Imagine the following cases. An elderly woman, unable to manage her bath time, requests that the home health agency not send any male nurses to care for her. When the agency is unable to find a female capable of bathing the woman, they send a male nurse, but the client refuses to admit the nurse into her house. Or imagine another scenario in a hospital where a surgeon is asked by a patient’s husband to keep men, especially black men, out of the operating room, as a condition for giving permission to conduct his wife’s needed surgery. Imagine a final case where a South Korean woman, who endured wartime occupation and atrocities by the Japanese military, requests that she not be treated by any male Japanese physicians or interns while in a Hawaiian hospital.

With healthcare institutions’ dual concerns for patient satisfaction and diversity in the workplace, there is sometimes uncertainty about the limits of accommodating patients’ preferences. Perhaps with greater frequency in the home health setting than in acute or long-term care, case managers are faced with patients’ requests to exclude caregivers based on race, gender, or other personal preferences. Since caregivers are invited into a person’s home, where there is less institutional control than in an acute or long-term care setting, it is plausible to consider seriously these requests. Nonetheless, they raise important questions. Is there any moral difference between accommodating requests for same-sex healthcare providers and accommodating requests for same-race providers? How should we distinguish, if at all, between a Muslim woman’s wishes to be treated by female caregivers, and those of the elderly Korean woman who, based on experience of fear and animosity, requests not to be treated by any Japanese male?

Ethics committees may not often have had to address cases such as these because the issues seem better addressed by human resources, or because the committees deal with more pressing clinical issues. It comes as no surprise then that a Philadelphia area hospital last year found itself caught off guard when a patient’s husband requested that no African American staff member enter his wife’s room. The staff accommodated his request until administrators reversed their actions.

While the situation was ultimately resolved in a manner that was publicly acceptable, the reasons were not transparent to the public or staff. Nor did it become clear how these decisions could be used in the future to distinguish acceptable from unacceptable accommodations. While gut intuitions are a good place to start the dialogue, they are unlikely to do the moral work or to provide the guidance that staff and the public need. Therefore, it is important both to consider seriously what reasons would allow some racial or gender preferences to be accommodated, and to explore the values that are either protected or harmed by doing so. After identifying reasons for allowing or not allowing accommodations, it is important to test the adequacy of the reasons against each new case.

Arguments for accommodating preferences are justified under the rubric of protecting patients’ wishes, privacy, or cultural differences. A primary value in healthcare is respecting patient choice because patients know best what kind of well-being they desire. The alternative would be to trample over patient choice, a dangerous precedent in a free society. Moreover, healthcare providers respect privacy based on a “do unto others” form of fairness, and they breach this privacy only at the patient’s request. Finally, it is plausible that healthcare providers respect cultural differences because what seems good to one culture might seem an abomination to another. These reasons seem particularly credible in home care situations, since until health care needs arose, the clients had full control over whom to invite or exclude from their homes.

So, are there any limitations on complying with a patient’s requests? To begin with, it is important to recognize that an organization is a moral agent with moral limits, regardless of a general need to support patient values. It is one matter for an individual who, for reasons such as privacy, modesty, fear, or bigotry wants to exclude individuals from his or her home, and another for the same individual to dictate how an institution should cooperate with such requests. An institution would be able to cooperate if the accommodation is done on the basis of reasons congruent with the organization’s mission and values. Institutions, therefore, need to explore more closely the client’s motivation and intentions, in order to determine whether they can cooperate.

Next, it is important to inspect particular cases in order to demonstrate how an institution as a moral agent can act to promote or undermine values. Take the case of a female patient who requests that she not have a male caregiver. As a general rule, institutions have been willing to support requests for same-sex caregivers because it respects patient privacy and personal dignity. When patients enter a healthcare institution, they do not surrender privacy rights, and they have a reasonable expectation not to have their bodies exposed to others, especially to those of the opposite sex. This social convention is respected in other areas of life, such as separate lavatory facilities. Moreover, healthcare institutions support same-sex caregivers because they realize a patient’s perception of appropriate care can be influenced by the caregiver’s gender. Women who request female obstetricians often feel they have gotten more sensitive care, as do male patients who have received sexuality-related treatment from male physicians. Therefore, if the request is motivated by modesty or religious tradition (e.g., Islam), or where perception has been demonstrated to improve the
quality of care, then accommodating preferences may be considered.

Now let’s examine the case of the husband who requests that males—black males in particular—not enter the operating room during his wife’s surgery. Here, the preference of gender and race are bound together. Given the previous case, if exclusion is only gender-based to protect modesty, a caregiver might honor the wish. But when the request is specified by race, should the preference be honored?

As noted before, respect for patients’ wishes and privacy is generally acceptable, but limited by whether an organization can morally cooperate with the request. Still, an organization’s moral obligation does not end here. First, institutions are obliged to protect the quality of care. Placing staff with less professional skills into a situation dictated by a patient’s request might harm the person the institution is obligated to help. Second, institutions must ensure that no racial harm occurs to staff. Institutions are obligated to consistently hire, promote, and deploy staff based on skills and ability. Institutions that oblige patient requests that are based on criteria that have nothing to do with the capability of the staff and quality of care, are violating fundamental rules of workplace fairness. Treating equally qualified employees differently, on the basis of characteristics that are largely irrelevant to the job, institutionalizes racism by limiting the opportunities of minority staff. Third, fulfilling patients’ racist requests undermines the common good. The common good is frequently misunderstood to be the aggregate happiness of individuals in the community; rather, it requires creating the social conditions in which it is possible for all individuals to flourish. Institutions play a critical role in creating these social conditions because of the power they wield on the one hand by organizing society through policies and choices that treat similarly situated people similarly, and on the other hand by refusing to promote policies and choices that disadvantage some citizens on an irrational basis. Therefore, institutions as moral agents have a responsibility not to cooperate with irrational requests that result in serious harm. That said, not all patients’ requests based on race seem morally the same. Take a race-preference case that is thought to be morally acceptable, namely same-race psychotherapists chosen because that relationship is clinically more effective. Does this psychotherapy case differ from a more general race-based request because the treatment of psychological transference is a recognized effective treatment modality, or because general race-based claims treat similarly qualified staff members unequally?

The Korean patient scenario is perhaps the most difficult to analyze morally. In situations where a patient’s request for caregivers is principally race-based, can there be any reason to accede to those wishes? Probably not. But saying that does not resolve the institution’s obligations to provide culturally competent care. In this situation, culturally competent care requires the institution to hire staff to reflect the community it serves. By hiring staff that reflects the patient population, an institution might mitigate the Korean woman’s fears. However, if the institution has diligently endeavored to have a culturally competent staff, yet is unable to meet the needs of the patient, then it may have to provide a clinically appropriate caregiver despite the patient’s requests. If the Korean woman’s case occurred in home health care, and if she refused a qualified provider on race alone, would the institution be within its moral bounds to refuse to care for her, especially if acceding to the wishes would in effect provide dangerous or substandard care?

Ethics committees that attempt to analyze cases such as those presented here, or other similar cases based on values of patient autonomy alone, are likely to come up short with reasons to distinguish same-sex or race-based preferences without consideration of the moral obligations of institutions. But ethics committees should realize that in the area of organizational ethics, the reasons that seem compelling in some cases might not be adequate for other cases. What would you think about a common practice where elderly African-American patients request “light-skinned” or “dark skinned” providers, and the decision is made by the nursing staff? What reason would you give to promote or prohibit the practice?