Does Race Have an Influence on Patients' Feelings Toward Physicians?

Klea Demetre Bertakis, MD, MPH
Sacramento, California

Much debate has been waged over the use of race as a criterion for admission to medical school. This study reports data relative to this issue, derived from interviews with 66 patients (40 black, 21 white, and 5 Mexican-American) of three family physicians (Asian, black, and white) in a county medical clinic serving welfare and low-income patients.

There were no significant differences in responses to each of 18 questions among the different racial groups of patients regardless of physicians seen. There were also no significant differences in responses among the different racial groups for each physician's group of patients taken separately, or when the three physicians' patients were compared in the aggregate (not divided into racial groups). Patients strongly agreed that it was important for the physician to be caring and competent and to listen to and understand what they had to say. They disagreed that these qualities were affected by the physician's race and did not seem to have a racial preference in their physician.

Race as a criterion for admission to medical school has been debated as necessary for improved health care for ethnic minorities. In 1968, medical schools were urged to respond formally to minority underrepresentation by the Association of American Medical Colleges (AAMC). The association recommended that "medical schools must admit increased numbers of students from geographical areas, economic backgrounds, and ethnic groups that are now inadequately represented."[1] Proponents of this recommendation affirm that using race as one criterion for selection is in the interest of the patient population at large. Studies show that white physicians tend to practice outside areas having large low-income and nonwhite populations.[2] It is assumed that many of the minority students will practice in ghetto areas

From the Department of Family Practice, University of California–Davis Medical Center, Sacramento, California. Requests for reprints should be addressed to Dr. Klea D. Bertakis, Department of Family Practice, University of California—Davis Medical Center, 2221 Stockton Boulevard, Sacramento, CA 95817.

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and thus improve health care to the poor and minorities.

There is a paucity of information on the distribution of physicians by race and ethnic group. In 1942, the ratio of black physicians to the black population was 1 to 3,377. Thirty years later, in 1972, there were 320,903 active physicians of whom 5,478 were black. This created a lower ratio of one black physician for about every 4,298 blacks, according to the United States Census Bureau's estimate of 23.5 million black people as of July 1, 1972.[3] The decrease in the black physician to black patient ratio demonstrates that the number of black people is increasing more rapidly than the number of black physicians. Haynes' report on the distribution of black physicians in the United States shows that black physicians tend to locate in areas where there is the greatest growth in the black population.[4] Instead of a proportional distribution, however, it appears that they selectively go to those areas where the median income of black families is relatively high and the quality of life differentials between white and black families are relatively low.[5] Certain states, such as Georgia and North Carolina, with large black populations have relatively few black physicians.[3] Moreover, although black physicians are more likely to concentrate in large cities than are the total universe of physicians, they tend to avoid metropolitan city "ghettos."[6]

The "social accessibility hypothesis" described by Thompson asserts that a sufficient number of minority physicians to meet the minority demand for medical services could potentially improve the overall health status of minorities.[3] The rationale for this hypothesis is that health professionals experience great difficulty in communicating with culturally different patients. However, this hypothesis assumes, for example, that the black physician operates within the same "life space" as the black patient (poor and nonpoor alike). It further assumes that the black physician is more likely to share the values of the black health care consumer with respect to the consumer's orientation toward health and medical care than is the nonblack physician. Unfortunately, there is a lack of data to confirm or deny these assumptions.[3]

A number of programs have been developed to bring professional health manpower to underserved urban and rural areas. Perhaps the most politically sensitive have been the affirmative action admissions programs. It appears that these programs tend to be based on two hypotheses. The first one is that minority professionals are more likely than nonminority professionals to practice in minority health manpower shortage areas. The second one is that minority professionals can provide better services to minority patients because of similarities in cultural experiences and languages.

