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Racial Bias in a Provider-Patient Relationship: May Give Rise to an Intentional Infliction of Emotional Distress Claim

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I. INTRODUCTION

Imagine you are a doctor working hard in the emergency room when suddenly a patient enters the hospital with injuries requiring immediate attention. Your first instinct is to assess and treat the injuries. You do not judge the patient for what happened or how it happened; you focus on asking questions that will give you answers necessary for treating the patient. Then, despite his injuries, he ignores your questions and you, the first doctor who is trying to save this man's life, are forcefully rejected by the patient. The patient screams with fear and anger in his eyes for another doctor. "Can anyone help me?" the patient yells as you stand by his side, helpless. Your superior walks by and you grab him to help. But even this highly regarded physician is rejected by the patient. Again, he yells, "Please, someone, help me!" Finally, a third younger doctor, after hearing that the first two doctors were rejected, is able to coax the patient into letting him treat the patient's injuries. You are very confused. You cannot understand why the patient would refuse your service. You studied just as long as everyone else. You work just as hard and are just as capable as anyone of treating any patient.

What you come to find out after the third doctor returns to update you on the patient is that the patient has a basketball-sized swastika tattooed on his abdomen. Therefore, he did not want black doctors to treat him—the first two doctors were black, the third was white. "Ah," you think, "now this makes sense; it was never about my qualifications, but my skin color." This is the storyline of a Grey's Anatomy episode[1] so it may be an embellished version of the racism that is

[1] Crash Into Me: Part 2, IMDB, https://www.imdb.com/title/tt1002869/ (last visited Apr. 29, 2019). *See also*, Lisa Gutierrez, *Hate, Even in the ER: Doctor Says Some Refuse Her Treatment Because of Her Race*, THE SACRAMENTO BEE (Aug. 16, 2017), https://www.sacbee.com/article167580377.html (explaining that because she is an Asian doctor, even though she received her M.D. from Yale, white nationalists refuse her treatment).

encountered today, but it is still relevant because both doctors and patients continue to experience racism in medicine today.[2]

Racism may not be as conspicuous as it once was in the United States, but unfortunately, it is still alive and well. Today, racism manifests differently than it used to. The more overt manifestations have faded over the years.[3] More common today is subtle racism or even racist biases that underlie one's beliefs,[4] which may even be subconscious. One institution where racism persists is medicine.[5] There are many aspects of medicine where racism may reside, but this Paper will focus on one area of medicine where racism still appears: the doctor's office. There may be racism towards the patient from the doctor—either subtle or overt—often in ways that influence the doctor's decision-making.[6] There can also be racism towards the doctor from the patient, which tends to be more overt.

This Paper will explore the issue of whether, once a patient-provider relationship has been created, an intentional infliction of emotional distress claim would be viable if brought by the patient after the doctor exhibited racial bias towards the patient or viable if brought by the doctor after a patient exhibited racial bias towards the doctor. This Paper recognizes that even though most claims will be brought under statutory discrimination claims, an intentional infliction of emotional distress (IIED) claim may be viable in certain circumstances. Thus, this Paper will

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[2] *See infra* notes 9–24 and accompanying text.

[3] MARK HALL, DAVID ORENTLICHER, MARY ANNE BOBINSKI, NICHOLAS BAGLEY & I. GLENN COHEN, HEALTHCARE LAW AND ETHICS 80 (Rachel Barkow et al. eds., 9th ed. 2018) ("These and other forms of overt discrimination have now largely disappeared as the result of various prohibitions contained in federal and state regulatory law, as well as in the hospital industry's own private accreditation code." (citing Sara Rosenbaum et al., *U.S. Civil Rights Policy and Access to Health Care by Minority Americans*, 57 MED. CARE RES. & REV. 226 (2000))).

[4] HALL ET AL., *supra* note 3, at 80 ("Serious concerns remain, however, over more subtle forms of racial bias in the delivery of health care services.").

