Capsule Commentary on Saha et al., Impact of Physician Race on Patient Decision-making and Ratings of Physicians

Avik Chatterjee, MD, MPH

Boston Health Care of the Homeless Program, Boston University School of Medicine, Boston, MA, USA.

J Gen Intern Med 35(4):1361

DOI: 10.1007/s11606-020-05738-w

© Society of General Internal Medicine 2020

Do we need a more diverse workforce to achieve health equity, or can physicians who communicate well, regardless of their race, provide high-quality care to all patients? Saha and colleagues examined the impact of physician-patient race concordance on ratings of physician communication and on patient decision-making.¹ Participants viewed video vignettes with an actor-physician reviewing cardiac catheterization results and recommending coronary artery bypass graft (CABG). The vignettes varied by actor race and communication style (high or low patient-centeredness, PCC).

White participants rated all physicians equally, but Black participants rated Black physicians as better than White physicians on all attribute scales. Results were similar for the decision to undergo CABG. Physician communication style moderated these differences; however, “the ratings of white physicians with a high PCC style were similar to the ratings of African-American physicians with a low PCC style.”

The encouraging news from this study is that teaching physicians to communicate better can somewhat improve patient interactions, even in the absence of a workforce that resembles our patients. The more difficult message from this study is that diversification of the health care workforce will be necessary to optimize physician-patient interactions with patients of color, and by extension, amelioration of health inequities. Given that fewer Black men entered medical school in 2014 than in 1978,² relying on the status quo or on minor changes in current recruitment strategies is unlikely to be successful.

Fortunately, a few pioneers have demonstrated strategies that may be helpful in diversifying the workforce. Quinn Capers and colleagues at Ohio State College of Medicine demonstrated that having medical school interviewers take the Implicit Attitudes Test, a measure of implicit bias, and debriefing interviewers on their scores resulted in a more diverse class of admitted students.³ Even more ambitiously, the University of New Mexico Health Sciences Center has created pipeline programs from middle school through the post-baccalaureate period to improve student, trainee, and faculty diversity with specific numerical, time-based goals.⁴ We desperately need creative, ambitious programs like these to attract a diverse, effective physician workforce capable of bridging the health equity chasm in the USA.

Corresponding Author: Avik Chatterjee, MD, MPH; Boston Health Care of the Homeless Program Boston University School of Medicine, Boston, MA 02118, USA (e-mail: Avc031@mail.harvard.edu).

Compliance with Ethical Standards:

Conflict of Interest: The author has no conflict of interest with this article.

REFERENCES

1. Saha S, Beach MC. Impact of physician race on patient decision-making and ratings of physicians. J Gen Intern Med. <https://doi.org/10.1007/s11606-020-05646-z>
2. Jacob JA. AAMC report examines how to increase the pipeline of black men entering medical school. JAMA - J Am Med Assoc. 2015;314(21):2222-2224. <https://doi.org/10.1001/jama.2015.12005>
3. Capers Q, Clinchot D, McDougle L, Greenwald A. Implicit Racial Bias in Medical School Admissions. Acad Med. 2016. <https://doi.org/10.1097/ACM.0000000000001388>
4. Kaufman A, Roth PB, Larson RS, et al. Vision 2020 measures University of New Mexico's success by health of its state. Am J Prev Med. 2015. <https://doi.org/10.1016/j.amepre.2014.08.001>

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.