This study examines the hypothesis that ethnic minority patients are more satisfied when served by physicians of their own race. A large poll of minority patients in the San Francisco Bay area was done under the auspices of the University of California–Berkeley, School of Public Health. Interview questions centered around the feelings about medical care in general and minority physicians in particular. This paper will discuss a portion of the data obtained. Other findings from the poll have been previously reported.[7]

Methods

The study was conducted at the Contra Costa County Clinic in Richmond, California, which serves welfare and low-income patients. Although the county is currently attempting to enroll its clinic patients in a health maintenance organization type of system, a majority of patients pay for services with MediCal stamps. All patients make appointments with the physician of their choice and are free to see the same physician or change to another physician.

The three clinic physicians participating in the study included an Asian female (Dr. A), a black male (Dr. B), and a white male (Dr. C). These three physicians saw patients in the family practice clinics at the Richmond Clinic, which also has other clinics for such specialties as obstetrics and gynecology, dermatology, and surgery.

A total of 66 patients took part in the study. Patients were selected in a random fashion from among those waiting to see the three participating physicians. Each physician had different hours for scheduled Family Practice Clinic patients and each had a different office and waiting area. Once the patient's cooperation was confirmed, he or she was seen by his/her physician and then met with

Table 1. Patients Participating in the Study

Ethnic Origin	Men	Women	Total Number	Percentage of Total
Asian	0	0	0	0
Black	13	27	40	60.6
White	8	13	21	31.8
Mexican-American	2	3	5	7.6
Total	23	43	66	100.0

Table 2. Number of Patients Arranged by Ethnic Group Seen by Each Physician

	Dr. A Asian		Dr. B Black		Dr. C White	
Ethnic Group	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Black	12	57.1	13	65	15	60
White	6	28.6	7	35	8	32
Mexican-American	3	14.3	—		2	8
Total patients	21	100	20	100	25	100

Significance of difference=.56

the interviewer to answer an 18-item questionnaire dealing with patients' perceptions of their physicians and how these are influenced by race. The interviewer was a white female, unidentified as having ties to the clinic staff. Questions were read to the patient by the interviewer, who then recorded the answers on the questionnaire. When necessary, informal vernacular or Spanish translation was used.

As seen in Table 1, of the 66 patients participating in the study, 23 were men and 43 were women. The composition of the study group reflected that of the clinic population: 60.6 percent black, 31.8 percent white and 7.6 percent Mexican-American. There was a small group of Asian patients at the Richmond Clinic; however, the number was so small that no Asians were available to be part of the study on the days that it was conducted. The number of Mexican-American patients was too small to be analytically interpreted.

As shown in Table 2, there were no significant differences in the racial distributions of patients seen by each of the three physicians.

Results

The questions on the questionnaire consisted of a statement followed by five Likert scale responses of agreement or disagreement and a sixth response for those patients who could not answer the question or for whom the question did not apply.

The data collected on the questionnaire were analyzed using the Mantel-Haenszel chi-square method. The responses were first compared among the different racial groups of patients, regardless of physician seen (Table 3). There were no significant differences between the racial groups on questions 1 through 18. For purposes of reporting the data, answers to each question were collapsed from six to four categories. Responses of 1, "strongly agree" were combined with 2, "agree." Responses of 3, "do not agree or disagree," were kept separate. Responses of 4, "disagree," and 5, "strongly disagree," were put together. Responses of 6, "do not know/not applicable," were also taken separately.