[5] *Id.*

[6] HALL ET AL., *supra* note 3, at 81 ("Discrimination can also arise in individual treatment decisions."). *But see*, *id.* (explaining it is hard to conclusively study discrimination as there may be distinctions between patients that justify differences in treatment).

evaluate solely the effectiveness and likelihood of success of an IIED claim when racism is present in a patient-provider relationship.

Part II will provide a brief background of discrimination in healthcare and an introduction to the provider-patient relationship and tort law. Part III will evaluate the viability of bringing a tort claim of intentional infliction of emotional distress if brought by either the doctor or patient after experiencing racial bias or explicit racism in the doctor's office.

Ultimately, this Paper will conclude that an intentional infliction of emotional distress claim may be successful against either the patient or the doctor. However, this Paper will find most claims are unlikely to succeed, due to the necessary, yet difficult-to-prove "outrageous and extreme" element of an IIED claim. This Paper will then argue that because of the unique nature of the provider-patient relationship, the bar for the "outrageous and extreme" element should be reduced. Finally, this Paper notes that claims regarding underlying or subconscious biases will be much harder to prove under the intentional infliction of emotional distress cause of action, but they should still be recognized by tort law because the biases can and have led to physical harm.

II. BACKGROUND

Discrimination

There is a long history of discrimination in the United States.[7] Correspondingly, there is a long history of discrimination within the healthcare system in the United States.[8] "At one time, it was commonplace, especially in the South, for hospitals to refuse admission to blacks."[9] Thankfully, a lot has changed since then, although racism has yet to be eradicated. As such, racism continues to exist in the healthcare system on an individual level within the provider-patient

[7] Mary Crossley, *Article: Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195, 221 (2003).
[8] *Id.* (referencing the Tuskegee Syphilis Study).
[9] HALL ET AL., *supra* note 3, at 80.

relationship.[10] In fact, the American Medical Association (AMA) recently adopted a policy recognizing racism as a public health threat.[11] While there still exists overt racial bias, subtle racial bias[12] has become more prevalent. And these biases come from both the patient and the provider's sides.

Coming from the patient's side there can be both overt and subtle racial biases toward the provider. A survey conducted by WebMD and Medscape in collaboration with STAT, "found that 59 percent [of doctors] had heard offensive remarks about a personal characteristic in the past five years—chiefly about a doctor's youthfulness, gender, race, or ethnicity."[13] Following the offensive remark, forty-seven percent of the doctors had a patient request a different doctor or a referral for another doctor.[14] The same study found that "African-American and Asian-American physicians were more likely to face such attacks" and that thirty-nine percent of black physicians experienced offensive remarks about their race.[15]

One example of overt racial bias toward a provider by a patient, was when a patient saw Dr. Punam Krishan in 2019. Dr. Kirshan is a general practitioner in Glasgow and when her patient walked in, the patient said, "I don't want an Asian doctor."[16] The receptionist replied, "She's

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[10] Crossley, *supra* note 7.
[11] *New AMA Policy Recognizes Racism as a Public Health Threat*, AMA ASSOCIATION (Nov. 16, 2020), https://www.ama-assn.org/press-center/press-releases/new-ama-policy-recognizes-racism-public-health-threat.
[12] *Id.* (describing the "operation of racial bias as 'subtle' or 'nuanced' and not perceived by the physician").
[13] Bob Tedeschi, *6 in 10 Doctors Report Abusive Remarks From Patients, and Many Get Little Help Coping With the Wounds*, STAT (Oct. 18, 2017) https://www.statnews.com/2017/10/18/patient-prejudice-wounds-doctors/.
[14] *Id.*
[15] *Id.*
[16] Sarah Johnson, *My Patient Made Racist Remarks About Me. I Decided to do Something About it,* THE GUARDIAN (Jan. 22, 2019), https://www.theguardian.com/society/2019/jan/22/patient-racist-remarks-nhs.

