

PATIENT PREFERENCES FOR PHYSICIAN CHARACTERISTICS IN UNIVERSITY-BASED PRIMARY CARE CLINICS

Jorge A. García, MD, MS; Debora A. Paterniti, PhD;
Patrick S. Romano, MD, MPH; Richard L. Kravitz, MD, MSPH

Objective: To examine patient preferences for age-, gender-, and racial/ethnic-concordant primary care physicians.

Design: Focus group interviews.

Patients and Setting: Forty-nine adults (African Americans, Caucasians, and Latinos) receiving their outpatient medical care in university-based primary care clinics in Northern California.

Main Measures and Results: Guiding questions were designed to elicit information about what patients look for in establishing and maintaining a therapeutic relationship with a primary care physician. Patients were prompted to provide examples and to discuss demographic-concordance factors. Many participants felt that their continuity of care was poor and that they could not choose their own primary care physicians in the academic system. Most reported tolerating these inconveniences for what they perceived to be a higher quality of care linked to medical innovations at academic medical centers. Patients' views regarding age concordance were varied and unrelated to gender or racial/ethnic group. Women in all English-proficient groups described gender concordance as important to their relationships with primary care physicians. Spanish-speaking participants uniformly preferred Spanish-speaking providers. African-American participants and Spanish-speaking Latino men felt that race/ethnic concordance contributed to a practitioner's empathy, and some were concerned by the lack of race/ethnic- or language-concordant doctors.

Conclusions: Examining patients' preferences for patient-physician demographic concordance provides insight into the patient-physician relationship. Addressing areas where these preferences affect communication patterns and perceptions of quality of care may lead to overall improvements in patient-physician relationships and health outcomes. (*Ethn Dis.* 2003;13:259-267)

Key Words: Ethnic Groups/Psychology, Patients/Psychology, Physician-Patient Relations

INTRODUCTION

A number of studies have examined the subject of gender or racial/ethnic concordance between patients and their physicians. These studies have linked patient-provider demographic concordance to communication and decision-making styles, patient satisfaction and quality of care perceptions, and health-care processes. With respect to gender, women express a preference for gender-concordant physicians more often than do men.¹⁻³ In a 1993 survey of Dutch households, Kerssens et al⁴ found that most women and men expressed no gender preference for their internists or general practitioners; however, when preferences were expressed, over twice as many women and approximately 9 times as many men preferred gender-concordant physicians. Most respondents with gender preferences indicated that it was easier to talk to a gender-concordant provider, and that they felt more at ease during intimate physical examinations by such providers.

The literature also provides evidence of patient preferences for race/ethnic-concordant providers. In a study by Cooper-Patrick et al,⁵ patients with racial/ethnic-concordant providers rated their physicians' decision-making styles as more participatory than did patients with race-discordant providers. Similarly, Saha et al⁶ demonstrated that Afri-

can-American patients with race-concordant physicians were more likely to rate their physicians as excellent, and to report receiving preventive and needed medical care during the previous year than those with race-discordant providers. Moreover, Hispanic patients with ethnic-concordant providers were more likely to be very satisfied with their overall health care than those with ethnic-discordant physicians. In a later study of data from the Commonwealth Fund 1994 National Comparative Survey of Minority Health Care,⁷ Black and Hispanic Americans who sought care from race-concordant physicians reported choosing these providers to satisfy personal and linguistic preferences, rather than for their greater geographic accessibility.

Among female patients, several studies have linked patient-physician gender concordance to specific processes of care. For example, compared to women with male physicians, women with female physicians have been reported to have higher rates of Pap testing,^{8,9} cholesterol screening,⁸ and mammography,⁹ or aggressive breast cancer screening (ie, mammography at ages 35-39 years).⁸ In addition, after adjusting for patients' preferences for using estrogen replacement therapy, Seto et al¹⁰ found that female physicians were more likely than male physicians to prescribe hormonal therapy for women.

