Do patients choose physicians of their own race?

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Do Patients Choose Physicians Of Their Own Race?

To provide the kind of care consumers want, medical schools might be able to justify using race as an admissions criterion.

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ABSTRACT: This study seeks to determine whether minority Americans tend to see physicians of their own race as a matter of choice or simply because minority physicians are more conveniently located within predominantly minority communities. Using data from the Commonwealth Fund 1994 National Comparative Survey of Minority Health Care, we found that black and Hispanic Americans sought care from physicians of their own race because of personal preference and language, not solely because of geographic accessibility. As minority populations continue to grow, the demand for minority physicians is likely to increase. Keeping up with this demand will require medical school admissions policies and physician workforce planning to include explicit strategies to increase the supply of underrepresented minority physicians.

Certain racial and ethnic minority groups are underrepresented among U.S. physicians. In 1990 blacks, Hispanics, and Native Americans accounted for 21 percent of the U.S. population but only 8.6 percent of physicians.\(^1\) The Council on Graduate Medical Education, the Bureau of Health Professions, the Association of American Medical Colleges, and the American Medical Association all support policies aimed at increasing the number of underrepresented minority physicians.\(^2\) These organizations base their positions on the principle of social equity. From a practical standpoint, however, they argue that minority physicians fulfill a pressing need in the U.S. health care system: They provide primary care for a disproportionately large share of the nation’s underserved...
communities, many of which are predominantly black, Hispanic, and Native American. Thus, these organizations assert, it is in the public interest to increase the numbers of underrepresented minority physicians and therefore justifiable to use race as a factor in selecting medical students. Others counter that increasing the supply of physicians in underserved areas should be achieved by providing better incentives for physicians to practice in those areas and by selecting medical students based not on their race but on other predictors of serving the underserved.

So far, the preferences of health care consumers have not been heard in this debate. Does the American public, and particularly its growing minority population, desire a more diverse physician workforce? Do minority consumers care about the race and ethnicity of their physicians? Recent studies suggest that they may. A national survey revealed that although black physicians make up only 4 percent of the physician workforce, they care for more than 20 percent of black patients in the United States. This finding suggests that black Americans may preferentially seek care from black physicians. It also may reflect, however, that many black physicians locate their practices in predominantly black communities and are therefore more geographically accessible to black consumers. If minority consumers seek care from physicians of their own race simply because of geographic accessibility, then policies aimed at better serving the needs of minority communities need not necessarily consider physician race. If they do so for other reasons, such as common language or culture, then increasing the supply of underrepresented minority physicians may be justifiable and necessary.

Data source. To explain why minority health care consumers tend to seek care from physicians of their own race, we analyzed data from the Commonwealth Fund 1994 National Comparative Survey of Minority Health Care, a telephone survey of a random sample of 3,789 adults in the forty-eight contiguous United States (response rate, 51 percent). The survey obtained data on respondents’ usual source of care, health status, and sociodemographic characteristics. Minority groups were oversampled. For the purposes of this analysis, we restricted the sample to the 2,045 black, Hispanic, and white respondents who reported having a regular physician (Exhibit 1). Hispanic respondents were primarily of Mexican (55 percent) and Puerto Rican (15 percent) descent. The majority were born in the United States; very few were recent immigrants.

Data analysis. Respondents reported their own race and ethnicity and were asked to identify their regular physician’s race as black, Hispanic, Asian, American Indian, non-Hispanic white, or other. We considered racial concordance to be present when re-
Respondent and physician were in the same group.

Respondents reported whether they chose their physician and, for those who did, whether their choice was influenced by the physician’s race or ethnicity or ability to speak the respondent’s language. To determine the influence of consumer choice on racial matching, we examined whether or not the ability to choose one’s physician was associated with having a physician of one’s own race. Respondents also were asked to rate the convenience of their physician’s office locations. We adjusted for these ratings to determine whether any association between choice and racial concordance was explained by greater geographic accessibility of racially concordant physicians. We also adjusted for other respondent characteristics, including age, sex, educational attainment, annual household income, primary language, birthplace, number of years in the United States (for immigrants), geographic region, urban/rural status, insurance type, health maintenance organization (HMO) membership, primary care site, sex of physician, and self-perceived health status. All analyses were stratified by respondents’ race.