Scottish."[17] The patient then responded, "She doesn't look Scottish."[18] While this occurred in Scotland, it is just one example of how racial bias permeates all sectors of the healthcare system.

An example of subtle racial bias toward a provider is when a patient continually questions the provider's competence. This was the case for Dr. Fatima Cody Stanford in 2019. While on a flight, a passenger needed medical assistance, so Dr. Stanford volunteered to assist.[19] Even after she presented her medical license, the flight attendants continued to question her, asking "are you a head doctor?" and "is this *your* medical license?"[20] Even though she was a Harvard-trained specialist,[21] the flight attendants questioned her competence. Why? Because she was black.

There can also be both subtle and overt racial biases by the provider toward the patient. One example of overt racial bias by a provider is what a Cleveland Clinic resident, Dr. Lara Kallab, was fired for in 2019.[22] While practicing medicine, Dr. Kallab tweeted multiple anti-Semitic tweets; one of which stated, "I'll purposefully give all the [Jews] the wrong meds."[23] An example of a subtle racial bias by a provider is assuming things about the patient based on personal characteristics. One of the reasons doctors may vary in their treatment of patients and practice of medicine may be based on bias, uncertainty, motives, and values.[24] There are studies that "have

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[17] *Id. See also*, Agencies, *Racist Couple 'Demanded White Doctor',* THE TELEGRAPH (May 25, 2014), https://www.telegraph.co.uk/news/health/news/10855575/Racist-couple-demanded-white-doctor.html; Altaf, Saadi, *A Muslim-American Doctor on the Racism in Our Hospitals*, KEVINMD.COM (Feb. 7, 2016), https://www.kevinmd.com/blog/2016/02/muslim-american-doctor-racism-hospitals.html; Jennifer Adaeze Okwerekwu, *A Patient Threatened to Shoot Me. Could I Then Give Him Good Care?,* STAT (Mar. 14, 2016), https://www.statnews.com/2016/03/14/difficult-patients-sabotage-medical-care; Jennifer Adaeze Okwerekwu, *The Patient Called Me 'Colored Girl.' The Senior Doctor Training Me Said Nothing,* STAT (Apr. 11, 2016), https://www.statnews.com/2016/04/11/racism-medical-education/ (demonstrating patients' racist behaviors towards physicians of color).

[18] Johnson, *supra* note 15.

[19] Vidya Viswanathan, *"Are You a Doctor?" The Unchecked Racism Faced by Physicians of Color*, VOX.COM (Jan. 7, 2019), https://www.vox.com/first-person/2019/1/2/18144979/doctor-racism-delta-airlines-dr-tamika-cross-fatima-cody-stanford.

[20] *Id* (emphasis in original).

[21] *Id.*

[22] Doctor's Voice, *What Should be Done About Racism in Medicine*, PHYSICIAN'S WEEKLY (Jan. 8, 2019), https://www.physiciansweekly.com/what-should-be-done-about-racism-in-medicine/.

[23] *Id.*

[24] HALL ET AL., *supra* note 3, at 26-35 (discussing clinical decision making).

documented that physicians treat blacks . . . differently for the same medical conditions."[25] For example, "blacks are less likely than whites to receive a kidney transplant, coronary artery bypass surgery, or other major surgical procedures."[26] There may be valid and legitimate reasons to take race into account, which is also known as race-based medicine,[27] but that is not the case here.

If racial bias continues to pervade medicine and the provider-patient relationship, is there any legal cause of action that the provider or the patient can bring when he or she experiences racial bias, whether overt or subtle? In order to address this specific question, contract law, tort law, and agency law need to be incorporated into this analysis through an examination of the provider-patient law.

Provider-Patient Relationship

A provider-patient relationship has been defined as "a consensual relationship in which the patient knowingly seeks the physician's assistance and in which the physician knowingly accepts the person as a patient."[28] This relationship is part contract, tort, and agency. The relationship is initiated when both the patient and the provider agree to be in the relationship. The provider is permitted to refuse to enter into the relationship for any reason or no reason.[29] The emphasis on

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[25] HALL ET AL., *supra* note 3, at 81.