We performed the current study to investigate patient preferences for age-, gender-, and race/ethnicity-concordant primary care providers. Our principal objective was to examine whether patients expressed preferences for demographically concordant primary care providers, and to explore whether, and how, such preferences translated into

From the Department of Internal Medicine/Division of General Medicine and the Center for Health Services Research in Primary Care, University of California, Davis School of Medicine, Sacramento, California.

Address correspondence and reprint requests to Jorge García, MD, MS; Division of General Medicine; University of California Davis Medical Center; Patient Support Services Building; 4150 V Street, Suite 2400; Sacramento, CA 95817-1498; 916-734-7004; 916-734-2732 (fax); jzgarci@ucdavis.edu

... compared to women with male physicians, women with female physicians have been reported to have higher rates of Pap testing,^{8,9} cholesterol screening,⁸ and mammography,⁹ or aggressive breast cancer screening (ie, mammography at ages 35–39 years).⁸

perceptions about quality of care. We employed a focus group methodology to meet these aims because we anticipated that provider preferences would be heterogeneous within gender and ethnic groups. We felt that this approach would allow us to utilize the dynamics of small group interaction to explore more thoroughly patients' thoughts and experiences, and to gain insights into the heterogeneity of responses within these groups.¹¹

METHODS

We conducted qualitative focus group interviews with ethnically diverse (African-American, Caucasian, and Latino [English- and non-English-proficient]) male and female patients from 2 ambulatory care clinics at the University of California, Davis Medical Center (UCDMC) in Sacramento, California. UCDMC is the largest hospital, and the sole academic center, in the north central part of the state, and serves a population that reflects California's economic and ethnic diversity. The purpose of these interviews was to explore the perspectives and experiences of diverse patients regarding patient-physician concordance, and to understand the con-

texts in which patients define their preferences for physician characteristics, and within which they might link these preferences to the quality of care they receive.

We conducted a total of 8 focus groups between December 1998 and July 1999. Each group included 4 to 8 patients of similar ethnicity and gender. Latinos who identified themselves as predominantly English- or Spanish-speaking were interviewed separately, since we anticipated that acculturation differences between these groups would lead to significant differences in their experiences and preferences.

Study Participants

We selected participants from computerized lists of patients attending UCDMC's General Medicine clinic. These lists were generated by the hospital's Information and Communication Services and stratified patients by gender, ethnicity, and language preference. We conducted a 1-in-k systematic sample of 100 potential participants from each list, using random starts and estimating k as a number less than or equal to the total size of each list divided by 100. All sampled patients were contacted and asked to participate in the study. Because the 4 Latino patient lists each had fewer than 100 patients, we conducted no systematic sampling for Latino patients, and contacted each individual on these lists. Due to difficulties recruiting Spanish-speaking Latinas from the General Medicine clinic, we used special outreach efforts to recruit additional patients from UCDMC's Family Practice clinic to ensure the participation of Spanish-speaking Latinas in our study.

On recruitment into the study, we collected information on patients' age, gender, self-reported ethnicity, primary language (English or Spanish), and self-reported estimates of the frequency of primary care visits. We collected additional information from "Spanish-speaking" Latinos about their perceived

need for a medical interpreter. All prospective participants were offered a \$20 incentive for their one-time participation in a 2-hour focus group interview. Eligibility criteria for participation included: 1) being 18 years of age or older; 2) having been followed by a primary care provider (seen on at least 2 occasions in the 18 months preceding the group interview); and 3) being willing and able to participate actively in a group discussion about factors that influence the patient-physician relationship. Eligibility was determined solely by patient self-report (ie, we did not attempt to validate a prospective participant's reports of eligibility).

