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Exploring the Provider Preferences of Multiracial Patients

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Abstract

Background: Patient–provider race concordance has been argued as one way to improve patient–provider communication, patient satisfaction, and even patient outcomes. However, much of this literature focuses on or assumes that both patients and providers identify with only one race. **Objective:** The purpose of this study was to understand multiracial patients' preferences in choosing a health-care provider. **Methods:** We conducted 15 interviews and 3 focus groups. We performed a directed content analysis to understand participants' expressed preferences. **Results:** Thirty-one participants shared their health-care preferences. Participants described proximity to their homes or work, convenience in terms of availability, and health insurance coverage as reasons for selecting a provider. The majority articulated preferences related to provider gender and race. However, participants noted key barriers to receiving care from their preferred providers. **Conclusion:** This study highlights the preferences for health-care providers and the factors influencing those preferences and decisions among multiracial individuals. Findings illustrate the need to increase health workforce diversity, especially among primary care providers. Findings also show the need for increased empathy and cultural sensitivity among health-care professionals.

Keywords

patient–provider interaction, minority health, healthcare disparities, culturally competent care

Introduction

Research has suggested that race concordance, occurring when the provider and patient are of the same racial or ethnic background, may improve patient–provider communication, patient satisfaction, and even patient outcomes (1,2). For example, Chen and colleagues found that experiences with racial discrimination in health-care settings influenced preference for providers of the same race, especially among African Americans and Latinos (3). Furthermore, they found that when racial concordance was present, patients tended to rate their satisfaction with the providers higher than patients who did not have a provider of the same race.

Studies have also found that cultural competence among providers may be more important than race concordance in improving patient satisfaction and outcomes. Cultural competency can be defined as the "ongoing capacity of health care systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable (4, p2)." In a study focused on the experiences of older adults from various racial and ethnic backgrounds, Phillips and colleagues found that perceived interpersonal sensitivity—one aspect of cultural competence—of the provider influenced satisfaction with care more than racial concordance (5). Another concept often discussed in health care is the notion of cultural humility which centers self-evaluation, critique, and efforts to address power imbalances in patient–provider relationships to provide more patient- and community-centered care (6). Cultural humility challenges the notion that providers can achieve a specified level of competence in cultural knowledge or interactions and pushes the provider to be a learner instead of seeking some level of expertise. Furthermore, Hoskins identified the concept of cultural attunement which aligns with the concept of cultural humility and also moves beyond the notion of competency as some achieved end, seeing attunement as an ongoing relational process (7). Importantly, the concept of cultural attunement requires providers to acknowledge the experiences and implications of racism and oppression in

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patients' lives. Cultural attunement, like humility, pushes providers to embrace the capacity to not know and set aside their own assumptions and worldviews to understand the experiences and perspectives of their patients.

However, much of the literature on racial concordance and cultural competency focuses on or assumes that both patients and providers identify with only one race. Given the increasingly complex multiracial society in America, where individuals identifying with 2 or more races are among the fastest growing population, a more complex understanding of what multiracial patients look for in a provider is needed (8,9). According to the United States 2010 Census, the multiracial population is the fastest growing racial category, increasing by nearly a third between 2000 to 2010 (8). Furthermore, a recent Pew Center report indicated that 6.9% of US population is multiracial (9). This study employs qualitative methods to explore multiracial patients' preferences in providers in an effort to bring about a more nuanced understanding of racial concordance and cultural competency in health-care interactions.

Method

This article presents a secondary analysis of a qualitative research study designed to explore the racialized experience of multiracial people and families in health-care settings. While a more detailed description of the recruitment and data collection process are documented elsewhere (10), here we provide a brief overview of the data collection and analyses processes.

Participants were recruited using a combination of purposive and snowball sampling (11). A total of 31 individuals participated in either an individual interview or a web-based focus group. Ninety-four percent of participants identified with more than one racial category, and 81% identified as female. Participants were eligible if they met the following 2 criteria: (1) self-identified with more than one race or they self-identified as a member of an interracial family relationship; (2) they or someone they considered to be part of their family had received health care in the past 12 months. We recruited participants until we reached thematic saturation, meaning until the research team saw no further unique patterns or themes emerging from the data (12,13). We began each interview or focus group by asking participants to share their experiences using health-care services. From there, we asked participants to share their perspectives about the role of race in their health-care interactions, their preferences in providers and where they sought care, and how they felt being a multiracial person or a member of a multiracial family shaped their experiences and preferences.

We analyzed data using an inductive grounded theory approach, identifying themes that emerged from the interviews and focus groups (14,15). To ensure the research was conducted and analyzed in a rigorous way, analysis followed an interpretive, multiphased approach (16). The research team reviewed participant responses and developed an initial coding schema. Through an iterative process, the research team added, refined, and defined codes. We employed a content analysis to identify instances where participants described preferences about physician selection, patient–provider communication, and suggestions for improving care (17,18). Themes were generated using the constant comparative approach, comparing relationships between codes (19,20).