[26] *Id.* (Referencing DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE (2015) and R Yearby, *Breaking the Cycle of Unequal Treatment with Health Care Reform*, 44 U. CONN. L. REV. 1281 (2010)). *See also*, National Center for Health Statistics, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities* (last updated June 22, 2017), https://www.cdc.gov/nchs/data/hus/hus15.pdf (presenting statistics in healthcare with an emphasis on racial and ethnic healthcare disparities).

[27] A discussion of race-based medicine is outside the scope of the article. For more information, see Dorothy E. Roberts' *Is Race-Based Medicine Good for Us?: African American Approaches to Race, Biomedicine, and Equality*, 36 J. LAW, MED. & ETHICS 3, 537-545 (2008).

[28] QT, Inc v. Mayo Clinic Jacksonville, 2006 U.S. Dist. LEXIS 33668, at *10 (N.D. Ill. May 15, 2006).

[29] Oliver v. Brock, 342 So. 2d 1, 3 (Ala. 1976) (quoting 61 Am. Jur. 2d, Physicians, Surgeons, and Other Healers, § 96) ("A physician is under no obligation to engage in practice or to accept professional employment, but when the professional services of a physician are accepted by another person for the purposes of medical or surgical treatment, the relation of physician and patient is created. The relation is a consensual one wherein the patient knowingly seeks the assistance of a physician and the physician knowingly accepts him as patient."). *But see*, HALL ET AL., *supra* note 3, at 79 ("On the other hand, without a statute that specifically prohibits the particular reason for discrimination,

freedom to contract is based on the contract principle that there is no duty to contract.[30] However, on occasion, public policy may supersede contract law, such as statutory limits on a provider's right to refuse. For example, a hospital may not turn away a patient in active labor.[31] Additionally, providers cannot refuse to treat a patient based on certain discriminatory grounds, including race, sex, or HIV status.[32]

Further, this freedom to refuse concept is based on the tort principle that there is no duty to treat.[33] Nevertheless, once the provider-patient relationship has commenced, the provider cannot terminate the relationship at that point. The relationship can only be terminated when the provider has done all that is in his or her power to treat the condition or symptoms.[34] Otherwise, if the provider has undertaken to treat the patient and the provider stops treating the patient prematurely, then there may be a claim for abandonment.[35] Abandonment is the premature or improper termination of the provider-patient relationship.

Moreover, the provider-patient relationship is inherently a fiduciary relationship.[36] The patient places his or her trust in the provider so that the provider can treat the patient in a way that is in the best interests of the patient.[37] And the physician agrees to "obtain informed consent, provide the highest standard of care, and commit not to abandon the patient without giving him or

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morally problematic denials of care are generally permissible . . ."). *See* HALL ET AL., *supra* note 3, at 59–60 n. 1 for discussion of no duty to contract under contract law and no duty to rescue under tort law.

[30] *Oliver*, 342 So. 2d at 3.

[31] *See* EMTALA, 42 U.S. Code § 1395dd discussed in Burditt v. U.S. Dep't of HHS, 934 F.2d 1362 (5th Cir. 1991).

[32] *See* HALL ET AL., *supra* note 3, at 53.

[33] Hurley v. Eddingfield, 156 Ind. 416, 59 N.E. 1058 (1901). Additionally, even the AMA code of medical ethics states there is not a duty to treat but that a doctor should assist the medical emergency the best he or she can. Principle IV, *Principles of Medical Ethics*, AMERICAN MEDICAL ASSOCIATION, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf (last visited Apr. 29, 2019).

[34] HALL ET AL., *supra* note 3, at 112–117.

[35] HALL ET AL., *supra* note 3, at 118 n. 3.