Data Collection

This research was approved by the UC Davis Human Subjects Committee. All participants gave their informed consent at the beginning of the focus group meeting. Focus group interviews lasted between 90 and 120 minutes, and were led by a facilitator matched to group members' gender, ethnicity, and linguistic ability. Discussions for the predominantly Spanish-speaking Latinos were conducted in Spanish. One investigator (JAG) moderated both Latino men's groups (English-proficient and Spanish-speaking), and another (RLK) moderated the Caucasian men's group. Other moderators included an African-American female physician, an African-American male facilitator, a Caucasian (White, non-Hispanic) female research psychologist, and a bilingual Latina postgraduate researcher. All focus group interviews were audio taped and transcribed, with participants identified by numbers to protect their confidentiality.

Gender- and race/ethnic-concordant moderators used a written guide to ask a series of questions that facilitated the group discussion. Guiding questions used to maintain the focus of the group interview included: 1) What do you look for in choosing a primary care physician (PCP)? 2) What factors influence your decision to stay with a particular

Table 1. Demographic characteristics of focus group participants

Race/Ethnicity	N (%)	Gender	Mean Age, Years (range)	
African-American	11 (22.4)	Female	5	65.5 (30–91)
		Male	6	53.1 (22–79)
Caucasian	14 (28.6)	Female	7	44.2 (20–68)
		Male	7	47.2 (31–82)
Latino (English-proficient)	12 (24.5)	Female	5	54.3 (37–65)
		Male	7	50.6 (45–56)
Latino (non-English-proficient)	12 (24.5)	Female	8	50.6 (19–72)
		Male	4	50.1 (30–67)
Total: 49 (100)		Female, N (%): 25 (51.0) Overall Mean Age: 52.0 Male, N (%): 24 (49.0)		

provider? 3) To what extent does physician gender influence your decision? To what extent do you believe this factor influences other (wo)men from your ethnic background? 4) To what extent does a physician’s ethnic background influence your decision? To what extent do you believe this factor influences other (wo)men from your ethnic background? Additional guiding questions prompted patients for their perceptions of and specific experiences with their PCPs. In addition, the responses of participants in each group provided prompts for further discussion, generating information about the range of personal experience in each focus group.¹²

The primary goal of these questions was to understand patients’ perspectives of factors important in establishing a meaningful and effective therapeutic relationship with a PCP. Each interviewer

communicated this goal at the start of each group interview. All interviewers were trained to use the set of guiding questions to assist group participants in maintaining this “focus” throughout the discussion. Interviewers were also trained to prompt all participants to elaborate on their responses, and to provide specific examples of their experiences, where appropriate.

Data Analysis

Two investigators (JAG, DAP) independently reviewed focused group transcripts for the natural language statements (ie, words and phrases in the participants’ own language) that described patient preferences for physician characteristics and aspects of care. The investigators agreed on the natural language statements to be classified under physician characteristics (eg, age, gender, ethnicity) and aspects of care (eg,

empathy, communication, continuity, accessibility, quality). Through an iterative process, the investigators inductively grouped similar statements into the same conceptual category. Where participants expressed differing opinions, investigators noted the range of perspectives, including positive and negative statements expressed about the same phenomenon. Disagreement among the investigators regarding the categorical grouping of natural language statements was resolved by splitting statements into different categories (or by creating sub-categories). In the subsequent section, we report the results of patients’ discussions about their experiences with PCPs, and their preferences for demographic concordance.

RESULTS

A total of 49 individuals participated in the 8 focus groups. Table 1 provides the demographic characteristics of this sample, and Table 2 summarizes the major themes discussed in each group.

Choosing a Primary Care Provider (PCP)

When asked what they look for in choosing a PCP, most focus group participants believed they “didn’t have a choice” of personal physician under the academic system of care. A participant in the English-proficient Latino men’s focus group stated,

“I don’t know about the rest of the fellows here, but I don’t really think that you have a choice of picking your doctor. [Several people comment, ‘Right.’] I’ve been coming [here to the medical center] probably . . . about thirty years . . . and during that time, I’ve had dozens of primary care doctors.”

The inability to choose a PCP did not always translate into dissatisfaction with one’s provider, however. An English-proficient Latina commented on her experience with her PCP: “I did not choose [my PCP]. I had another doctor and he left, and then I was given her.