We imported deidentified participant responses into Dedoose, a computer assistive qualitative analysis software (21). Two researchers applied these codes to each participant response independently. We compared our coding application, identifying similarities and differences. We communicated regularly about the codes and coding applications. We reconciled our discrepancies through consensus and consulted with our Stakeholder and Patient Advisory Group, consisting of patients, clinicians, and scholars, about emerging themes.

Results

Participants described proximity to their homes or work, convenience in terms of hours of availability, and coverage by their health-care insurance as the primary reasons for selecting their providers. In terms of preferences for providers, 3 themes emerged: (1) preferring a provider who was a woman of color, (2) the importance of empathy and cultural sensitivity, and (3) factors that influenced their preferences and choices.

We use the terms "people of color" or "person of color" throughout this article in an attempt to be inclusive and illustrate the collective experience of systemic racial and ethnic marginalization. We acknowledge that not all people of color individually experience this marginalization in similar ways, and individuals who identify as people of color may have phenotypical characteristics that are associated with being white. However, Vidal-Ortiz notes (22), the term "People of color is, however it is viewed, a political term, but it is also a term that allows for a more complex set of identity for the individual—a relational one that is in constant flux." Given this description, the term is useful in the context of this study for both people who identify as multiracial and those who identify as monoracial as it allows for the fluidity of identity and experiences.

Preference for Women of Color Providers

The participants, the majority of whom identified as multiracial and female, described a preference for women providers of color. Participants noted key barriers to receiving care from their preferred providers, namely, issues related to access. Participants noted that women providers of color were underrepresented and often did not practice in locations conveniently located or at clinics covered by their health insurance.

Participants noted seeking out women of color providers because they felt a sense of comfort and relatability. As one participant noted, "Ideally they [provider] would be a woman and a person of color because that would make me feel more comfortable." Another participant spoke about their past experience with providers and how that informed their decisions:

> I pretty much exclusively had female doctors. I feel that female doctors tend to be more open minded than male doctors. I feel that when I have a male doctor they tend to be very—they don't listen as well. It's hard to find a woman of color doctor, but if I can, that's something that I will look for, or a LGBT doctor. I mean, there's like three trans doctors in the world.

Participants also noted they specifically sought out women of color providers in an effort to support women of color in health-care professions, who also served as role models for their children. As one interviewee noted:

> When we first moved to Oregon, we were selective with our choices and hoped that the one Black pediatrician in the community would be our main doctor. We had dreams of both of our girls growing up with a woman of color role model.

Another interviewee shared their desire for providers to understand their racial identity, but also placed great value on supporting other women of color.

> Of course, I want a provider who will understand and respect my Mixed identity, but I actually consider the provider's race more than my own because I want to support women of color doctors.

Provider Empathy and Sensitivity

While participants as a group expressed a preference for women providers of color, for most, the reason for this selection was the desire for a provider who was culturally sensitive and could empathize with their experiences as a person of color. Participants described wanting providers who could relate and connect to their experience, who recognized how health disparities impact people of color, and who actively engaged them and their families in their health and health care. One interviewee noted:

> Definitely, I do target more providers that have an Asian background. So, it's regardless whether they're Chinese or Japanese or Thai. As long as they're Asian, I feel like there's some sort of cultural overlap that I don't need to quite say out loud or in terms of mannerisms, I don't have to code switch. So, it just feels more familiar to me.

Another interviewee discussed the importance of having a provider that understood issues that disproportionality impact certain racial and ethnic groups. They noted, "I may choose someone who understands common health problems Japanese people have and that take my concerns seriously."

Although most participants did not speak about seeking out a multiracial provider explicitly, they did discuss how their own racial identity as a person of color shaped their desires to also see a provider of color. As one participant described:

> As my mixed-race identity is so salient for who I am, I tend to gravitate towards ethnic racial minority health care providers - though I have to be honest - I rarely come across them.

Other interviewees highlighted the desire for providers who had experience and were comfortable working with people of color, regardless of the providers' race. For example, one participant clarified that:

> It plays into my decision in that I want to choose a provider who has experience working with people of many backgrounds. I look for someone who will not be discriminatory, but I don't seek out any particular race.

One participant summarized their ideal provider as someone who "[. . .] is willing to take time to really listen, to get to know us better, to think about, you know, more than just what our numbers are, but how we're doing in a bigger, holistic sense."

