

CASE AND COMMENTARY

Does a Patient's Trauma History Ethically Justify a Discriminatory Clinical Referral?

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Abstract

This article analyzes a child psychiatrist's referral approach when the patient's care must be transferred to an adult psychiatrist and the otherwise best adult psychiatrist has "accented" language, which is associated with the patient's prior trauma. The analysis considers the value of simplicity and a related "simplicity strategy," revealing that many ethical factors lay behind the simplicity approach. The inquiry then addresses simplicity regarding practical wisdom and context. The paper argues that simplicity should mean considering just what's relevant and no more. Applied to the case, simplicity includes respect for persons, openness, honesty, trustworthiness, beneficence, nonmaleficence, ethics of care, professional empathy, group inquiry, epistemic humility, and justice. An objection regarding undue complexity is noted and refuted.

Case

SR, age 18, has seen her child psychiatrist since age 16, when she witnessed her sister's sexual assault by a home intruder. The perpetrator shouted with a heavy accent during the incident. Since then, Dr J, the child psychiatrist, has helped SR reduce her fear of men speaking accented English. When SR turns 18, Dr J states that she should transition from Dr J to continued therapy with an adult psychiatrist. "OK," says SR. "I hope the new doctor's as nice as you."

Dr J knows many adult psychiatrists who could further assist SR with her posttraumatic stress. Dr J especially prefers Dr C, who has often helped Dr J's other patients needing comparable care transitions. However, Dr C's English is heavily accented. SR has not explicitly favored an adult psychiatrist who speaks nondescript English, but Dr J naturally worries that Dr C's speech pattern would further traumatize SR. Dr J is uncertain about disclosing Dr C's personal characteristics to SR because such disclosure might discriminate against or disrespect Dr C. On the other hand, Dr J worries whether it would be ethically or clinically appropriate to refer SR to Dr C without alerting SR to the language issue. Dr J could refer SR to other adult psychiatrists, but Dr J thinks they would be less effective than Dr C.

Commentary

I sometimes envied clinical colleagues who saw clear clinical options for a patient while nuanced possibilities swirled in my brain. Their mantra might well have been “KISS,” the well-known acronym for “Keep it simple, Stupid!” Constructively, I take KISS to mean that wise approaches avoid extraneous factors. That is, simplicity is clinically helpful. Avoiding the pejorative “Stupid,” perhaps a simplicity strategy labeled SS captures Dr J’s best response.

Simplicity as an Ethical Value

In the case of SR and her child psychiatrist’s referral dilemma, 3 alternative scenarios suggest how the value of simplicity can illuminate factors of ethical relevance.

Scenario 1. Let’s suppose SR is legally an adult with sufficient capacity for health care decisions. Further suppose that Dr J recommends Dr C to SR, explaining Dr C’s “accent” issues. To SR, Dr J might then state: *Given your great progress, I think you will quickly work through negative reactions to Dr C’s speech. Your usual fear response should be shorter and less intense. Dr C is really wonderful. I suspect you’ll quickly move beyond or accept his accent. Working with Dr C seems your best route to continued recovery. However, I certainly will honor your decision to see another psychiatrist. A good but second-best psychiatrist would be Dr D. I suggest mulling over this choice a few days. I’ll arrange an appointment with Dr C, D, or another psychiatrist you would prefer. Also, SR, I would be fine with your choice for someone besides Dr C. Our relationship won’t suffer.*

In blunt (SS) shorthand, some might ask, “What’s the problem?” SR is of age and has capacity. After Dr J explains the choices, SR gets to decide. Period. Simple enough. Moreover, Dr J is honest and open with SR, mentioning Dr C’s accented English despite being concerned about doing so. Dr J thus likely would maintain or enhance SR’s trust. And trust is doubly involved.¹ If Dr J refers SR to Dr C without alerting her to the language issue, either Dr J is professionally incompetent in ignoring potential harm, or Dr J is dishonest. Regardless, SR would probably consider Dr J untrustworthy. Then SR’s future trust in health care professionals could decline, undermining her later health care. (As philosopher Annette Baier noted, trust is hard-won and easily lost.²) In addition to issues of trust, if SR did not expect Dr C’s accent, her encounter with Dr C could be needlessly traumatic, contravening Dr J’s duties to do no harm and to do good. Also, Dr J’s ignoring SR’s risk for further trauma would demonstrate a failure of empathic insight and attendant caring responses.³ Dr J’s openness, respect for SR’s autonomy, and trustworthiness are the clinical ethical values that applying SS illustrates through this particular case variation.

Scenario 2. Let’s instead suppose Dr J recommends only Dr D, who speaks without an accent. Also presume SR later learns Dr J generally recommends Dr C rather than Dr D. SR thus decides that Dr J didn’t really consider her a mature adult and didn’t honor her

capacity to assess referral pros and cons. She determines Dr J is untrustworthy, but now for different reasons.

Given this adverse outcome, the SS approach of ensuring SR's participation in assessing her referral options again seems best. Clinical ethical values and duties support honoring SR's capacity and right to choose, as explained above. Also, if SR makes an informed choice to see Dr C, Dr J avoids treating Dr C unfairly. That is, Dr J avoids discriminating against Dr C for a speech pattern unrelated to Dr C's professional competence. As a justice matter, then, Dr J ensures that Dr C has an equitable opportunity to be SR's new psychiatrist while honoring SR's capacity to conjointly make a referral decision.