**Race/Ethnicity Of Patients And Physicians**

For blacks and Hispanics there was a significant correlation between patients’ ability to choose their physicians and seeing physicians of their own race (Exhibit 2). Nearly a quarter of blacks and

### EXHIBIT 1
Characteristics Of Survey Respondents Having A Regular Physician, 1994

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Blacks (n = 645)</th>
<th>Hispanics (n = 542)</th>
<th>Whites (n = 858)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years)</td>
<td>42.9</td>
<td>40.4</td>
<td>46.9</td>
</tr>
<tr>
<td>Male</td>
<td>39%</td>
<td>43%</td>
<td>44%</td>
</tr>
<tr>
<td>College graduate</td>
<td>19</td>
<td>16</td>
<td>22</td>
</tr>
<tr>
<td>Household income $35,000 or more</td>
<td>31</td>
<td>40</td>
<td>43</td>
</tr>
<tr>
<td>Primary language English</td>
<td>98</td>
<td>67</td>
<td>99</td>
</tr>
<tr>
<td>Born in U.S.</td>
<td>90</td>
<td>61</td>
<td>96</td>
</tr>
<tr>
<td>In U.S. 10 years or more</td>
<td>98</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>Urbana</td>
<td>50</td>
<td>51</td>
<td>30</td>
</tr>
<tr>
<td>Suburbana</td>
<td>27</td>
<td>36</td>
<td>43</td>
</tr>
<tr>
<td>Rurala</td>
<td>23</td>
<td>13</td>
<td>27</td>
</tr>
<tr>
<td>Northeast</td>
<td>24</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>South</td>
<td>51</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>Midwest</td>
<td>15</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>West</td>
<td>9</td>
<td>40</td>
<td>19</td>
</tr>
<tr>
<td>Employed</td>
<td>64</td>
<td>71</td>
<td>62</td>
</tr>
<tr>
<td>On Medicare</td>
<td>19</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>On Medicaid</td>
<td>15</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Uninsured</td>
<td>17</td>
<td>22</td>
<td>8</td>
</tr>
</tbody>
</table>

**SOURCE:** Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.

a Urban, suburban, and rural status assigned according to U.S. Census Bureau definitions.
Hispanics with racially concordant physicians reported that they explicitly considered physician race or ethnicity when selecting their physicians. Among Hispanics, 42 percent factored language into their choice of a Hispanic physician.

After controlling for other factors, including physician’s office location, there remained a significant association among black respondents between the ability to choose one’s physician and having a physician of one’s own race. Physician practice location per se was not an independent factor in explaining the pairing of black patients and physicians. However, blacks who saw black physicians were younger than those with nonblack physicians, had lower levels of education, more often lived in urban areas, and were more likely to be uninsured. These factors likely reflect the fact that many black physicians locate their practices in poor, urban, predominantly black communities and are therefore accessible to residents there.

Hispanics seeing Hispanic physicians were more likely to speak primarily Spanish, reflecting the importance of language to many Spanish-speaking patients when choosing a physician. Other characteristics associated with racial concordance between Hispanics and their physicians likely reflect the geographic distribution of Hispanic physicians. For instance, the higher likelihood of seeing a Hispanic physician in urban areas and in the South probably reflects greater access to Hispanic physicians in these areas than in rural areas and other U.S. regions, particularly the Midwest.

Whites obtained care from white physicians partly because the latter were more geographically accessible than minority physicians were, especially for white consumers not enrolled in HMOs. The sex of respondents and physicians, as well as respondents’ country of birth, number of years in the United States, primary care site, and

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### EXHIBIT 2

<table>
<thead>
<tr>
<th>Choice/actor</th>
<th>Black respondents</th>
<th>Nonblack respondents</th>
<th>Hispanic respondents</th>
<th>Non-Hispanic respondents</th>
<th>White respondents</th>
<th>Nonwhite respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice influenced by</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s race or ethnicity</td>
<td>91%</td>
<td>85%</td>
<td>94%</td>
<td>87%</td>
<td>93%</td>
<td>89%</td>
</tr>
<tr>
<td>Physician’s ability to speak patient’s language</td>
<td>23%</td>
<td>10%</td>
<td>22%</td>
<td>5%</td>
<td>6%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**SOURCE:** Commonwealth Fund 1994 National Comparative Survey of Minority Health Care.

