



In the Literature

PATIENTS' ATTITUDES TOWARD HEALTH CARE PROVIDERS COLLECTING INFORMATION ABOUT THEIR RACE AND ETHNICITY

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Efforts to address racial and ethnic disparities in health care face a major hurdle: accurately collecting data on patients' race, ethnicity, and preferred language, which are crucial in designing and implementing disparity-reduction programs. Providers are often reluctant to risk alienating patients by collecting this potentially sensitive information. Some patients, meanwhile, have concerns about why such information is needed.

Is there an acceptable way to ask patients about race and ethnicity that manages to avoid eliciting concern?

According to a new Commonwealth Fund-supported study, "[Patients' Attitudes Toward Health Care Providers Collecting Information About Their Race and Identity](#)," (*Journal of General Internal Medicine*, October 2005), there are indeed right and wrong ways to ask. While most patients interviewed agreed that hospitals and clinics should document the racial and ethnic makeup of their patient populations, there were clear variations in participants' comfort. Levels were highest when patients were told that the information would be used to monitor and ensure equal quality of care for all.

Methods

The researchers, led by David W. Baker, M.D., M.P.H., of the Northwestern University Feinberg School of Medicine, conducted the study in the General Internal Medicine clinic of Northwestern University. The clinic does not routinely collect information on patients' race and ethnicity. A total of 220 white, black, Hispanic,

Asian, multiracial, and other patients were interviewed as they exited the clinic about their attitudes and concerns around the collection of race and ethnicity data.

Results

Fully 80 percent of participants agreed that it is important for health care providers to collect and track information on patients' race and ethnicity. While 28 percent expressed significant discomfort disclosing their own information to a clerk or administrator, many of these respondents said they would feel more comfortable providing the information to a nurse or a doctor.

Comfort levels were significantly lower for blacks than for whites, and blacks were more likely than whites to express concern that the information would be used to discriminate against patients. Further, compared with whites, blacks and Hispanics more often said that they would be somewhat or much less likely to go to a hospital or clinic that routinely collected this information (19% and 26%, respectively, compared with 7% for whites).

Patients were then read four different rationales for collecting this information: to monitor and assure quality of care for all patients (Quality Monitoring); to abide by government recommendations (Government Recommendation); to ensure appropriate hiring and training of medical personnel (Needs Assessment); or to monitor and assure quality of care for the individual patient (Personal Gain).

The Quality Monitoring statement had the most positive impact on patients' comfort

levels. For the 112 participants (51%) who expressed any level of discomfort reporting their race and ethnicity, this reason for collecting such data brought about the most significant improvement in comfort: 25 percent said that it made them somewhat more comfortable, and 26 percent said it made them much more comfortable. For nonwhite participants, the Government Recommendation rationale actually reduced comfort levels, possibly because this message implies the information is not useful to health care providers themselves in improving quality of care. Respondents also were less comfortable with the Needs Assessment rationale, which, the authors speculate, might be because of concerns that staff would be trained in racial stereotyping. Patients also did not respond positively to the Personal Gain statement, prompting the researchers to surmise that this statement may have sounded like a promise the provider could not fulfill.

Policy Implications

Collecting information on patients' race and ethnicity is a necessary first step toward eliminating disparities in quality of care. While a large majority of patients support the policy, some may experience discomfort when asked for this information, and their attitudes could discourage some providers from collecting it. The researchers say these issues can be addressed by clearly explaining to patients and community leaders the reasons for

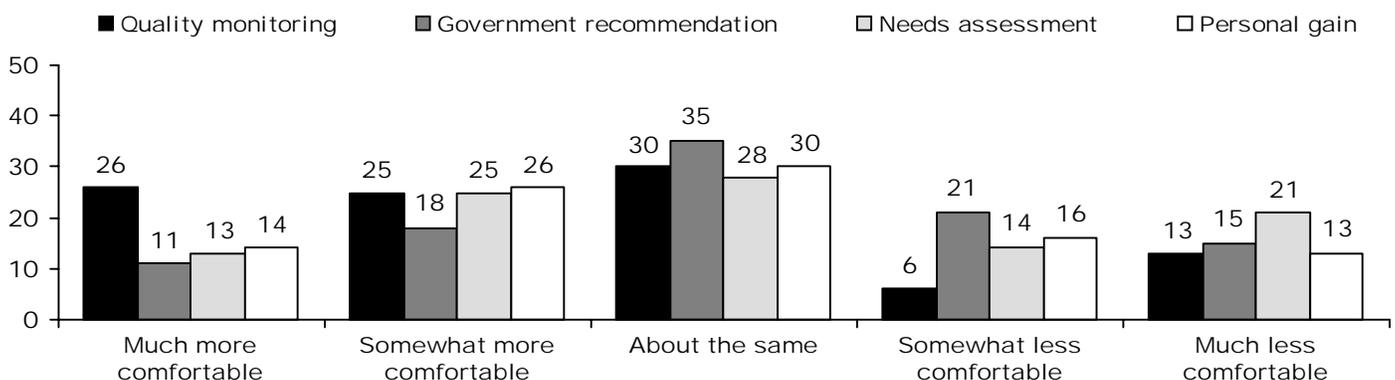
gathering these data, and by seeking their input about how best to do it. Most importantly, providers that collect such information must use the information to examine and address disparities, and then share the results with patients and communities, the authors say.

Facts and Figures

- Among those clinic patients who were not fully comfortable giving race and ethnicity information to a clerk, some said they would feel more comfortable if they were asked this question by a nurse (42%) or doctor (54%).
- Despite relatively high levels of comfort about providing race and ethnicity information, over half of participants were somewhat concerned (20%) or very concerned (31%) that this information could be used to discriminate against patients.
- A total of 8 percent said they would be more likely to go to a hospital or clinic that routinely collected information about race and ethnicity; 14 percent said they would be less likely to go.

Change in Comfort Level in Reporting Race and Ethnicity to Provider

Percent change in patients' comfort level after hearing four rationales for collecting information



Notes: The data shown are for the 112 patients who said they were not completely comfortable giving race/ethnicity information at baseline (i.e., comfort level <10). P<.001, P=.03, and P=.05 in pairwise comparisons of Statement 1 to Statements 2, 3, and 4, respectively.

Source: D. W. Baker et al., "Patients' Attitudes Toward Health Care Providers Collecting Information About Their Race and Ethnicity," *Journal of General Internal Medicine*, October 2005 20(10):895-900.