Table 2. Summary of major themes by race/ethnic and gender group

Race/Ethnicity	Gender	Congruence by		
		Age	Gender	Race/Ethnicity Language
African-American	Female		✓*	✓
	Male			✓
Caucasian	Female		✓	
	Male			
Latino (English-proficient)	Female		✓	
	Male			
Latino (non-English-proficient)	Female			✓
	Male		✓	✓

* ✓ denotes factors generally felt to be of importance to a particular race/ethnic and gender group.

But I was glad because I really like her. I *really* like her.”

In spite of some satisfaction, African-American patients not only felt an inability to choose their PCP, but also perceived that they had a limited range of options. One African-American man remarked, “. . . it would be nice if I had the luxury where I could say, yeah, give me the brother [the African-American physician], you know, but the brothers ain’t showin’ up in the medical schools . . . I don’t see ’em. So we don’t have that luxury, you know, of a choice.” An African-American woman expressed the same sentiment by saying, “If I had to pick, I would prefer to have an African-American [doctor], but . . . you can’t really decide who you can have. You know they choose everything for us . . .” Another woman immediately reacted to this statement saying, “I haven’t even seen any [African-American doctors] over here [at the medical center].”

Spanish-speaking Latinos uniformly preferred Spanish-speaking providers, reportedly because of communication issues or concerns. One man recounted how he specifically requested a Spanish-speaking doctor at his first clinic visit: “. . . I told them that I spoke and understood English but that it was occasionally difficult—particularly in medicine and in the courts, English is very difficult—so I prefer a doctor that speaks Spanish, male or female . . .” Another man described a different experience in the clinic: “. . . when I came here, no one asked me if I wanted a Spanish-speaking provider. They just told me, ‘You have an appointment with Dr. X.’ I don’t even remember his name . . . I would have preferred someone who spoke Spanish.” Another man emphasized his preference for a Spanish-speaking provider by expressing his frustration with medical interpreters who had failed to convey all of his concerns: “. . . I understand many things that I say to [the interpreter] and he does not say what I want him to tell [the doctor] . . . the interpreter needs to know *every-*

thing that the patient says in order to tell it to the doctor. . . in fact, where will we find all the necessary Spanish-speaking doctors, right?” Spanish-speaking women expressed a similar preference for Spanish-speaking providers. In describing her doctor, one Latina commented: “. . . I have a doctor who’s very good. She’s very concerned about my health and is always attentive, and I can call her for any matter.” This woman added that she could contact her PCP (at her home or in the clinic) whenever she felt the need to speak to her. She explained, “I’m very satisfied with my doctor—primarily because she speaks Spanish.” Another woman illustrated her preference for a Spanish-speaking doctor by describing the awkwardness of having an interpreter present during a breast or vaginal exam, particularly when the interpreter was a man. She reasoned that having a Spanish-speaking provider would mitigate her discomfort by reducing the number of people present during these sensitive examinations.

Quality of Care

Most focus group participants experienced high turnover rates with their PCPs, primarily related to the physicians’ completion of residency training. In addition, some patients perceived a lack of continuity in the teaching clinic, as noted by the concern of this African-American woman: “I don’t like to be in the assembly line, if you know what I mean. I like to have my own doctor . . . I do not like *any* doctor coming in to see me. I like my *own* doctor.” Other patients reported that they didn’t have a “basic doctor” to help them, and African-American women noted that they didn’t know “who my primary care doctor is” more frequently than did individuals in other groups.

Focus group participants reported a willingness to sacrifice continuity of care for what they perceived as a higher quality of clinical care linked to medical innovations at academic medical centers. One participant from the Caucasian

men’s focus group stated, “. . . my interest in [this medical center] is through watching *Pulse* [a local television program about medical center physicians and their research], which I think is a wonderful program and really sells this place.” An African-American man claimed,

“. . . what I like the most is that the younger students are learning right now, so they know more, then you’ve got these experienced doctors who’ve been doin’ it [caring for patients] for years, and if they need new treatments, they learn it right then and there ‘cause it’s a school . . .”