*a* *p* ≤ .05 for race-specific comparison of respondents with racially concordant versus nonconcordant physician; Pearson’s chi-square test.

*b* Denominator includes only those respondents who reported choosing their regular physicians.
health status were not significantly associated with having a physician of one’s own race among either minority groups or whites.

Discussion And Policy Implications

Black and Hispanic physicians account for 4 percent and 5 percent, respectively, of all U.S. physicians. According to our national survey, they care for 25 percent of black patients and 23 percent of Hispanic patients. This disproportionate racial pairing is undoubtedly attributable in part to the fact that many black and Hispanic physicians locate their practices in predominantly black and Hispanic communities. Our analysis demonstrates, however, that it is also attributable to the choices of minority health care consumers.

It is noteworthy that we found an association between choice and racial pairing of patients and physicians in this geographically diffuse sample. Given the nationwide scarcity of black and Hispanic physicians, it is likely that many of our minority respondents, especially in rural areas, did not have access to minority physicians and thus, even if able to choose their physician, would not have been able to choose a physician of their own race. If we had selectively sampled persons having a diverse pool of physicians to choose from, the association between choice and racial pairing would likely have been stronger among both blacks and Hispanics.

Why do minority patients choose physicians of their own race? While our analysis suggests that language is one explanation, other reasons remain unclear. It is possible, as postulated by the late Herbert Nickens, that minority physicians are “more culturally sensitive to their populations and organize the delivery system in ways more congruent with the needs of a minority population.” Future research should focus on what it means to be more culturally sensitive and how health care providers from all backgrounds can become better equipped to care for diverse patient populations. In the meantime, minority consumers are likely to continue to seek out physicians of their own race and ethnicity.

This demand for minority physicians is likely to increase in the next century as U.S. minority populations continue to grow rapidly. In 1999 blacks and Hispanics made up 12 percent and 11 percent, respectively, of the U.S. population. By 2050 these proportions will increase to 14 percent and 25 percent. Under current policies the supply of minority physicians is unlikely to keep up with demand. A recent analysis projected that establishing a physician workforce that mirrored the diversity of the U.S. population in 2010 would require doubling the number of blacks and Hispanics and tripling the number of Native Americans in medical training.

The past two decades have seen some movement toward this
goal. Between 1982 and 1995 the percentage of underrepresented minorities entering medical schools rose from 8.4 percent to 12.4 percent.\textsuperscript{13} These increases were largely credited to affirmative-action policies as well as to “educational pipeline” programs.\textsuperscript{14} In the past three years, however, this trend has reversed. The proportion of underrepresented minorities entering medical schools dropped in 1996 to 11.8 percent and then again in 1997 to 10.9 percent.\textsuperscript{15} Changes in affirmative-action policies across the nation appear to be at least partly responsible. In 1995 the regents of the University of California eliminated their schools’ ability to consider race, ethnicity, or gender as factors in admissions. One year later California citizens extended this ban to all public institutions. In 1996 the U.S. Fifth District Court of Appeals, in \textit{Hopwood v. Texas}, imposed the same restriction on public schools in Texas, Louisiana, and Mississippi. In the wake of these decisions, enrollment of underrepresented minorities in medical schools declined nationally, with nearly half of the total decline occurring in the four states directly affected.\textsuperscript{16}