[36] Fallon E. Chipidza, Rachel S. Wallwork, Theodore A. Stern, *Impact of the Doctor-Patient Relationship*, NCBI (Oct. 22, 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4732308/#bib1.

[37] Crossley, *supra* note 7 at 239.

her adequate time to find a new doctor."[38] These are examples of duties that the providers owe patients once they are in a provider-patient relationship. The providers must uphold their duties and not take advantage of their positions because, in this special relationship, there is a power imbalance due to the provider holding most of the power. For this reason, the patient is very vulnerable. This relationship is fiduciary based because the patient is putting his or her trust in the provider. The patient trusts the providers' competence, knowledge, and that the provider will do what is in the best interests of the patient. In addition, the patient trusts the provider in a way that is reminiscent of the trust in a pastor or priest.[39] This is likely due to the fact that historically, there was a very strong connection between healing/health/medicine and religion. For example, a traditional shaman is highly respected and practices both divination and healing.[40]

This type of trust continues today because "uncertainty and fear regarding illness and medical care persist, which helps keep alive the reliance on hope, faith, [and] confidence" in the provider.[41] And, often, when patients are going through an illness, patients may regress to helplessness.[42] When a patient regresses to dependency and helplessness, he or she may crave the authority of a provider.[43] This regression gives the provider even more power over the patient, but, it is not necessarily harmful because the patient may heal faster if he or she can relinquish some of the responsibility of taking care of him or herself.[44] The provider-patient relationship is a sacred and essential part of healthcare. However, due to the power imbalance, the relationship has the potential to cause the patient harm, such as when racial bias is involved.

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[38] *Id.*
[39] HALL ET AL., *supra* note 3, at 21.
[40] *Shaman*, OXFORD ENGLISH DICTIONARY (2nd ed. 1989).
[41] HALL ET AL., *supra* note 3, at 15–24.
[42] *Id.*
[43] *Id.*
[44] Chipidza, et. al., *supra* note 36.

Tort Claims

Tort law is basically the civil version of criminal law. A tort is "a wrongful act other than a breach of contract, for which relief may be obtained in the form of damages or an injunction."[45] Tort law is applicable here because tort law often imposes duties on certain groups of people, such as doctors. In the doctor-patient context, duties attach to any doctor at the moment the provider-patient relationship is created. In this Paper, an assumption will be applied that there is no issue regarding whether a provider-patient relationship was established. Because of the nature of the provider-patient relationship, the patient is vulnerable. If the patient's vulnerability is taken advantage of by the provider, then the patient may have a tort claim. There can be tort claims for both emotional harm and physical harm. Tort claims for emotional harm include negligent infliction of emotional distress (NIED) and intentional infliction of emotional distress (IIED). Only the tort of IIED will be analyzed in Part III. Assuming a provider-patient relationship has been created because the patient has sought care from the doctor and the doctor has agreed to treat the patient, next, whether racial bias can be grounds for a tort claim needs to be determined.

III. ANALYSIS

Intentional infliction of emotional distress is defined as "extreme and outrageous conduct [that] intentionally or recklessly causes severe emotional harm to another . . ."[46] This definition contains four elements: (1) extreme and outrageous conduct, (2) intentional or reckless, (3) causation, and (4) severe emotional harm. The first element—extreme and outrageous conduct—is a high standard. It is more than just "ordinary insults and indignities."[47] The conduct must rise to a level that "goes beyond the bounds of human decency such that it would be regarded as

[45] *Tort*, Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/tort (last visited Apr. 29, 2019).
[46] Restatement (Third) of Torts § 46 (1965).
[47] Restatement (Third) of Torts § 46 cmt. d.

intolerable in a civilized community."[48] Intentional, half of the second element, means the actor "acts knowing that the consequence is substantially certain to result."[49] Recklessness, the other half of the second element, means "behavior that is so careless that it is considered an extreme departure from the care a reasonable person would exercise in similar circumstances."[50]