Barriers and Facilitators of Choice

Most participants acknowledged how their personal circumstances, home location, and health insurance influenced their flexibility and choice in providers. Some aspects, such as insurance, could be both a facilitator and a barrier. For example, one participant described how her experience choosing providers has changed with her income and insurance coverage:

> I think part of that is also my insurance. I now have the flexibility to fire my doctors if I don't like them and go somewhere else. And for the majority of my life, that was an option. I could go where the insurance would pay and they had availability . . . I think that having a good job with quality healthcare insurance has made it much easier for—it feels like a luxury. I really am able to choose who I want my providers to be. I can go to an acupuncturist or I can go to my primary care physician. I just have more choices, and, in my life, that came with money.

Another interviewee also noted the impact of insurance and cost on choice:

> Insurance is obviously pretty high up there, what's covered and what's not covered. . . . You can pick a cheaper plan where the number of folks you can go to is substantially more limited or you can pay more to have more flexibility. And after a year or two on the pretty limited plan, it was worth it for me to pay a little bit more to have more flexibility.

Interviewees also discussed how their home location shaped their access to providers, with some noting they sought services outside of their network or far from home to be able to see a provider of color. As one interviewee shared:

> I am still using my OBGYN in New Orleans because I do not want to deal with going to a doctor in a predominantly white area (Boulder, Colorado). I feel that as a biracial person, it is

more readily accepted in the South than it is in other places because there are higher numbers of non-white groups—or at least that's how it feels.

Discussion

This study highlights the preferences for health-care providers, as well as salient factors that influence those preferences and decisions, among multiracial individuals. While participants described a preference for women of color providers and culturally sensitive providers, more broadly, patients also desired attentive care that was sensitive to their experiences as racialized beings. Participants discussed barriers in being able to choose providers that met their preferences, namely a dearth of providers of color, especially women of color.

Findings highlight the need to increase the racial and ethnic diversity of the health workforce to reflect and better meet the needs of the increasingly diverse US population, particularly among primary care providers. Research has documented that health-care professionals of color can help improve patient trust and satisfaction, which can in turn influence adherence to medication, preventative care, and other health behaviors (1,2). Yet, studies continue to find that people of color remain underrepresented in the higher level clinician roles (eg, physicians, physician assistants, nurse practitioners) (23), and it is often difficult for patients to select a provider who is a person of color. This was evidenced in interviewee experiences, as they often had difficulty finding providers of color for themselves or their family members. While not all people of color desire to see a health-care provider who is also a person of color, it is imperative that patients have a diverse range of providers from which to choose.

Findings also highlight the need for increased empathy and cultural attunement among health-care professionals, regardless of race. Given the barriers that limit a patient's ability to choose their ideal provider, it is imperative that health-care providers, regardless of race or where they practice, have a level of cultural sensitivity in working with patients of color, especially multiracial individuals and families. Jackson and Samuels developed the culturally attuned model of care for multiracial individuals (24). They highlight the importance of challenging traditional discourses of race and culture when working with multiracial individuals and families, positing that, "Being culturally attuned also requires practice wisdom that draws from the client and family system's unique racial and cultural experience while also using an empirically, historically, and professionally derived knowledge base." Although their model is focused primarily on social work settings, it holds relevance to many areas of health care and is particularly relevant to providing patient- and family-centered care and implementing efforts to address racial bias and discrimination in health-care settings.

Limitations

There are a few limitations to acknowledge in this study. First, the majority of our sample identified as college-educated women. This limitation could have constrained the range and types of preferences and choices influenced by education, gender, and age. Second, this was a self-selected sample and some of the participants had education or interest in multiracial studies or public health, thus potentially having more advanced understanding of the health-care system and the complexity of racial identity. The strength of this study is its internal validity, yielding consistency of themes emerging within and across interviews and focus groups. Furthermore, external validity is supported in that many of the themes that emerged reflected previous research findings on patients' racialized experiences with health care, as well as literature on the experiences of multiracial people and families (3,25–28). As this study was exploratory, it was not meant to be representative of the full diversity of the multiracial patient population yet illuminates opportunities for improving systems to better provide culturally responsive patient- and family-centered care. Finally, there is still much research to be done in the field connecting patient outcomes to provider characteristics. This study lays the groundwork for future, larger scale work connecting patient experiences, provider characteristics, and patient outcomes.

Conclusion

The factors that patients find important when selecting a primary care provider are influenced by a number of variables including access, communication, cultural responsiveness, and provider race. Of salience in this study was the importance of having the option to see a provider who is also a person of color, as well as the ability of providers to be adept and sensitive when working with people of color. The ability to deliver care that is culturally attuned is of particular importance when working with multiracial patients and families, where race and racism play complex roles in lived experiences and interactions with the health-care system.

Authors' Note

This study received an exempt determination from the University of Washington. No personal identifiers have been included.

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