When a Family Requests a White Doctor

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abstract

Parents sometimes request that a doctor of a particular race or ethnic group not care for their child. Such requests sometimes seem legitimate and other times seem offensive. The difference reflects a clash of fundamental values. Generally, we try to respect patient or parental preferences. Requests based on racist attitudes, however, do not seem worthy of respect. But where should we draw the line? In this ethics rounds, we present a situation in which parents requested a white doctor and analyze the ways in which doctors might think about and respond to such a request.

Some ethical dilemmas arise when there is a clash of fundamental moral principles. Discrimination in the workplace on the basis of gender, race, or skin color is simply wrong. But it is also wrong not to respect patients’ and parents’ right to choose their physician. What, then, should we do, if, as sometimes happens, parents want to choose their physician on the basis of the physician’s gender, race, or ethnicity? Should we uphold the principle of nondiscrimination? Or should we uphold the principle of parental rights to choose their child’s doctor? We live in a diverse, pluralistic, and culturally complex society where some people’s values, lifestyles, choices, or words offend other people. In this Ethics Rounds, we present a case in which a family requested to be treated by someone other than an African-American pediatrician.

Comments are provided by pediatricians Kimberly Reynolds and Jeffrey Brosco of the University of Miami and by John Cowden, a general pediatrician and Medical Director of the Office of Equity and Diversity at Children’s Mercy Hospital in Kansas City. Dr Reynolds is a general pediatrician completing an academic primary care fellowship at the University of Miami Miller School of Medicine. Her research focuses on historically underserved populations. Dr Brosco is a pediatrician, historian, and Chair of the Pediatric Bioethics Committee at Holtz Children’s Hospital (Jackson Health Systems) in Miami.

THE CASE

Dr Angela Rowe is a third-year pediatrics resident on her emergency medicine rotation. This particular emergency department is very busy, and Dr Rowe has been on her feet most of the night. Approaching midnight, she walks into her next patient’s room and sees a well-appearing 3-year-old little girl, a woman, and a man. She smiles and greets them, “Good evening everyone. I am Dr Rowe, the resident who will be taking care of you this evening. Are you the mother and father?” The parents nod. As she typically does to begin a visit, she kneels down to engage the 3-year-old patient, who is cowering on her mother’s lap. Before she is able to stretch out her hand for a “high 5,” the patient’s dad says quietly, “I’m sorry. Please do not touch my daughter. We would prefer a different doctor.” Dr Rowe is taken aback initially, but she figures there must be a religious or cultural reason that they prefer a doctor of a particular race or ethnic group.
male provider over a female one. “May I ask why?” she states in a calm voice, to confirm her suspicion. “We want a white doctor,” the father states calmly. Fearing she misheard him, Dr Rowe asks, “Excuse me?” The father reiterated: “We would like a white doctor, please.” The father remains calm and is even pleasant. Dr Rowe stumbles backward, bewildered and dumbfounded, and mumbles, “I’ll be back in a minute.” She steps out of the room to collect her thoughts. She sees her attending, Dr Lowry, standing nearby, so she walks over and tells him the situation. What should Dr Lowry do?

**DR REYNOLDS COMMENTS**

Such a request for a white physician cannot be evaluated without taking into account the history of racial relations in American medicine. In 2008, the American Medical Association (AMA) apologized for its history of discrimination against black physicians. The apology came after more than a century of discriminatory practices. In 1870, the organization refused to seat 2 black delegates at its annual meeting. Subsequently, a series of policies were enacted that marginalized black physicians and worked to deny them access to membership in the AMA. Black physicians across the country counteracted the discrimination by forming the National Medical Association. Blacks were also banned from hospitals or forced to practicing in segregated wards. Black physicians responded by opening their own hospitals and medical schools; however, all but 2 of these schools (Meharry and Howard) were closed in 1910 as a result of the Flexner report, which was commissioned by the AMA. After the closing of black medical schools, the number of African-American physicians plummeted, because traditional medical schools in the Jim Crow era continued admitting blacks in low numbers.