More recent challenges to affirmative action have eliminated consideration of race in public institutions in Washington State and are imminent in several other states. The American public appears to believe that considering race in admissions, hiring, and contracting constitutes discrimination and is therefore unjustifiable. Based on our analysis, however, medical schools and health plans might rationally argue that the consideration of race in these realms is reasonable and indeed necessary, to create a physician supply that reflects consumers’ preferences. Where consideration of race is not permitted, innovative strategies, such as Texas’s top 10 percent rule, which has shown promise in increasing underrepresented minority enrollment in undergraduate colleges, should be developed to ensure that enrollment of underrepresented minorities in medical schools keeps up with public demand.\textsuperscript{17}

Increasing the number of minority physicians may also improve the quality of health care for minority populations. Numerous studies have demonstrated racial disparities in access to high-quality care.\textsuperscript{18} These disparities appear to be at least in part related to racial, cultural, and linguistic barriers between minority consumers and predominantly white health care providers.\textsuperscript{19} Increasing the diversity of the physician workforce may help to reduce the racial inequalities that continue to serve as an intractable blemish on the U.S. health care system.

We do not mean to imply that patients should only obtain care from physicians of their own race and ethnicity. Rather, the goal should be to improve the cultural competence of all providers, so that patients can receive appropriate and excellent care regardless of
from whom they receive it. It is unlikely, however, that such competence to serve an increasingly diverse population will be achieved unless the physician workforce becomes more diverse.

Concerns of social equity and the needs of underserved communities provide strong arguments for increasing the supply of minority physicians in the United States. Our findings provide yet another motivation: responding to consumer choice. On this basis, medical schools may justify the consideration of race in admissions as a means toward producing the physician workforce that health care consumers want. If states continue to dismantle affirmative action, it will be imperative that they implement and support alternative strategies to comply with public demand for minority physicians.

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NOTES
1. Association of American Medical Colleges, Minority Students in Medical Education, no. 11 (Washington: AAMC, 1998).
5. Moy and Bartman, “Physician Race.”
7. We used random-digit dialing using a stratified sampling process to ensure proper representation of households from each of the forty-eight contiguous states and from central-city, suburban, and rural areas. Black and Hispanic Americans were oversampled through a process of screening multiple national cross-sections. Of the 3,789 respondents, 669 were Asian, Native American, or of nonspecified race and were excluded from our analyses because they were
not sampled using a nationally representative framework. Among the remaining 3,120 respondents, 959 did not have a regular physician, including 31 percent of blacks, 41 percent of Hispanics, and 20 percent of whites. Another 116 did not identify their physician's race, leaving a final sample of 2,045 black, Hispanic, and white respondents with a regular physician of known race. To limit the effects of nonresponse, we weighed the data according to parameters from the most recently available census statistics. For a more detailed outline of survey methods, see Louis Harris and Associates, Health Care Services and Minority Groups: A Comparative Survey of Whites, African-Americans, Hispanics, and Asian-Americans (New York: Louis Harris and Associates, 1994).

8. Results obtained from logistic regression analysis using racial concordance as the dependent variable and the following independent variables: chosen physician (yes/no), convenience of physician's practice location (four-point scale), age (years), sex, educational attainment, annual household income, primary language (English versus other), birthplace/years in U.S. (born in U.S.; immigrated more than twenty years ago, ten to twenty years ago, less than ten years prior to survey year), geographic region, urbanicity, insurance type, health maintenance organization membership (yes/no), primary care site (physician's office, public clinic, emergency department), sex of physician, and health status (four-point scale). A table of odds ratios with confidence intervals for these factors is available from the authors on request. Contact Somnath Saha, Medical Service (P3MED), Portland VA Medical Center, 3710 S.W. U.S. Veterans Hospital Road, Portland, Oregon 97207.

9. AAMC, Minority Students in Medical Education.
13. AAMC, Minority Students in Medical Education.
14. For example, the AAMC’s Project 3000 by 2000, a program launched in 1991, aimed at increasing the pool of qualified minority medical school applicants through a variety of mechanisms.
15. AAMC, Minority Students in Medical Education.
17. Texas implemented a program of guaranteeing admission to state universities for all high school students in Texas graduating in the top 10 percent of their class. California and Florida are proposing similar programs. See J. Wilgoren, “Texas’ Top 10 Percent Law Appears to Preserve College Racial Mix,” New York Times, 24 November 1999, Al.