Incidental Finding

Category: Stories
written by Deborah Pierce | April 21, 2017

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“You need to give me the name of a different specialist,” Ashley asserted.

For several years, Ashley, age twenty-nine, has been my patient at the residency practice where I work as a family doctor. Our relationship is not entirely comfortable; after visits, she frequently seems dissatisfied, yet she refuses to see anyone else.

Ashley’s body is a source of distress to her, often developing various pains and discomforts that fade away without explanation. In search of relief, she asks for many tests, but often, when I recommend a treatment, she refuses it or has difficulty tolerating its effects. When we talk, she’s usually very guarded about any aspects of her life besides those directly related to her symptoms.

I often feel ambivalent about ordering tests for Ashley, because all tests carry risks. Mostly, the risks are small. But one big and worrisome risk is the possibility of an incidental finding—something unusual that requires further testing and that would have posed no problem had it gone undiscovered.

Today, Ashley’s exam did reveal an incidental finding—one completely unexpected and deeply disturbing.

Complaining of joint pain, she’d asked me for a referral to an orthopedist. In such cases, my usual move would be to refer the patient to a group practice of orthopedists, but for Ashley, I felt that Dr. Mohammed was clearly the best choice. Besides being a thorough, skillful clinician and surgeon, he’s a wonderfully sensitive and compassionate person. His manner is gentle; his communications to patients and colleagues are clear. He’s cared for several complicated patients of mine over the past few years, and all were delighted with his care. Dr. Mohammed would, I knew, respond to Ashley’s demands and questions with exceptional kindness and patience.

Admiring him as I do, I was astonished when she refused my recommendation.

“Why wouldn’t you want to see him?” I asked.

“I need to see someone who was trained in America,” she insisted.

Inwardly, I cringed. I’ve known that it was only a matter of time before I’d have to confront xenophobia in a patient, but still I felt at a loss about how to proceed. I’d anticipated hearing such comments from patients, or even from colleagues; somehow, though, I hadn’t expected them to surface in this way.

“What makes you think he wasn’t trained here?” I countered. “In fact, he went to medical school and trained at the university here.”

“I Googled him one other time,” Ashley responded, looking a bit flustered. “I’m sure you’ve mentioned him to me before. And I need some other choices, since I won’t see him.”

I had a feeling that I knew what the problem was. I feared that she was refusing to see him based on her assumptions about his religion or ethnicity, and about how she imagined they might affect his care of her.

Trying to find a way to gently challenge these assumptions without antagonizing her, I replied, “I’m not sure who you were looking up, but regardless, he did train here. And while there are many excellent orthopedists in town, I think Dr. Mohammed would do especially well with you, as he does a lot of work with people whose pain is hard to diagnose.”

Ashley’s expression grew angrier. “Oh, so you think I’m crazy? Why do you think I’m so hard? Just give me the name of another doctor. You need to understand that in the city where I grew up, there was a public medical school, and they just experimented on patients.”

“Well, you know that I graduated from a public medical school also,” I said, trying to stay calm. “So I don’t really know what you mean by that.”

“Oh, the local university medical center is terrific,” she said quickly.

Her sudden shift of topic and tone perplexed me; somehow, it seemed to leave me little room to either clarify her views or challenge them.

It’s commonplace for patients to express preferences for certain characteristics in a physician, I reminded myself. *Many women prefer female gynecologists, and patients tend to favor physicians who speak their language, share their religious or ethnic background or are of a certain age. If Ashley refused to let a nurse give her a vaccine because she objected to people of the nurse’s ethnicity, that would clearly cross a line. This situation falls in between.*

I could refuse to refer her to anyone besides Dr. Mohammed, I reflected. *But then I’d be denying her the alternatives that I’d give any of my other patients. That hardly seems reasonable.*

At any rate, it was clear that Ashley wouldn’t see Dr. Mohammed. Feeling unsettled, I filled out a referral to a different orthopedic group, wished her well and left the room—without making sure that she’d booked a follow-up visit, as I’d normally do. As she left, my inner turmoil continued, and I began to second-guess my decision.

I felt both relieved that our visit had ended without a direct confrontation and afraid that Ashley might believe that I’d endorsed her biases. Fiercely, I wished that I’d found some way to push her to state her prejudices openly—and yet, I also felt keenly aware that, in leaving her follow-up unscheduled, I was hoping that she wouldn’t return soon, so that we wouldn’t

have to revisit this.

As a physician, when I uncover an incidental finding—an adrenal-gland tumor, lung mass or abnormal lab result—I have clinical protocols to guide my decision-making. These protocols factor in the risks, benefits and costs of every option.

But there are no protocols for an incidental finding of suspected bigotry. And it's hard to gauge who may be harmed by letting it go unchallenged.

Of course, I told myself, *Ashley didn't come right out and say that she was refusing to see Dr. Mohammed because of his presumed religion and heritage—though it's hard to think of another explanation. Ultimately, she's the one who'll lose; she'll get excellent care from another orthopedist, but without Dr. Mohammed's extraordinary thoroughness and compassion.*

Our encounter raised questions that I continue to wrestle with: When is it okay to acquiesce to a patient's request for specific physician characteristics, and when is it not? Do I have an obligation to challenge my patients' false, hurtful prejudices? And does that obligation vary, depending on the situation and on my relationship with them?

Also, what should my role be in advocating for colleagues like Dr. Mohammed? If Ashley were a friend or family member, I hope that I'd have the courage to name the implicit bias in what she said about him—and to speak out against it.

When does supporting a patient's preference cross the line into enabling bigotry?

I'm still looking for answers, and I fear that these questions will arise more and more often.

About the author:

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