The third element—causation—means that the conduct must have led to the injury. The conduct must have been a "proximate cause" of the injury. But it does not necessarily have to have been the only cause of the injury. With regard to the fourth and final element, it requires both severity and harm. Courts tend to use the following standard as a test for severity: "The law intervenes only where the distress inflicted is so severe that no reasonable person could be expected to endure it."[51] Three factors that courts have used in determining whether the emotional harm is severe are duration, intensity, and the outrageousness of the conduct.[52]

Further, courts have recognized claims for IIED as a result of racial bias. For example, in 1991, in *Brown v. Manning*, the court denied summary judgment of an IIED claim where an insurance company claims examiner had a conversation with the injured person in a car accident.[53] Manning was the claims examiner and Brown was the injured person whose car was hit.[54] During a disagreement on the phone, Brown stated, "I have a right to say where I get my damn car fixed.[55] To which Manning replied, "That's what's wrong with you n*ggers now, you don't follow orders . . . Either you are going to accept my offer or hell with you."[56] The first call from the claims

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[48] *Id.*
[49] *Id.*
[50] *Reckless*, CORNELL L. LEGAL INFO. INSTITUTE, https://www.law.cornell.edu/wex/reckless (last visited Apr. 29, 2019).
[51] Restatement (Third) of Torts § 46 cmt. j.
[52] *Id.*
[53] 764 F. Supp. 183, 188 (M.D. Ga. 1991).
[54] *Id.* at 184.
[55] *Id.* at 185.
[56] *Id.*

examiner was in July.[57] In November, Brown received a letter asking Brown to call the insurance company, and when he did, he was connected with Manning.[58] Brown asked Manning what he was going to do about his broken car.[59] Manning replied, "Nothing. I don't give a damn about your, I don't give a damn about your car; and furthermore, you can suck my long white d*ck, n*gger."[60] After this conversation, Brown blacked out and had to be taken to the emergency room.[61]

The next day, Brown received two phone calls from unidentified callers; the first one of which Brown's wife answered.[62] The caller told Mrs. Brown that she should, "tell your husband we are going to kill him if he don't [sic] back down. If he should get fired, we, the Ku Klux Klan, are going to kill him, we love stringing out n*ggers."[63] The second call later that evening, the caller told Brown:

> Yes, you n*gger, we're going to blow your f*cking brains out. We love stringing n*ggers up there on trees and cutting their d*cks off. If you don't drop the charges against this person, the man, we're going to kill your mother f*cking ass, you hear me n*gger, do you hear me n*gger?[64]

The question the court addressed was whether the statements allegedly made by Manning were sufficient as a matter of law to support an IIED claim.[65] The court emphasized that Manning was in a special relationship with Brown because Manning's position could affect the interests of Brown. Ultimately, the court held that the actions *did rise* to the requisite level of outrageous and egregious conduct needed to support an IIED claim.[66] Therefore, the outrageous and extreme

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[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.* at 185–186.
[65] *Id.* at 186.
[66] *Id.* at 187 (emphasis added).

conduct element is possible to meet, and this case gives us an example of what that conduct may look like. In addition, not only was the conduct outrageous and extreme, but it occurred more than once, so the duration and repetition may be a factor for courts to consider.