By contrast, medical treatment by physicians-in-training led some Spanish-speaking Latinas to believe they were receiving substandard, or “experimental,” treatment. One of these women stated,

“. . . first the student has to put his hand in to check us and depending on what the student sees, the doctor arrives and also puts his hand in, and then they send you home in worse shape than before. It’s as if they grab you like a rabbit to experiment on you. First the students and then, if they see that it’s necessary, they call the doctor. And, it should be that if someone comes in with a severe pain, the doctor should be first.”

However, a Latina in the English-proficient group enthusiastically commented about her experiences with physicians at the medical center: “No, they [patients outside of the medical center] said that the doctors here experiment on you. You’re like a guinea pig. But I don’t feel like that. Because if I was a guinea pig, at least I like the [way the medical center doctors] reconstructed my face and my eye and everything else.”

Age Concordance and Perceived Quality

While some focus group participants believed that younger physicians at medical centers learn “state of the art” medicine, patients’ general discussions regarding preference for age concordance with their PCPs were varied, and did not relate to gender or racial/ethnic group composition. One African-American

ican man claimed, "age . . . wouldn't matter because no matter what, by this being a school, everybody's gettin' all the same knowledge. Just the older doctors . . . are more experienced . . ." An English-proficient Latino stated, ". . . the younger doctor, he's not gonna make a decision himself. He's gonna have one [doctor] that's been there ten, fifteen years down the road that he's gonna ask him some questions . . . [get] his advice." Most focus group participants equated age with experience and/or education. Many were certain that younger physicians would enthusiastically absorb any and all new clinical information and, at the same time, would have a structured system of supervision provided by older, more experienced medical center physicians. Nonetheless, most participants did not perceive a strong link between the overall quality of care that they received and the age of their PCPs. As one Caucasian woman remarked, ". . . age doesn't matter. It's [the physicians'] experience, their characteristics, and their compassion [that matters]. Period."

Gender Concordance and Perceived Quality

Women in the African-American, Caucasian, and English-proficient Latina groups all described gender concordance as important to their relationships with PCPs. Describing her method for selecting a PCP, a Caucasian woman explained, ". . . first of all, I look for a woman doctor, if possible, because I feel that a woman doctor has more understanding, and she listens better . . . they do have understandings of things we are going through with our special sets of problems, and the way that our bodies and minds and souls and everything are made up . . ." Based on her previous experiences with medical care, an English-proficient Latina said, ". . . sometimes I feel more comfortable to talk about certain things, like being a battered housewife . . . because she [a woman physician] . . . knew how I re-

ally felt . . . and made me feel a little more comfortable." Most women felt that gender-concordant practitioners could understand important life experiences that they considered "part of being a woman." Further, many female focus group participants noted that a gender-concordant practitioner would accommodate the needs and demands of a patient's family members and other dependents. A woman in the African-American focus group stated, ". . . one of the things that I would really like to have in my primary care physician is a female, and what I've discovered recently is if I schedule my appointments with my mom, you know, it [coordinating a joint family visit] kind of takes camaraderie . . . it's a nice way to spend time together." Later in the discussion, this participant proclaimed her unequivocal preference for female physicians: "Hands down female . . . I mean a female doctor completely . . . I mean for examinations, for everything . . . there is an understanding you don't have to worry about. Theirs is a kind of comfort, a kind of nurturing that goes between you, you know." In contrast, Spanish-speaking Latinas stated that they had no preference regarding their provider's gender. In fact, one woman argued that in her experience with a female provider, the provider was "rough and discourteous."

In general, women's preferences for female providers were linked to greater expectations for the kinds of care they hoped to receive from their PCPs. While men in all groups denied PCP gender preferences, they maintained an interest in having a doctor who would "listen to me and try to relate to what I'm explaining," and who would "show some interest in me and my health." Spanish-speaking Latinos stated that they preferred a relationship with their PCP that was like a friendship. One Spanish-speaking man summarized this by stating, "the key issue is the humanness of the person [the doctor]." In general, men, unlike women, did not link these characteristics to gender.