Although Dr Rowe is likely too young to have lived through the era of explicit racism, some of the effects of this history persist: black physicians remain underrepresented in medicine. Black patients continue to encounter implicit and explicit forms of bias that contribute to health disparities. Black physicians are less likely than white physicians to hold leadership positions in hospitals and medical schools.

Even today, the AMA, the American Hospital Association, and the American Academy of Pediatrics do not have explicit policies or practice guidelines outlining the appropriate steps to take when a patient makes a request for a physician of a certain race. The AMA does state in its opinion 9.123 that hostile language or acts of prejudice toward physicians “may constitute sufficient justification for the physician to arrange for the transfer of care.” But that opinion does not obviously apply to this situation.

Dr Lowry’s honoring of this family’s request feels wrong. It seems to affirm the legitimacy of racist views. It may implicitly suggest that Dr Rowe is somehow less capable than her white peers. But there are a few good reasons why, perhaps, it should be honored.

First, some would argue that honoring the request for a white physician is in accordance with the ethical principle of patient autonomy. It might also show cultural sensitivity. After all, when a female Muslim patient asks for a female physician, most physicians comply with ease and without debate. If a Spanish-speaking patient requests a Spanish-speaking physician, most would adhere to the request within reason (ie, the request doesn’t delay care, there is such a physician available, etc). Patients are usually more satisfied when they are cared for by a racially concordant physician. It seems inconsistent to value patient preferences in some contexts but not in others.

However, granting the request for a white physician could potentially send a message to Dr Rowe that she is not good enough. It could reaffirm years of discrimination and racism against black physicians. If the hospital leadership goes along with the request, it may give the perception that honoring race-based physician requests is hospital policy, which is likely not the case.

Dr Lowry could explain to Dr Rowe that she needs to deal with the issue on her own. He could coach her on what to say but ultimately leave the discussion with the family up to her. By using this approach, Dr Rowe will gain valuable experience in tackling a deeply troubling situation that will no doubt recur at some point in her career when she herself is the attending physician. The parents may also gain a level of respect for Dr Rowe that would be prized in the physician-patient-family dynamic and would assist in building a therapeutic alliance. Or, this method could fail miserably and create more distrust between the family and Dr Rowe.

Alternatively, Dr Lowry could march into the room and firmly assert that Dr Rowe is a capable resident physician who will see the patient. This approach is what feels right: the unambiguous, egalitarian option in which the attending physician rights the wrong and the various parties move in step with his view without dissent. Should Dr Lowry go this route, he will be backed by the case law; health care practitioners have sued their employers who granted the race-based requests of patients in the past and have won their cases, as recently as 2010. Thus, Dr Lowry’s refusal to allow a white physician to take over care of the patient may be the appropriate course of action. On the other hand, this response squashes any further dialogue, whether positive or negative. This tactic also fails to fully address the perceived racism that led to this request. Furthermore, it opens the
door to the resident physician performing poorly due to a stereotype threat. "Stereotype threat" refers to the anxiety that is created when a member of a particular group is confronted with the possibility of reinforcing a negative stereotype. The anxiety that is produced subsequently results in lower performance. On the other hand, if the family stayed and continued to receive care from Dr Rowe, she may feel empowered to care for the patient. But there may still be a tense family-physician dynamic due to the partially resolved nature of the conflict. Both Dr Rowe and the parents may feel that their voices were not heard in this scenario. This tension could lead to compromised care of the patient, which would not be in step with the ever-present edict to "do no harm."

**DR BROSCO COMMENTS**

Anger is nearly everyone’s immediate reaction to this case. How can parents express and act on racist views in a public setting to a caring professional who is trying to help their child? Then we stop and think. Doctors often must care for people whose beliefs or actions we find odious. Professionalism requires that we put our own feelings aside. We may disagree with the strict hierarchical relationship between men and women proffered by some religious groups, for example, but we would likely try to honor a request that a female patient be attended to by a female physician. Still, race-based requests feel different. Our nation’s long history of slavery and racism increases the emotional and ethical intensity of this case. Even if not familiar with specific examples, most people would readily acknowledge that racism is a painful thread in the history of medicine in the United States. Among other events, one thinks of the biological views of blacks that rationalized slavery in the 19th century, the closing of black medical schools as part of Flexner era reforms in medical education in the early 20th century, the segregated hospital wards defined by Jim Crow laws through the mid-20th century, and the deception of black research subjects and withholding treatment during the Tuskegee syphilis experiments conducted by the US Public Health Service through the early 1970s. The legacy of this shameful history includes widespread distrust of the health care system by many African Americans, low representation of blacks among the health care professions, limited participation by minorities in research projects, and persistent disparities in health outcomes among racial/ethnic groups, related at least in part to ongoing discrimination in the US health care system.

