Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Practice Patterns of Minority Physicians

To the Editor:

The admission of minority students to medical school through special admission programs continues to be a controversial subject, as demonstrated by the article by Klea Bertakis, "Does Race Have an Influence on Patients' Feelings Toward Physicians?" *(J Fam Pract 13:383, 1981)*.

In the introduction, Bertakis states that the rationale for affirmative action programs is based on two hypotheses: that minority physicians are more likely to practice in minority health-care provider shortage areas, and that minority physicians can provide better services to minority patients because of similarities in cultural backgrounds. An attempt was made to disprove the first hypothesis by citing references and the second by citing data from her study. A close look reveals she was unsuccessful in each case.

Two statements are made in the introduction insinuating that black physicians do not locate practices in minority health-care provider shortage areas. ". . . it appears that they selectively go to those areas where the median income of black families is relatively high. . . ." The reference cited quotes no data to support such a statement and cites four references, three of which are from 1962 or earlier, prior to Medicaid/Medicare.[1] The pertinence of such a reference to black physician practice site selection in this day and age is open to serious question.

". . . they tend to avoid metropolitan city ghettos." The reference cited here makes this claim simply because Chicago's black physician-population ratio is 12 percent below the national average and because 15 percent of the graduates of Howard and Meharry practice in California.[2] That appears weak, at best.

Currently there simply are no good data on the location of practices of minority physicians. It has been shown, however, that recent minority dental school graduates do serve minority patients to a greater degree than do other graduates and do tend to locate their practices close to, or in, health care provider shortage areas.[3] This study was quoted, but not in regard to this issue.

The design of the study contains several serious flaws. The patient population studied was from a clinic with an ethnically and racially mixed group of physicians. Patients who felt more comfortable receiving health care from a physician group more uniform in cultural-ethnic background would have self-selected out of the study by going elsewhere.

The validity of a questionnaire to elicit physician preferences based on race has to be seriously questioned. It seems likely that few people would openly admit to an interviewer their racial or ethnic preferences in physicians, if such preferences existed. Data from the study suggest such an underreporting. While 90 percent of white patients stated they did not prefer a physician of their own race, only 62 percent felt that minority physicians were as well trained as non-minorities. This suggests a racial preference that patients are unwilling to admit upon direct questioning.

The validity of the questionnaire can also be challenged by statistics such as 97.5 to 100 percent being satisfied with their last visit, 95 to 100 percent feeling the physician listened to what they had to say, and 92 to 100 percent feeling the physician understood what they had to say.

Finally, the rationale for minority admissions to medical school go well beyond the two stated by the author. Other reasons include equalizing opportunity for minority youth, correcting past discrimination in medical school admissions, providing role models for the minority community, and eliminating stereotyping and racism within medical education. Certainly it would be ideal to place more emphasis on "interactional qualities and skills that transcend race or ethnicity." Too often, however, such qualities are defined by the majority and are often subtly discriminatory. Only 12 years ago admissions criteria selected for qualities that were considered to be independent of race, and the result was a 2.4 percent en-

Continued on page 232

Continued from page 229

rollment of minority medical students in US schools.[4] One can only hope that the author is not advocating a return to such a system.

Doug Campos-Outcalt, MD
Sacramento, California

References

1. Gray LC: The geographic and functional distribution of black physicians. Am J Public Health 67:519, 1977
2. DeVise P: Physician migration from inland to coastal states: Antipodal examples of Illinois and California. J Med Ed 48:141, 1973
3. Montoya R, Hayes-Bautista D, Gonzales L, et al: Minority dental school graduates: Do they serve minority communities? Am J Public Health 68:1017, 1978
4. Alexis CP: After Bakke, what? JAMA 240:831, 1978

To the Editor:

The data presented in Dr. Bertakis' article, "Does Race Have an Influence on Patients' Feelings Toward Physicians?" *(J Fam Pract 13:383, 1981),* shows only that patients who have made appointments to see a particular physician have positive feelings about that physician. Patients who might have been dissatisfied with the physicians at the clinic because of racial or other factors were excluded from the study. The dissatisfied patients would be less likely to have made a clinic appiontment and to have been available for an interview. For the study to have any validity, people who came to the clinic and failed to return or who switched providers would have to be interviewed.

The study reports no difference in the distribution of patients of different ethnic groups to the three providers. The article does not state which statistical method was used to decide that there was no significant difference between the physicians' panels of patients. The article does not report the size of the clinic population from which the sample was drawn. Sixty-six, nonrandomly selected members of a large population may not provide sufficient evidence to draw any valid conclusions about the hypothesis that ethnic minority patients are more satisfied when served by physicians of their own race.

This study attempts to support the anti-affirmative-action myth that there is no evidence that minority physicians address better than white physicians the health-care needs of underserved communities. Dr. Strelnick and I have discussed this and other anti-affirmative-action myths in a recent monograph.[1] Minority physicians do serve minority communities. White providers tend to establish practices among their ethnic group of origin and away from low-income minority populations.[2] Black physicians are more likely than white physicians to enter primary care specialities.[3] Minority physicians tend to locate their practices in areas which are accessible to low-income patients.[4] Graduates of Howard and Meharry Medical School work in municipal hospitals serving low-income populations more frequently than do other physicians.[5] The survey of black dental graduates Dr. Bertakis cited, but failed to mention the results, revealed that 85 percent of black dental graduates in California had practices that were more than 50 percent minority. Eighty percent of the black dental graduates in Los Angeles and Alameda counties were located in or adjacent to federal manpower shortage areas.[2]

The survey presented in this article does not support the conclusion that more attention should be given to interactional qualities than to race or ethnicity in order to se-

Continued on page 234

Continued from page 232

lect applicants with the greatest potential to serve patients. Patients *may not* consider the race of a physician important. This is a moot point if there are no physicians in their neighborhood. The fact that only 62 percent of whites vs 80 percent of blacks agreed that minority physicians are as skilled as nonminority physicians suggests that race *is* important to about one third of the white patients.

I am a black, board-certified family physician. I work in an urban National Health Service Corps practice that is 99 percent black or hispanic. Most of the physicians who serve in and around this neighborhood are minority physicians. Family medicine has much to offer in areas where there is such a need for primary care. Further efforts are needed to increase the number of underrepresented minority physicians who play a critical role providing primary care in underserved communities.

Richard G. Younge, MD, MPH
The Council's Center for Problems of Living
New York, New York

References

1. Strelnick AH, Younge RG: Double Indemnity: The Poverty and Mythology of Affirmative Action in the Health Professional Schools. New York, Health Policy Advisory Center, 1980
2. Montoya R, Hayes-Bautista D, Gonzales L, Smeloff E: Minority dental school graduates: Do they serve minority communities? Am J Public Health 68:1017, 1978
3. A manpower policy for primary care: Report of a study. Washington, DC, Institute of Medicine: National Academy of Sciences, May 1978
4. Lloyd SM, Johnson DG, Mann M: Survey of graduates of a traditionally black college of medicine. J Med Educ 53: 640, 1978
5. Koleda M, Craig J: Minority physician practice patterns and access to health care services, looking ahead. Natl Plann Assoc 2:1, 1976