Ethnic Concordance and Perceived Quality

African-American women and men affirmed that race/ethnic concordance enhanced patient-provider communication by contributing to a practitioner's ability to be more empathetic. Echoing the sentiments of other women in the African-American focus group, a participant explained, ". . . an African-American [PCP] would kind of be a little bit more attentive or understanding about what our needs really are. Not just what they think we should have." African-American men agreed. One man described his previous experiences with African-American physicians:

" . . . it makes it nicer, 'cause like when you go in there . . . you talk to 'em like on a different level. Just like if I was Jewish and I went in and seen a Jewish doctor; a Jewish doctor's gonna talk about Jewish stuff. So, you feel more comfortable . . . when you got it the same race. It is a difference. It's a big difference."

Another man stated, ". . . if we had more Black doctors when we go in, we can sit down and say 'Hey brother! You know, 'What's happening?' . . . you can really be comfortable . . . maybe some of us [African-American patients] would be a little bit more comfortable about opening up to a Black doctor than we would to a White doctor."

Because of this, some African-American men and women said they were concerned, since they saw few African-American doctors at the medical center: ". . . I ain't gonna see no . . . Black interns over at the primary care. . . . The only thing I see is White and Chinese or Japanese. I don't even see one . . . even one [African American] dressed like a doctor. I wonder where they're at."

Spanish-speaking Latino men perceived that a provider who shared their ethnic and cultural background would be better able to care for them, as revealed in this exchange between three of the group's participants:

[Participant 1]: "There is a preference. With the [non-Latino, Spanish-speaking

doctor] there are no similar customs. I prefer the Mexican [doctor]. There is a person-to-person union."

[Participant 2]: "Perhaps, as he said, because of the customs. For example, if I come because something has harmed me, the doctor would already know. I don't know, perhaps it's the same roots."

[Participant 3]: "Yes, one's roots are most important . . . a Latino [physician] already knows the illnesses that Latinos suffer with . . . he knows what we eat, how we live, et cetera."

Spanish-speaking Latinas did not share this belief; however, in dismissing the relevance of ethnic concordance, they emphasized their strong preference for Spanish-speaking providers. One woman summarized the group's sentiments: "I also don't have a preference for [a doctor] of any given race . . . but the only thing . . . I'd like [my doctor] to speak my language so that I could understand him better." Caucasians and English-proficient Latinos did not believe that race/ethnic concordance was essential to good care. A Latino from the English-proficient focus group said, "I don't have a problem with any race or anything. I mean, all I'm lookin' for is a good doctor . . . period. You know? I mean, he could be purple with orange spots on him . . . as long as he gave me good medical care I could care less." A Caucasian woman remarked, "The best doctor I had here was a gay, Black doctor . . . I almost followed him to his new place of practice because, and I told him, 'You're the best doctor I've had.'"

DISCUSSION

This study was conceived and conducted to inform our understanding of patient preferences for demographically concordant PCPs, including how these preferences might translate to patients' quality of care perceptions. Anticipating that provider preferences might vary as much within as between gender and ethnic groups, we utilized a focus group methodology. Our results demonstrate

that participants indeed held a wide range of opinions in this regard. When asked about the factors that influence their decision to establish a relationship with, or remain with, a particular PCP, many focus group participants reported that they could not choose a personal physician in our academic system. Most identified housestaff graduation as a key reason for their lack of choice, and some described their continuity of care as poor. These results are not surprising, given the constant turnover of resident physicians in the continuity clinic, the constraints of their limited outpatient schedule, and the absence of explicit mechanisms by which patients can select their own PCPs. The findings mirror resident physicians' perceptions of the lack of continuity in ambulatory teaching clinics,¹³ as well as the results of other studies documenting the limited continuity of care in academic outpatient clinics.¹⁴⁻¹⁷ Lichstein¹⁸ commented on the significance of "the annual problem" of resident graduation, suggesting that the separation can evoke grief responses in both patients and residents that can lead to maladaptive behaviors if overlooked.