Courts have recognized claims for IIED in the provider-patient context as well. For example, in *Greer v. Medders*, which was on appeal from a grant of summary judgment for the defendant, the court held that the defendant was not entitled to summary judgment because there was a material question of fact as to whether there could be IIED claim.[67] In *Greer*, Mr. Greer was in the hospital recovering from surgery when his surgeon went on vacation.[68] A new doctor, Dr. Medders, was assigned to him while the other surgeon was away.[69] Dr. Medders failed to visit Mr. Greer for several days, which caused Mr. Greer to call Dr. Medders' office and complain.[70] Sometime after the complaint, Dr. Medders went to Mr. Greer's room and "in an agitated manner" stated the following in the presence of a nurse and Mr. Greer's wife: "Let me tell you one damn thing, don't nobody call over to my office raising hell with my secretary . . . I don't have to be in here every damn day checking on you because I check with physical therapy . . . I don't have to be your damn doctor."[71] Mrs. Greer then asserted he would no longer be her husband's doctor.[72] In reply, Dr. Medders stated, "If your smart ass wife would keep her mouth shut things wouldn't be so bad."[73] Following that conversation, Mr. Greer began suffering from "episodes of uncontrollable shaking, for which he required psychiatric treatment."[74] The court, emphasizing the nature of the provider-patient relationship, held that it could not as a matter of law find the

[67] 176 Ga. App. 408, 409, 336 S.E.2d 329, 329–330 (1985).
[68] *Id.* at 408, 336 S.E.2d 329.
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *Id.* at 408–409, 336 S.E.2d 329.
[74] *Id.*

statements to be insufficiently abusive to support an IIED recovery.[75] In other words, there was a genuine issue of material fact as to whether the statements were outrageous and extreme enough to rise to the level of an IIED claim.

Thus, it logically follows that if courts recognize a claim for IIED because of racial slurs and if courts recognize a claim for IIED in the provider-patient context, then courts should recognize claims for IIED as a result of racial bias in the provider-patient context.

All of the IIED elements can be satisfied when a provider exhibis racial bias towards a patient under the following circumstances. Element one—outrageous and extreme conduct—may be satisfied in the provider-patient context with conduct that the provider exhibited in *Greer*. Additionally, because of race, someone may be particularly susceptible to emotional distress.[76] Further, the trier of fact should take "into account changing social conditions and the plaintiff's own susceptibility" in determining whether the particular conduct was outrageous.[77] "Evidence of vulnerability is relevant in considering whether the defendants acts outrageously."[78] Element two—intentional or reckless—can also be satisfied as seen in both *Greer* and *Brown*. In both cases, the fact that the person was making the statements was enough to constitute intent or recklessness because someone does not make statements like that without it being intentional or reckless. Element three—causation—can be satisfied if the patient suffers some harm that the patient would not have suffered but for the provider's conduct. In *Greer*, but for the physician's statements, he would not have had uncontrollable shaking. In *Brown*, he would not have blacked out but for the insurance claims examiner's statements.

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[75] *Id.* at 409, 336 S.E.2d 329–330. *See also,* McQuay v. Guntharp, 336 Ark. 534, 986 S.W.2d 850 (1999) (considering the nature of the physician-patient relationship).
[76] Contreras v. Crown Zellerbach Corp., 88 Wn.2d 735, 565 P.2d 1173 (1977).
[77] *Id.* at 742.
[78] Spinks v. Equity Residential Briarwood Apartments, 171 Cal. App. 4th 1004, 90 Cal. Rptr. 3d 453 (2009).

The fourth element—severe emotional harm—can be satisfied if it is severe enough that it requires treatment.[79] In *Greer*, the patient suffered from episodes of shaking so severe that he required psychiatric treatment. In *Brown*, the patient had to be taken to the hospital because he blacked out. Additionally, the level of severity required may be decreased, making it easier to be considered "severe" due to the nature of the relationship between the parties. Both courts emphasized in *Brown* and *Greer* that the relationship between the parties is important and should be considered. In *Brown*, it was a business relationship and in *Greer*, it was a provider-patient relationship. The court in *Brown* reasoned that a jury could find that the insurance claim examiner's conduct "went so far beyond the norms of acceptable *business behavior* as to produce a character of outrageousness that might not exist if the parties were *simply members of the general public* . . ."[80] And it is known that in entering a provider-patient relationship, the provider takes on duties to actually treat the patient and act in the best interests of the patient. It seems that if the conduct was outrageous enough, similar to the racial statements made in *Brown*, that there could be evidence sufficient to support an IIED claim by a patient against a provider.