But how does that history help us decide an appropriate response to this case? Pursuing the best interests of the child is not a helpful guide. I assume that the child is not in any imminent danger and that other physicians are available. It is possible that adherence to treatment by the parents would increase if the advice came from a white physician.

The most important person in this scenario is the pediatric resident. She is at the beginning of her career. Experiences like this will shape her as a professional. If the attending physician reinforces the negative stereotype by honoring it, she may come to believe that she is, in fact, inferior to her white colleagues. Self-perception affects quality of performance. The attending has a responsibility, as a teacher and mentor, to act in a way that will minimize the ill effects of blatant racism.

He should do this by affirming Dr Rowe’s ability and encouraging her to complete the encounter. Some residents in this situation may be too angry or too hurt to want to continue. They should not be forced to do so. If she is willing, then the attending and the resident should return together to the examination room and inform the family that Dr Rowe is a competent doctor and that, if they don’t want her to care for their child, they can seek care elsewhere.

Health care professionals and the institutions they work in are moral actors. Sometimes the issues are explicitly ethical, such as end-of-life decisions or organ donation policies. Other times the moral nature of health care practice is implicit, such as how to treat indigent patients or unwed mothers. Health care professionals and institutions simply cannot be “value neutral.” In this case, they should not allow explicit racism to hold sway.

**DR COWDEN COMMENTS**

Dr Lowry faces a request from a parent that challenges a central assumption in contemporary US society: that racial discrimination is wrong. Yet, he faces the request in the context of the patient-physician relationship, where ethical and legal responsibilities prohibit a physician from forcing unwanted care on a patient. Dr Lowry also must support a resident who feels confused and likely offended by an unexpected interaction. All the while, he has to manage any personal offense or distaste he might feel about the request and the family making it. How can he resolve these tensions and also tend to Dr Rowe’s emotional distress?

Kimani Paul-Emile, Associate Professor of Law at Fordham University, examined the conflicts between medical ethics and antidiscrimination principles in her extensive article, "Patients’ Racial Preferences and the Medical Culture of Accommodation." She calls patients’ routine refusal of care by physicians of a particular race “one of medicine’s open secrets” and cites evidence that hospitals often yield to these preferences. Her examples include the story, originally told by...
Kenneth Kipnis,\textsuperscript{10} of a Korean patient who refused potentially life-saving treatment out of fear of his Japanese physician team. This fear was based on historical mistrust, and after his request for a different care team was met, he accepted treatment and made a full recovery.

The idea that we would allow patients to guide how they receive care comes from the ethical principle of respect for patient autonomy, which grounds the legal concept of informed consent. By placing the patient in control of care decisions, we respect the autonomy and integrity of the individual as a free agent. We protect patients against the threat of unwanted or poorly understood care by empowering them to refuse care or to refuse to be cared for by a particular physician. We follow patients’ preferences as a way of fulfilling the fiduciary responsibility at the heart of our profession: a commitment to serve patient interest and welfare above all. In addition to these ethical and professional obligations, the law of battery prohibits us from caring for patients against their will, because any unwanted touching of the patient’s body can be considered battery. All of these compel us, and Dr Lowry, to accommodate, if possible, the man’s wish to choose his child’s doctor on the basis of whatever criteria are of value to him.