Scenario 3. Let's finally suppose that Dr J recalls his medical school ethics group. Faculty mentors promoted the value of collective inquiry when deliberating about puzzling cases. Faculty also recommended consulting published analyses and evidence. So Dr J consults his long-standing partner, who draws on experiences. The partner suggests talking with Dr C, who might have encountered comparable problems. Dr J talks with Dr C, who says something like the following: *Yes, some patients are first discomfited because I'm "different." If their diversity exposure is limited, they seem particularly unsure I'm a good choice. With those patients, I transparently acknowledge my otherness and how I might be different from them. My direct approach is typically successful. I honor patients' reasonable distrust (from their perspective) and openly address it. And, if you like, I can share my phrases and strategies for putting such issues, as I've learned to say, "on the table." I would follow this approach with SR. If she then wants to see another psychiatrist, so be it.*

In this scenario, Dr J twice used group inquiry. One source was his partner's family, educational, and professional background—indicating an extensive group membership. Moreover, Dr C, we might suppose, had discussed the language issue with other colleagues, families, and so forth. Dr C had learned from his actual experiences and had developed significant practical wisdom about how to address a concrete professional challenge involving patients' needs or preferences related to one of his personal features. By using group inquiry, Dr J reinforces respect and justice, keeping the patient's interests (rather than Dr J's own) central. And by using group inquiry, Dr J honors Dr C's professional skills while attesting that Dr C's accent is immaterial except for a particular patient's challenge. Hence, Dr J avoids unjust discrimination. Let's further suppose, then, that Dr J communicates Dr C's revelations to SR and then supports SR's informed choice.

In Scenario 3, the value of simplicity motivates drawing from collective inquiry. Practical wisdom generates the SS of asking a partner and directly consulting Dr C without divulging SR's identity. The approach is "simple" because it employs the clear idea of drawing from collective input and wisdom. Also, when applied to this particular scenario, the SS helps illuminate the importance of clinical neutrality and patient centeredness. Dr

J nonjudgmentally acknowledges SR's potential reactions to Dr C, consults Dr C, and focuses on ensuring SR's informed choice.

Simplicity, Complexity, and Practical Wisdom

In deciding what we health care professionals clinically should do, we must obviously assess all relevant factors. But—crucially—context matters. As a cardiologist (my first career), suppose someone needed urgent intervention. I had better draw on all relevant information available, say, in 15 minutes. Other pertinent facts might emerge over 24 hours. So what? Irrelevant in the moment. Without quick clinical action, the patient might die or be irreparably and severely damaged.

The SS means that I should just consider what's most relevant in those 15 minutes. I should not then worry about what would take 24 hours to learn. And my decisions, of course, are not just technically clinical but informed by my ethical orientation to urgency's practical necessities. I'm choosing (or recommending) what would be best for patients and minimizing harm while respecting their personhood, enabling their choices, treating them fairly in a caring manner, and doing so in the moment.

Simplicity as an ethical value suggests the importance of discerning all that matters clinically and ethically for a decision. But no more. Ethical choices are often complex in clinical care. (And elsewhere for that matter.) Analysis of SR and Dr J's case reveals this complexity. The superficial SS approach might jump on respect for autonomy—apparently end of story. But respect for autonomy actually resonates here with respect for persons, openness, honesty, trustworthiness, beneficence, nonmaleficence, ethics of care, professional empathy, and group inquiry. And, oh yes, justice and humility! To consult Dr C, Dr J had to admit he was unsure about what to do. If not, no consulting others.

Clinical and ethical practical wisdom ought to draw on this sophisticated sense of what the value of simplicity implies. The superficial SS could mean ignoring potentially relevant matters. But the SS unthinkingly applied produces lousy clinical or ethical judgments. We have to face what matters. But context constrains what matters for a given clinical or ethical decision. We must discern a [situation's boundaries and needs](#).

Objection and Counterargument

A critic of my scenarios and comments might argue that the approach produces outcomes that in sum are too complex: if clinicians actually tried applying this analysis, the multiple aspects would bog them down. Delayed judgments could then worsen patient outcomes. However, this hypothetical critic misunderstands clinical and ethical decision making. Seasoned health care professionals know that often many data sources and guidelines should influence their advice. Examples are lab tests, radiographic information, ultrasound images, MRI scans, more patient or family history, the patient's

clinical trends, [ethical principles](#), professional boundaries, and so on. Experienced clinicians efficiently sift and sort information from these sources. And practical wisdom includes humbly knowing how to promote mutual decision making with patients and when to request clinical and ethical consultation.

Conclusions

This paper discusses a child psychiatrist's referral options when a traumatized patient fearfully responds to accented English and the ostensibly best adult psychiatrist for her speaks with a heavy accent. Traced through 3 clinical scenarios, the analysis shows the value of simplicity in ethical clinical judgment. Employing simplicity initially seems straightforward: explain the patient's options and she can decide (ie, express respect for autonomy). However, many ethical factors underlie what seems simple; what seems simple is complex. The value of simplicity and the related SS mean considering just what's relevant, and no more. And what's relevant for respecting autonomy and applying simplicity here include respect for persons, openness, honesty, trustworthiness, beneficence, nonmaleficence, ethics of care, professional empathy, group inquiry, justice, and epistemic humility. An objection regarding the undue complexity of SS was refuted. Applying the SS shows how to acknowledge a patient's potentially discriminatory preference without making an inequitable or disrespectful clinical referral.

References

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Editor's Note

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The author(s) had no conflicts of interest to disclose.

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