Framing the debate: race-based requests in medicine

Leading scholars have argued that when a healthcare professional and patient’s race align, a provider can speak better to certain beliefs, religious practices, and cultural norms of their patients. There are also subtler, yet equally important, benefits of having your provider look like you, including patient-compliance as well as the potential for less polarising power dynamics in the provider–patient relationship. But not all reasons for race-based requests should be accepted, especially where they are based on discriminatory attitudes. In what follows, I hope to show that requests for race-based concordance is a complicated area of medicine, and it is one that is not easily dealt with through formalised policies. Instead, well-reasoned judgements by the care team through a deliberative process, that begin with ethical frameworks, might provide a more fruitful way forward.

Acceptable forms of race-based requests

There is evidence that requests for race-based concordance, where the race of the healthcare professional and patient align, can lead to better trust between the physician and patient, especially where the patient is of a background that has been historically disenfranchised by institutional racism. Research suggests minority individuals may be more likely to trust a provider that looks like them, and this can contribute to patient compliance and better outcomes. In a similar vein, Dayna Bowen Matthew (2015) argues that if a white, middle-class physician tells an intercity, minority person to take their medication, that patient may be less likely to comply. However, where the provider–patient relationship is good, or the patient feels more comfortable with the provider, it is possible to improve health outcomes.

Skills-based requests

There are good reasons why a patient might want to choose a physician of a specific cultural background or race. Skills-based requests include language proficiency, cultural consciousness, and dietary considerations (these are not attributes physicians are born with, but skills they develop throughout their lives and careers). In some specialties, such as dermatology, physicians with a darker skin pigment can provide skilled information to patients with dark skin. This is distinct from assigning a physician to a patient for no other reason than skin colour, which is a consideration not based on any skill.

This kind of skills-based request can come with difficulty, and there might be unforeseen problems by accommodating patients’ preferences for race using skills-based reasons. There are, for example, people in the UK who may look white, but know more about Latinx culture than someone who was born in parts of the Latin world and look Latinx. Just because someone was born into a culture and looks a certain way does not mean they can work as a healthcare provider with respect to that culture. While such a (skills-based) request does not externally appear racist, it does not always lead to the best outcomes.

Problematic race-based requests

There can be harms, however, to requests for race-based accommodation grounded in the wrong reasons. Assigning physicians to a patient solely because of skin colour sets a risky precedent since it could promote discrimination. In a paradigm where patients can choose the race of their provider, there are possible discriminatory actions against minority providers. These kinds of discriminatory actions against healthcare professionals undermine their worth as people and as colleagues, and it could lead to poorer health outcomes for patients if those individuals do not feel supported by the institutions for which they work.

Accommodating racism in emergencies: a sick child with racist parents

In a BMJ viewpoint piece, Qureshi et al (2021) discuss their stance on accommodating racist parents who request race-based concordance in emergency situations involving a child. In describing the tension that exists between different stakeholders, authors focus on the rights of various stakeholders to try and understand what actions might be permissible. At every point in their article, the authors condemn racism in the medical
context. However, they conclude that in emergency situations where a child’s wellbeing is at risk of harm, care teams ought to abide by parents’ request for prejudiced race-based accommodation to ensure the child receives needed care quickly. One could imagine, for example, that if such a request were not made, and the parents were turned away from the clinic, this could compromise the health of an acutely ill child.

There is an opposing view; not assigning the best physician for each job poses a safety risk, and disrupting the workflow of a team could potentially lead to worse outcomes for the patient as well as the healthcare team that have to deal with the repercussions of racism. Assigning the best available physician based on skill to attend to a patient’s medical needs increases the likelihood of a good outcome.

Further, the discriminatory effects of these requests lead to outcomes that do not allow healthcare professionals to flourish in their work environments. For example, Moghal (2014) discusses a case of acute illness in a child whose parents made a race-based request specifically for a white British doctor to look after the care. While the care team accommodated this request, the fact that it was race-based (and not skills-based) lead one clinician to ‘feel defined and judged by my ethnic origin rather than my professional capability’ (Moghal 2014, p.1). The negative feelings felt by the clinical team in such a situation could become embodied and affect the care provided to future patients. Protecting employees from discrimination and harassment could allow them to thrive, potentially becoming better practitioners, and this might improve patient care.

There are additional harms that might come from such an accommodation. This includes other parents knowing that race-based requests are being honoured, and therefore many more individuals might attempt to make racist requests in emergency situations. More data would need to be collected to determine whether this would in fact occur. Additionally, honouring a request based on racism as model behaviour to the child might suggest the parents were right with their racist preference, and it could reinforce racist attitudes that might become internalised by the child.

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Parents have a set of positive duties to take care of their children, and this is observed in law. There are laws within each country that suggest if parents are going to put their children in harm, the state has a right to intervene. In the UK, for example, the Children Act (1989) makes accommodations for when a child is likely to suffer any sort of significant harm, and there is instruction for local authorities to take care of the child under their jurisdiction. More recently, and within our current political climate, the role of parental rights over their children has not been clearly defined. There are multiple recent judgements that take different stances on what parental rights include.

While there is a legal ‘nuclear option’ of removing a child from their parent, doing so can have dire consequences. However, not removing a child from their parent, especially one who needs urgent care, could also lead to deleterious effects. There is no right way forward that can be applied to every instance. And if it is not clear cut in the case presented above by Qureshi et al — a case that is meant to represent ‘low-hanging fruit’ — then it is less likely to be clear in cases with myriad other complexities with regard to race.

Ethical frameworks as an approach

In recognising all the unique reasons why people might ask for certain accommodations, one begins to see top-down policy statements and laws about what individuals ought to do as problematic. For example, the British Medical Association has published guidance titled ‘How to manage discrimination from patients and their guardians/relatives’. Within that document, there is a focus on instances of abuse or harassment as they relate to racism, but as described above, instances of racism might be more nuanced, including microaggressions, and it could be difficult to label actions as abuse or harassment. No single policy, law, or definitive stance put forward by commentators in the ethics literature can account for all the complexities that might occur in clinical practice. Do we then let medical professionals who understand the complexity of each case deliberate the details of the case and come to a judgement about the right way forward? And what skills would professionals need in order to carry out this deliberative work?

A framework is meant to be vague. Quite literally ‘a frame’, it provides structure that one can then build specificity into. An ethical framework, as distinguished from ethical codes, provides more of a heuristic approach, a process through which practitioners can develop well-reasoned answers. An ethical framework provides structure that then allows practitioners to think through ethical issues and come to a conclusion in line with the facts and values that are present in each case. These frameworks include — but are not limited to — Jonsen, Siegler, and Winslade’s Four-Quadrant Approach, Beauchamp and Childress’ Four Principles, and The Ethox Structured Approach. Each framework does not tell us the right way forward — rather, it tells us what kinds of considerations we ought to have. A code or an argument produced in an adversarial style, however, suggests something that is unchanging. That approach might be helpful in moral philosophy, but in an ever-changing environment of clinical medicine, having physicians begin with a framework and reason for themselves might produce better answers for the nuanced cases that patients bring to us.

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