Despite this clear duty of the physician to abide by patient preference, if Dr Lowry reassigns Dr Rowe to another patient on the basis of her race, does he violate the law? Title VII of the Civil Rights Act of 1964 prohibits employers from assigning work on the basis of employee race. It specifically identifies customer preference as a generally invalid reason for such assignment. Paul-Emile argues that adhering to patients’ racial preferences falls outside the intended scope of Title VII due to several factors:

\ldots the unique nature of the physician-patient relationship, the fact that this relationship may be constitutionally protected, the significance of race in the therapeutic enterprise, the fact that the accommodation of patients’ racial preferences in the hospital setting does not appear to adversely affect physicians by race, and the evidence demonstrating that acceding to patients’ requests has been shown to increase patient satisfaction and improve care.\textsuperscript{8}

Nevertheless, in this scenario, Dr Lowry must be sensitive to the difference between his decision about taking care of a patient whose parent wants someone of a different race and using his authority to make that decision for someone subordinate to him.

But this case touches on something even deeper than medical ethics or the law. A request such as the one made by this father triggers strong emotional reactions. The present scenario in which a person asked for a white doctor surely sparked an immediate narrative in the reader’s mind. What color skin do the parents have in your narrative? The scenario doesn’t specify their race. What if they are white? What do you assume to be their motive? What if the parents have dark skin? Do some requests deserve more respect than others? Why?

A 2010 survey study of predominantly white, male emergency medicine physicians showed that patient characteristics affected how likely a physician was to accommodate patient requests on the basis of race, religion, and gender.\textsuperscript{11} Higher accommodation scores were given for nonwhite and Muslim patients. Muslim women had the highest scores across all combinations of characteristics. Provider characteristics mattered, too: female and nonwhite physicians were more likely to accommodate than were male and white physicians.

In this case, Dr Lowry has options, but he must organize his actions around the ethical and legal principles described above, not around emotional reactions to the challenge he faces. I would recommend the following:

1. Dr Lowry should speak with the family alone. It is essential that Dr Lowry understand more about the family’s request. Not only can he confirm or dispel his initial assumptions about their motive. He can also decide how critical this request is for the family. Is this a religious question? A race superiority issue? Will they accept care from a nonwhite doctor if a white doctor is not available? With this information, he will be in a much better position to decide what to do.

2. What Dr Lowry learns will affect what he says next, but standing up for the principles of the hospital and for Dr Rowe will be important. He might say, “It is not common practice at our hospital to match providers and patients based on race, as we are fully confident that all of our providers offer equally good care no matter what their race. Dr Rowe will take excellent care of your daughter.” It is not the role of Dr Lowry to defend societal values and teach the family a lesson on race relations. But making an unequivocal statement about Dr Rowe and the hospital’s principles avoids offering implicit agreement by saying nothing at all.

3. If there is sufficient staffing to avoid affecting the care of other patients, I believe that Dr Lowry should accommodate the family’s request. If there is not, he can explain to the family that it will not be possible to provide a white doctor: If they continue to refuse treatment, he can refer them to another emergency department, assuming the clinical issue is not urgent. If it is, he would find himself in a new ethical dilemma: when to remove decision-making capacity from the parent. Given an urgent situation, the hope is that
a respectful approach would be able to convince the family that it is in their daughter’s benefit to be cared for by Dr Rowe rather than have delayed care or no care at all.

4. It may be appropriate to call an ethics consult if the above approach is unsuccessful in reaching a clear decision and if the delay involved in calling the consult would not harm the child.

5. Finally, Dr Lowry must tend to Dr Rowe’s needs and discuss the situation with her to get her input and reactions.

Racial interactions always will be accompanied by assumptions and emotions and may lead to anger, confusion, and frustration. In the hospital setting and within the special context of the patient-physician relationship, we have ethical and legal guideposts that help us through complicated encounters. It is essential that we rely on them. Although there is not (and should not be) a standard answer for every race-based patient request, the primacy of patient autonomy and our fiduciary duty require us to set aside any distaste we may have for our patients’ views. We have committed to caring for all patients with equal professionalism and quality no matter our opinion of them. We must have a very high threshold for denying a patient his or her preferred form of care, even when meeting a request causes us personal distress.