Participants explained that they tolerated the drawbacks of the academic practice setting in order to take advantage of the perceived higher quality of care at the medical center, which these patients linked to the center's diagnostic and therapeutic innovations. In surveying the parents of children whose resident pediatricians were graduating and leaving their hospital-based continuity clinic, Serwint et al¹⁹ found that most parents were willing to make a similar trade-off. In particular, 96% of respondents stated that they would continue to have their children receive medical care at the current site, because they knew that the children would receive "good care" in this system.

Patients' discussions regarding age concordance were varied, and did not relate to gender or ethnic group composition. Patients most frequently asso-

ciated a physician's age with perceptions of her/his overall competence, including the ability to stay on top of medical information and to ask questions, or to admit not knowing "the answer" without the fear of being perceived negatively by patients. Medical sociologists have described uncertainty in medicine to be based on 3 factors: the limits of medical science, the limits of a physician's knowledge-base, and the ability to tell the difference between the limits of medical science and personal knowledge.^{20,21} Although most of the patients in our focus group interviews did not express a preference for PCP age-concordance, many expressed a desire for their PCP to recognize areas of uncertainty in medical knowledge, and in the PCP's own stock of knowledge, and to have the ability to distinguish the uncertainty of medicine from personal uncertainty. In these instances, patients felt that the quality of care they received at the medical center was enhanced by their ability to discuss uncertainties with physicians of varying ages, levels of enthusiasm, and experience.

The male participants in our study expressed no specific preference for gender-concordant physicians. Nonetheless, all groups of English-proficient women described patient-PCP gender concordance as desirable because they felt that female physicians would have more empathy for patients. In general, these participants perceived that female physicians, being women themselves, could better "relate" to female patients' lifestyles and experiences in the female body. In addition, these patients felt that, relative to male physicians, female physicians had a broader understanding of relevant social issues, such as child rearing, caregiving, and battering. In expressing these preferences, female patients shared the notion that an enhanced patient-provider relationship would directly contribute to improvements in the overall quality of care that they received. These results are consistent with those in previous studies,

which have shown that female and male PCPs have distinct practice and communication styles,^{9,22-27} leading some to posit that patients who prefer female physicians may be seeking a more sensitive or empathetic style of medical care.²⁷ Surprisingly, Spanish-speaking Latinas did not share these sentiments. To our knowledge, their lack of PCP-gender preference has not been previously described, and may reflect these women's prior experiences with providers, or their perception that linguistic barriers are more important.

African-American women and men, and Spanish-speaking Latino men, reported a preference for ethnic-concordant PCPs, perceiving that such concordance would lead to more empathetic and/or effective therapeutic relationships. Of note, not every participant expressed such a preference, which we would expect from previous studies, and a cursory consideration of human diversity. Nonetheless, those who did express a preference for an ethnic-concordant provider clearly linked it to the expectation or perception that they would receive higher quality medical care by enhancing their communication, and possibly their relationships, with such providers. As a dimension of care, patient-physician communication has been widely recognized and utilized as an important process measure of health-care quality in a number of studies,^{6,7,23,25,33} including the benchmark Medical Outcomes Study,³⁵ and the Commonwealth Fund's study on quality of care for minority patients.³² Ostensibly, patients felt that these more robust relationships would improve the quality of care they received.

Further, some participants expressed concern at the lack of race/ethnic- or language-concordant doctors at the medical center, while others resignedly discussed this as an unpleasant "reality" that they had come to accept. African-American participants more generally felt that African-American physicians would be less prescriptive in their pro-

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vision of care, and more able to elicit genuine communication from their patients.