Since the harm must be outrageous, it will likely prove to be too high of a standard for most patients to reach, even considering the fact that it might be lowered due to the nature of the provider-patient relationship. While IIED claims are becoming more common, as are emotional and mental injury claims, it will be difficult to succeed on an IIED claim. In addition, there may be an affirmative defense that the defendant may make to defeat an IIED claim. First, the plaintiff needs to make sure there is no first amendment issue, meaning the plaintiff must make sure the defendant's speech is not within a protected category. Second, the plaintiff needs to make sure that

[79] *See also,* Champlin v. Washington Trust Co., 478 A.2d 985 (R.I. 1984) (considering that the plaintiff never sought treatment from a provider so less likely to be severe harm).
[80] *Id.* (emphasis added).

in agreeing to be treated, and signing a contract, that the contract does not release the provider from any IIED claims. Third, but least likely, there may be an affirmative defense similar to contributory negligence if the patient and provider both got into a name-calling, racial-slurring argument.

In addition, for the same reasons above, the provider should be able to bring an IIED claim against a patient if all the elements are satisfied, which should logically be possible. Overall, providers and patients should not be afraid to pursue an IIED claim because it is a valid tort claim. However, it should be reserved for certain circumstances because of how the law views IIED claims at the moment. However, the bar for outrageousness should be lowered because of the sacred nature of the provider-patient relationship.

Finally, an intentional infliction of emotional distress claim will likely not be a viable claim for the more subtle biases, such as the physician's bias when he or she treats the patient based on personal characteristics. Mary Crossley, in her article titled *Infected Judgment: Legal Responses to Physician Bias*, explores possible claims for subtle racial bias.[81] She explores medical malpractice,[82] informed consent,[83] liability for breach of fiduciary duty, and then goes on to discuss discrimination claims.[84] She concludes that theoretically, a biased medical decision violates the physician's duty to a patient, but practically it will be hard to prove it in court.[85]

IV. CONCLUSION

Even though the physician in the scenario described at the beginning of this Paper was treated horribly by a racist patient, she still chose to perform surgery on him to save his life. This

[81] Crossley, *supra* note 7 at 244.
[82] *Id.*
[83] *Id.* at 248.
[84] *Id.* at 263–268.
[85] *Id.* at 244. She also discusses that judges are reluctant to intrude on a provider's judgment. *Id.* at 291.

shows that despite the horrible conduct on the patient's part, there is still good that can come from a horrible situation. Unfortunately, there is a long history of racism in the United States and in the United States' healthcare system. As a result, racism continues to permeate the provider-patient relationship today on both the provider and the patient's sides. One way to combat this racism is to bring an intentional infliction of emotional distress claim against the provider (if you are a patient) or against the patient (if you are a provider). It will be a very high bar to reach, but it is possible to reach it, as we saw in *Brown* and *Greer*.

Additionally, there may be other claims the provider or patient could bring, which should be explored in the future including: breach of fiduciary duty; statutory discrimination; breach of one of many of the provider's tort duties; negligent infliction of emotional distress; tort assault; reputational-harm claims for the provider; and physical harm claims for the patient if the racial bias caused physical harm. Sometimes tort law will not be able to provide a solution for the emotional harm the provider and the patient suffer. We are going to have to work together as citizens of the United States to continue combating racism. Maybe while the law cannot heal the harm done by racism, we as citizens can try to heal that harm as we go on to become physicians and patients. Relatedly, there may be social remedies that can be utilized including training in medical schools for cultural competency and teaching children in school about our dark, racist history. Additionally, the AMA encourages physicians to examine their own practices "to ensure racial prejudice does not affect clinical judgment in medical care."[86] Racial bias should not be permitted to invade one of the most sacred and vulnerable relationships there is in the world—the provider-patient relationship.

[86] *Racial Disparities in Health Care*, AMA Policy Compendium at E-9, 121.