Perhaps that wasn’t the approach that adequately addressed the racism. Perhaps it was not the approach that would allow me to grow as a clinician or the approach that is the most culturally competent. But in that moment, it was what I appreciated the most. The family agreed to let me care for the patient. I diagnosed her with otitis media and sent her home to continue treatment as an outpatient. The family remained cordial throughout the encounter and briefly thanked me before they left the emergency department.

Physicians should not have to “go it alone” in high-stakes situations that can be fraught with tension, communication difficulties, and often anger and resentment. The American Academy of Pediatrics could help pediatricians deal with race-based requests by developing a policy statement that addresses race-based physician requests. Hospitals and other health care organizations must also develop policies regarding race-based requests. In an increasingly diverse country that will consist of majority-minority by 2050, we must tackle issues related to race, prejudice, and discrimination head on.

JOHN D. LANTOS COMMENTS
Toni Morrison once wrote, “I always looked upon the acts of racist exclusion, or insult, as pitiable, for the other person. I never absorbed that. I always thought that there was something deficient about such people.”12 Parents who refuse medical care for their child because they don’t like the color of the doctor’s skin are deficient in just the way Morrison suggests. Yet, as noted above, patient preferences for particular physicians exist along a spectrum of justifiability. Deciding whether to honor those requests requires nuanced ethical judgment. Such requests are most understandable and justifiable when they reflect personal experiences of racism or discrimination. Thus, the fears of the Korean patient are rooted in personal history and are thus understandable and not blatantly discriminatory. The same might be true for a Holocaust survivor with a German physician.

Requests are least justifiable when they are based in prejudicial attitudes about a certain ethnic or racial group in the absence of any such personal experience. In this case, we assume that the father’s request is not based on the father’s personal experiences of bad treatment at the hands of African Americans but is, instead, rooted in plain old-fashioned racism. Lumping the 2 motivations together and seeing both as simply expressions of parental preferences that deserve equal respect ignores ethically relevant features of the situations.

Reasons and motives matter. Some patient preferences are more ethically justifiable than others. A parental request for a different physician that is based only on the color of their doctor’s skin needn’t be honored. Such parents may be informed that such requests will not be honored. They should be informed that they are free to seek care elsewhere. When offered such a choice, as in this case, most parents will gratefully accept good medical care for their child. The parents, the child, and the doctors will all be better off as a result.

REFERENCES
1. Davis RM. Achieving racial harmony for the benefit of patients and communities: contrition, reconciliation, and collaboration. JAMA. 2008;300(3):323–325
A NEW WAY TO TIE A KNOT: I have quite an extensive collection of neckties including my own and those that my father gave me. Over the past two years, however, I have worn a necktie at work less frequently. The hospital and university are supportive of casual attire. I still wear ties a couple of days each week and on most days during the winter months. Recently, however, I was in a meeting with a faculty neurologist (who is from England) and his necktie caught my attention. While the tie was a lovely shade of pink, what was really striking was the knot. I had never seen a knot like it before. When I asked him about it, he replied that it was an Eldredge knot.

As reported in The New York Times (Men’s Style: June 10, 2015), neckties have an interesting place in a man’s wardrobe. They represent great sartorial freedom, yet are associated with work and a desk job. While I have a tendency to accessorize with unusual patterns or colors in my neckties, it turns out that one can tie the knot in myriad ways. Last year, a group of mathematicians announced that there are 177,000 ways to tie a necktie. While that may be true, the number used is much less. In 1999, a book was published detailing 85 ways to tie a necktie. An internet search turns up a number of sites detailing anywhere from 15 to 30 common ways to tie a necktie. These range from simple three- and four-step knots (such as the Oriental and classic four-in-hand) to much more complex knots (like the nine-move Balthus, named after an artist in the 1930s). According to one website, the Eldredge was designed in 2007 by Jeffery Eldredge, a system analyst working in a tie-mandatory workplace who was tired of using the classic four-in-hand. The eye catching knot is large, involves 15 steps, creates a tapered fishtail braid-like effect, and is definitely not for the faint of heart or sartorially cautious.

While I have learned a great deal about knot-tying and am impressed by my friend the neurologist, I think I will keep it simple and stick with the “four-in-hand” knot for now.

Noted by WVR, MD
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