic analysis. 2012;2.
- NVivo qualitative data analysis Software [computer program]. Version 102014.
- Tobin GA, Begley CM. Methodological rigour within a qualitative framework. *J Adv Nurs.* 2004;48(4):388-396. <https://doi.org/10.1111/j.1365-2648.2004.03207.x>.
- Birt L, Scott S, Cavers D, Campbell C, Walter F. Member checking: a tool to enhance trustworthiness or merely a nod to validation? *Qual Health Res.* 2016;26(13):1802-1811. <https://doi.org/10.1177/1049732316654870>.
- Choo ESH. 1/ We've got a lot of white nationalists in Oregon. So a few times a year, a patient in the ER refuses treatment from me because of my race. 2017.
- Caudle DJ. I have had patients refuse to see me because of my race as well. It's astonishing - but happens. 2017.
- Yang Y. 1/ Today's #MedEdMethodsMonday reviews strategies for responding as a bystander to #microaggressions and #bias from patients. Have you seen a patient make a #sexist, #racist, ***ist comment towards a learner or peer? 2020.
- Reddy S. How doctors deal with racist patients. *The Wall Street Journal.* 2018. <https://www.wsj.com/articles/how-doctors-deal-with-racist-patients-1516633710>.
- Novick DR. Racist patients often leave doctors at a loss. *The Washington Post.* 2017. https://www.washingtonpost.com/opinions/racist-patients-often-leave-doctors-at-a-loss/2017/10/19/9e9a2c46-9d55-11e7-9c8d-cf053ff30921_story.html?utm_term=.ad2cd993f3a4.
- Poole KG Jr. Patient-experience data and bias - What ratings don't tell us. *N Engl J Med.* 2019;380(9):801-803. <https://doi.org/10.1056/nejmp1813418>.
- Williams M. Sick and tired. *Obstet Gynecol.* 2019;133(3):568-570. <https://doi.org/10.1097/aog.00000000000003117>.
- Jagsi R. A piece of my mind. How deep the bias. *JAMA.* 2008;299(3):259-260. <https://doi.org/10.1001/jama.299.3.259>.
- Olayiwola JN. Racism in medicine: Shifting the power. *Ann Fam Med.* 2016;14(3):267-269. <https://doi.org/10.1370/afm.1932>.

33. **Wheeler M, de Bourmont S, Paul-Emile K, et al.** Physician and trainee experiences with patient bias. *JAMA Intern Med.* 2019;179(12):1678-1685. <https://doi.org/10.1001/jamainternmed.2019.4122>.
34. **Sue DW, Capodilupo CM, Torino GC, et al.** Racial microaggressions in everyday life: implications for clinical practice. *Am Psychol.* 2007;62(4):271-286. <https://doi.org/10.1037/0003-066x.62.4.271>.
35. **Fine ES, Bell J, Fabian C, Carnes M; Neimeko CJ, Romero M.** Teaching academics about microaggressions: A workshop model adaptable to various audiences. presented at: Understanding Interventions 2018; Baltimore, MD.
36. **Cheryan S.** Understanding the paradox in math-related fields: Why do some gender gaps remain while others do not? *Sex Roles.* 2012;66(3-4):184-190. <https://doi.org/10.1007/s11199-011-0060-z>.
37. **Pololi L, Cooper L, Carr P, Cooper LA.** Race, disadvantage and faculty experiences in academic medicine. *J Gen Intern Med.* 2010;25(12):1363-1369. <https://doi.org/10.1007/s11606-010-1478-7>.
38. **Montenegro RE.** My name is not "Interpreter". *JAMA.* 2016;315(19):2071-2072. <https://doi.org/10.1001/jama.2020.2976>.
39. **Filut A, Carnes M.** Will losing black physicians be a consequence of the COVID-19 pandemic? *Acad Med.* 2020. <https://doi.org/10.1097/ACM.0000000000003651>.
40. American Medical Association. *AMA code of medical ethics: American Medical Association;* 2016.
41. **Warsame RM, Hayes SN.** Mayo Clinic's 5-Step Policy for Responding to Bias Incidents. *AMA J Ethics.* 2019;21(6):521-529. <https://doi.org/10.1001/amajethics.2019.521>.
42. **Mello MM, Jagsi R.** Standing up against gender bias and harassment — A matter of professional ethics. *N Engl J Med.* 2020;382(15):1385-1387. <https://doi.org/10.1056/nejmp1915351>.
43. **Goldenberg MN, Cyrus KD, Wilkins KM.** ERASE: a new framework for faculty to manage patient mistreatment of trainees. *Acad Psychiatry.* 2019;43(4):396-399. <https://doi.org/10.1007/s40596-018-1011-6>.
44. **Wilkins KM, Goldenberg MN, Cyrus KD.** ERASE-ing patient mistreatment of trainees: Faculty workshop. *MedEdPORTAL.* 2019;15:10865. https://doi.org/10.15766/mep_2374-8265.10865.
45. **Sue DW, Alsaïdi S, Awad MN, Glaeser E, Calle CZ, Mendez N.** Disarming racial microaggressions: Microintervention strategies for targets, White allies, and bystanders. *Am Psychol.* 2019;74(1):128-142. <https://doi.org/10.1037/amp0000296>.
46. **Nonaka I.** A dynamic theory of organizational knowledge creation. *Organ Sci.* 1994;5(1):14-37. <https://doi.org/10.1287/orsc.5.1.14>.
47. **Carnes M, Devine PG, Isaac C, et al.** Promoting institutional change through bias literacy. *J Divers High.* 2012;5(2):63-77. <https://doi.org/10.1037/a0028128>.
48. **Carnes M, Devine PG, Baier Manwell L, et al.** The effect of an intervention to break the gender bias habit for faculty at one institution: a cluster randomized, controlled trial. *Acad Med.* 2015;90(2):221-230. <https://doi.org/10.1097/ACM.0000000000000552>.
49. **Carnes M, Fine E, Sheridan J.** Promises and pitfalls of diversity statements: proceed with caution. *Acad Med.* 2019;94(1):20. <https://doi.org/10.1097/acm.0000000000002388>.
50. **Campbell MR, Brauer M.** Incorporating Social-Marketing Insights Into Prejudice Research: Advancing Theory and Demonstrating Real-World Applications. *Perspect Psychol Sci.* 2020. <https://doi.org/10.1177/1745691619896622>.
51. **Tankard ME, Paluck EL.** Norm perception as a vehicle for social change. *Soc Issues Policy Rev.* 2016;10(1):181-211. <https://doi.org/10.1111/sjpr.12022>.
52. **Carnes M.** The American College of Physicians is working hard to achieve gender equity, and everyone will benefit. *Ann Intern Med.* 2018;168(10):741-743. <https://doi.org/10.7326/m18-0837>.
53. **Carnes M, Handelsman J, Sheridan J.** Diversity in academic medicine: the stages of change model. *J Womens Health.* 2005;14(6):471-475. <https://doi.org/10.1089/jwh.2005.14.471>.

Publisher's Note: Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.