These findings reflect those of prior studies from the behavioral sciences and medical literature. Research in the field of counseling psychology has provided some evidence to support the existence of client preferences, albeit not universal, for ethnically concordant counselors,²⁸⁻³⁰ and one study even linked client-therapist ethnic and linguistic concordance to the length or outcome of mental health treatment for ethnic minority patients.³¹ Recent survey findings indicate that, compared to Caucasians, Latino, Asian, and African Americans are more likely to experience problems communicating with their physicians.³² Studies of patient-physician communication demonstrate that physicians have poorer interpersonal skills³³ and are less likely to use a participatory decision-making style with non-Caucasian patients, compared to Caucasians.³⁴⁻³⁶ However, all of these studies involved predominantly White physicians. Only one previous study compared physician-patient communication in racially/ethnically concordant and discordant dyads⁵; concordance was associated with a clear perception that physicians em-

ployed a more participatory style of decision-making.

Spanish-speaking participants uniformly preferred Spanish-speaking providers, consistent with their perception of the central role of communication in the patient-physician relationship. Spanish-speaking Latinas reported that having a physician who spoke their language meant better care, irrespective of physician race/ethnicity. Spanish-speaking Latinos, however, believed that both ethnic and linguistic concordance contributed to good quality, empathetic care. Perceptions of illness and responses to it vary by race/ethnicity³⁷⁻³⁹ and culture,⁴⁰ and possibly ethnically concordant physicians seem more empathetic due to their greater sensitivity to these variations. Unfortunately, we were unable to convene additional focus groups to confirm or refute this unexpected difference between Spanish-speaking men and women. Our findings suggest that acculturation has a significant effect on the views of Latino patients, as English-proficient Latinos were more likely than African Americans or Spanish-speaking patients to express the same sentiments as Caucasians on the relevance of ethnic concordance and the risks of experimentation at the medical center. This finding is consistent with previous survey research demonstrating significant differences between the healthcare experiences of English-speaking and Spanish-speaking Latinos, as well as between English-speaking and non-English-speaking Asian Americans.⁴¹

Our qualitative study has 2 important limitations. First, the data represent a survey of attitudes and beliefs that may or may not correlate with the focus group participants' actual actions and behaviors. Therefore, in establishing or maintaining patient-PCP relationships, participants may actually behave in ways that would not be predicted by their statements regarding certain physician characteristics. Second, the participants clearly are not representative of all patients, nor of patients seen at the aca-

demical medical center where this study was conducted. As such, our results may not generalize to other groups of patients or to other clinical settings. These limitations highlight the need for additional studies, using both qualitative and quantitative methods, to validate and extend our findings.

Nonetheless, this examination of patients' preferences for demographically concordant PCPs provides new insights into the complexity of the patient-PCP dynamic by demonstrating how these preferences can influence patients' quality of care perceptions. Attention to patient preferences for demographic concordance with their PCPs may improve patient-physician communication, and have the potential to strengthen the therapeutic relationship. This, in turn, may lead to improvements in health outcomes, particularly for women, African Americans, and Spanish-speaking Latino patients.

Although our study does not directly link patient preferences for demographically concordant PCPs to outcomes or processes of care, our findings do bring us a step closer to understanding how diverse communities of patients perceive their relationships with their PCPs and the impact these relationships have on the quality of care these patients receive. In particular, we found that some patients expressed clear preferences for gender- and/or ethnically concordant PCPs, whom they felt could offer better healthcare quality, relative to demographically discordant providers. If confirmed, these findings have potential policy implications. For example, healthcare systems may respond to consumer preferences by hiring providers who match the demographic composition of the communities they serve. In turn, medical school and residency training programs might face increasing pressures to train a physician workforce that more closely matches the gender and ethnic distribution of the US population.

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AUTHOR CONTRIBUTIONS

Design and concept of study: García, Paterniti, Romano

Acquisition of data: García, Kravitz

Data analysis and interpretation: García, Paterniti, Kravitz

Manuscript draft: García, Paterniti, Romano

Acquisition of funding: García, Romano, Kravitz

Administrative, technical, or material assistance: García, Paterniti, Kravitz

Supervision: García, Paterniti