COMMENTARY

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'I want a doctor who looks like me': The dilemma of race-based requests

Patient experience has found its way to the top of the list of priorities for healthcare organizations, which are now obliged to gather and interpret patient feedback in a way that optimizes medical care. Requests for providers based on race and ethnicity create an uncomfortable, delicate situation that hard-line policies fail to adequately address. Ideally, the race of a provider shouldn't matter in providing the best care to patients. But what if it does?

Ideally, the provider's race shouldn't matter, but what if it does?

PATIENT EXPERIENCE HAS BECOME A TOP PRIORITY

The consumer-centric shift of healthcare has moved patient attitudes, preferences, and experience to the top of the list of priorities for healthcare organizations. As such, patient experience has become an important part of healthcare administration and management, with organizations dedicating personnel and resources to maintain a competitive advantage. Healthcare organizations track patient experience data with automated postcare surveys, patient advisory councils, online consumer communities, and direct patient feedback. Patient-centered healthcare organizations use this information to drive operational strategies and continual practice redesign, and some of the data are used to determine insurance reimbursement.

MINORITY PHYSICIANS FACE BIAS

Not surprisingly, bias often finds its way into patient experience data. Patients tend to prefer healthcare providers of similar race and ethnicity.[1] Thus, minority providers, particularly those from groups that are underrepresented in medicine in the United States, such as African Americans and Latinos, at times find themselves receiving lower patient experience scores than their white colleagues.[2,3] Besides potentially lowering the performance evaluations and reimbursement for minority physicians, such systemic implicit bias contributes to the feelings of frustration, isolation, and burnout faced by minority physicians in healthcare.

Online provider profiles and information have aided patients in selecting healthcare providers. However, you can't always get the doctor you want: limited access, narrowing insurance provider networks, and team-based models of care create a situation in which many patients are still assigned providers without knowing their race, ethnicity, sex, or other characteristics.

It is thus not uncommon for patients to request to be seen by a different provider of a specific race or ethnicity for future visits. Healthcare system and practice leaders now find themselves in the uncomfortable position of deciding how to manage such requests, finding a balance between accommodating patient preference and protecting their providers from bigotry.

Small medical practices, particularly those not affiliated with integrated delivery systems, may lack the brand recognition of large medical groups. Therefore, a substantial proportion of their initial patient appointment requests could be provider-specific, making random assignment based on availability less likely. Still, depending on the racial and ethnic diversity of the practice, the challenge of managing patient preferences could mirror that of large healthcare systems.

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NOT ALL REQUESTS ARE ROOTED IN RACISM

Many would argue that patient requests for providers on the basis of race, ethnicity, and other personal characteristics should not be accommodated. Perhaps it would be better to try to create a safe, ethnically diverse, culturally competent environment where all patients and providers feel welcome. But what if such selection is in the best interest of a particular patient? What if accommodating a request rooted in bias translates into better health outcomes?

The life expectancy of African Americans continues to lag behind that of white Americans—74.8 years vs 78.5 years. The current life expectancy of African American males is 71.5 years.[4] Additionally, black Americans have a higher rate of death for 9 of the 15 leading causes of death, including many preventable conditions such as heart disease, malignant neoplasms, cerebrovascular diseases, diabetes, renal disease, and hypertension.[5]

Among the factors contributing to these healthcare disparities is the low number of African American physicians. Currently, just over 4% of practicing physicians and less than 6% of US medical school graduates are black.[6] Moreover, African American applicants to US medical schools have a lower rate of acceptance than other racial and ethnic groups, contributing to the small pool of black healthcare providers.

In the early 2000s, LaVeist et al[7] showed that patient-provider race concordance resulted in increased utilization of health services and fewer delays in seeking care, particularly among African Americans. Last year, researchers in Oakland, CA, found that black men were more likely to engage in preventive services when recommended by black physicians.[8] They estimated that such a change in behavior could translate to a 19% reduction in the cardiovascular mortality gap between white and black men.[8] It is thus deduced that increased access to African American male physicians could improve health outcomes in African American male patients.

CONSIDER THIS PATIENT

A middle-aged black man calls a healthcare system to make an appointment to establish care and asks, "Do you have any black physicians on staff? If so, I would like to see one." How a safe, ethnically diverse, culturally competent hospital system responds to this type of request from such a patient is a complex undertaking. Ideally, the race of a provider shouldn't matter in providing the best care that this patient has the right to seek. But what if it does? What if accommodating such a request is something that we know can result in not just an improved patient experience, but also improved engagement in preventive services and potentially better health outcomes? Would it then be unethical to automatically deny such a request?

Furthermore, why would this patient have such a request? Does the request come from bigotry, racism, or hatred? Alternatively, does it matter that he is part of a community that has been the victim of enslavement and subsequent political, social, and economic disenfranchisement in this country? Does it matter that he comes from a community that has a history of being discriminated against and abused, notably in the healthcare system? Does it matter that the patient likely has experienced explicit and implicit bias in and out of the healthcare setting?

Particularly if the volume of requests for providers on the basis of race and ethnicity is not overwhelming, it would be reasonable to seek to understand the reason behind each request. Requests deemed inappropriate could present an opportunity to provide education and to reduce bias. For those deemed befitting and free of discriminatory intent, it is hard to argue against accommodation.

It is comforting to think that optimal medical care is color-blind, and it is easy and convenient to assume that patient requests for providers on the basis of race and ethnicity are inappropriate. However, there are data and trends that suggest otherwise. Not all patient requests are rooted in bigotry and racism. Some are rooted in history, pain, and survival.

It is comforting to think that medical care is color-blind, but data suggest otherwise

REFERENCES

1. **LaVeist TA, Nuru-Jeter A**. Is doctor-patient race concordance associated with greater satisfaction with care? J Health Soc Behav 2002; 43(3):296–306. pmid:12467254
2. **Poole KG Jr**. Patient-experience data and bias—what ratings don't tell us. N Engl J Med 2019; 380(9):801–803. doi:10.1056/NEJMp1813418
3. **Sotto-Santiago S, Slaven JE, Rohr-Kirchgraber T**. (Dis) incentivizing patient satisfaction metrics: the unintended consequences of institutional bias. Health Equity 2019; 3(1):13–18. doi:10.1089/heq.2018.0065
4. **Centers for Disease Control and Prevention**. Health, United States, 2017. https://www.cdc.gov/nchs/data/hus/2017/fig01.pdf. Accessed February 13, 2020.
5. **Xu J, Murphy SL, Kochanek KD, Bastian B, Arias E**. Deaths: final data for 2016. Natl Vital Stat Rep 2018; 67(5):1–76. pmid:30248015
6. **Association of American Medical Colleges**. Figure 6. Percentage of U.S. medical school applicants by Black subgroups, 2015. http://www.aamcdiversityfactsandfigures2016.org/report-section/section-3/. Accessed February 13, 2020.
7. **LaVeist TA, Nuru-Jeter A, Jones KE**. The association of doctor-patient race concordance with health services utilization. J Public Health Policy 2003; 24(3–4):312–323. pmid:15015865
8. **Alsan M, Garrick O, Graziani G; National Bureau of Economic Research**. Does diversity matter for health? Experimental evidence from Oakland. NBER Working Paper No. 24787. https://www.nber.org/papers/w24787. Accessed February 13, 2020.

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