Table 3. Patient Majority Responses to the Questionnaire

	Black		White	
	Number	Percent	Number	Percent
1. I was satisfied with my last visit 1-2 Strongly Agree/Agree	39	97.5	21	100
2. If I needed a physician, I would see the same physician again 1-2 Strongly Agree/Agree	40	100	21	100
3. The skill or competence of the physician I last saw is important to me 1-2 Strongly Agree/Agree	40	100	21	100
4. The caring and attention (attenciones) shown me by the physician are important to me 1-2 Strongly Agree/Agree	39	97.5	21	100
5. I was comfortable with the physician I last saw 1-2 Strongly Agree/Agree	38	95	21	100
6. This was affected by the physician's nationality, race, or ethnicity 4-5 Disagree/Strongly Disagree	40	100	21	100
7. The physician I last saw listened to what I had to say 1-2 Strongly Agree/Agree	38	95	21	100
8. This was affected by the physician's nationality, race, or ethnicity 4-5 Disagree/Strongly Disagree	40	100	20	95.24
9. The physician I last saw understood what I wanted to say 1-2 Strongly Agree/Agree	37	92.5	21	100
10. This was affected by the physician's nationality, race, or ethnicity 4-5 Disagree/Strongly Disagree	40	100	21	100
11. I understood what the physician I last saw had to say 1-2 Strongly Agree/Agree	40	100	21	100
12. This was affected by the physician's nationality, race, or ethnicity 4-5 Disagree/Strongly Disagree	40	100	21	100
13. I feel that physicians vary greatly in their abilities 1-2 Strongly Agree/Agree	35	87.5	18	85.7
14. This difference is caused by the type of training they received	No Majority Response			
15. Minority physicians are generally as skilled as non-minority physicians 1-2 Strongly Agree/Agree	32	80	13	61.9
16. Even if minority physicians are less well trained, they have other qualities that compensate for these limitations	No Majority Response			
17. Given equal ability as a physician, I would prefer a physician of my own nationality, race, or ethnicity 4-5 Disagree/Strongly Disagree	36	90	19	90.48
18. Given equal ability as a physician, I would prefer a physician of a different nationality, race, or ethnicity 4-5 Disagree/Strongly Disagree	35	87.5	20	95.24

For questions 1 through 4, the majority of patients "strongly agreed or agreed" that they were satisfied with their last visit, would see the same physician again, and thought both the competence and caring shown by the physician were important to them.

In questions 5 through 12, the majority of patients "strongly agreed or agreed" that they were comfortable with the physician they had just seen and that the physician had listened to and seemed to understand what they had to say. All patients also "strongly agreed or agreed" that they understood what the physician had to say to them. In addition, most patients "disagreed or strongly disagreed" that these qualities were affected by the physician's nationality, race, or ethnicity.

In question 13, a majority of patients thought that physicians did vary in their abilities. In question 15, however, they responded that minority physicians are generally as skilled as nonminority physicians.

On questions 14 and 16, both racial groups were widely divided in their answers to these questions, and there was no one majority response. In other words, there was no general agreement as to whether the differences in physicians' abilities were caused by the type of training they received (question 14) or whether minority physicians, even if less well trained, had other qualities that would compensate for any possible limitations (question 16).

Most patients did not have a racial or ethnic preference for their physician, given equal ability, as seen in their responses to questions 17 and 18.

The responses by Dr. A, B, and C's patients were taken separately. On each question, 1 through 18, there were no significant differences among the different racial groups in Dr. A, B, and C's three separate groups of patients. Their responses to all questions were similar to those shown in Table 3.

There were no significant differences in the racial distribution of patients seen by each of the three physicians separately (Table 2). In order to learn if the three participating physicians attracted different kinds of patients with differing opinions, Dr. A, B, and C's three separate groups of patients (not broken into racial groups) were compared for responses to each question on the questionnaire. It was found that for each question, 1 through 18, the responses of Dr. A, B, and C's patients taken as a whole (without regard to racial group) did not significantly differ. Each of the three physicians saw a group of patients that were similar in their racial make-up and responses to the questionnaire.

Comment

Medical education is undergoing many changes. One of these is the reexamination of criteria for admission to medical school. There has been much debate for and against using race as a criterion. This study attempted to contribute additional information by asking ethnic minority patients how the race of their physician influenced their opinions. No significant differences were found in the racial distribution or opinions of patients seeing the three physicians (Asian, black, and white) in the study. The majority of patients did not consider race or ethnicity an important factor in their feelings towards their physicians. They did, however, consider interactional skills as important.

This study, therefore, suggests that in selecting medical school applicants with the greatest potential for serving patients, more attention should be given to interactional qualities and skills that transcend race or ethnicity. Additional studies of a similar nature will be needed to further clarify this issue.

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