

IN THE LITERATURE

Disentangling Evidence and Preference in Patient-Clinician Concordance Discussions

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Abstract

Debate about whether and when to accommodate patient requests for concordant clinicians should consider evidence. This article examines how existing evidence could be used to interpret or inform ethical arguments about whether to accommodate such requests. Studies on patient-clinician concordance yield mixed and inconclusive results. Concordance might contribute to increased patient satisfaction and trust, but these results are not consistent and could be the result of clinicians' communication skills. Given this evidence and the risk of social harm in honoring concordance requests, this article argues that patients' concordance requests should be honored only when health care services would be denied to a patient, such as in a case of a clinician's conscientious objection to providing a service. All other requests should be scrutinized for a reasonable ethical justification.

Concordance Requests

In this article, we review evidence about patient-clinician concordance—that is, shared characteristics like gender, race, or socioeconomic status—and discuss how it bears on the debate about whether to accommodate patients' requests for clinicians with specific characteristics. Patients may request a clinician with a specific characteristic for a variety of reasons, including personal preference, [religious values](#), or assumptions about who provides the best care. Some might argue that patients, as the vulnerable party, ought to have their requests accommodated but draw a line when preferences are based on socially unacceptable reasons grounded in prejudice, sexism, or racism.

To approach these ethically tricky questions, we examine evidence of the effects of patient-clinician concordance and whether it justifies accommodation. While the evidence does not resolve the ethical questions about when or why to accommodate patient requests, it can help distinguish types of cases and limit the kinds of arguments to accept to support accommodation. We start with 2 counterfactual evidence scenarios and describe commitments that would follow. Next, we discuss evidence of the effects of patient-clinician concordance, which suggests that reasons to accommodate a patient's request for a clinician with a specific trait are limited. Finally, we examine cases

in which a lack of concordance might imply that health care services would be denied to a patient. Such cases arise when patients and clinicians hold different views about what constitutes health care. We suggest a reasonableness requirement for assessing patients' concordance requests, a higher standard than mere preference.

Accommodating Concordance Requests

We begin by proposing 2 hypothetical cases about evidence for concordance.

First, suppose there is strong evidence demonstrating that patient-clinician concordance directly improves patient outcomes. We could improve health simply by matching patients to clinicians who are "like them." Patient requests for concordant clinicians would be justified as choices for more effective care. We could even go so far as to argue that there is a moral obligation to arrange concordance since to not do so would deny patients an effective intervention.

In this first hypothetical case, there could be negative consequences of intentionally arranging concordance despite its appearing justified. It would stretch the health system past capacity because there are not enough clinicians of a certain race or ethnicity (hereafter, "race") and **gender**, like black male physicians.¹ Instead of reducing health disparities between social and racial groups, in this scenario it would exacerbate them due to the lack of minority clinicians. Classifying patients by characteristics they are seeking in clinicians could also lead to increased stereotyping, social segregation, and xenophobia—intrinsically harmful social outcomes. Patients could be stratified into groups that reinforce separate but equal treatment, a harmful social paradigm (albeit one not eliminated in our own day). Another possible outcome of purposeful concordance is that it could reinforce negative patient views of clinicians as biased, views borne of social and political inequities manifest in black patients historically not being treated by white physicians.² Even given the putative clinical benefits of concordance, such deleterious social consequences would argue against it.

In the second hypothetical case, suppose there is strong evidence that patient-clinician concordance has *no* effect on patient care or outcomes. In this case, accommodating patient requests for a concordant clinician would not benefit patients. Since there would not be a medical reason for concordance, the justification would rest on the value of respecting patient preferences and choice. The importance of this case is to illustrate that if there is no evidence of effects of concordance, the possible justifications for accommodation narrow.

The medical system allows patients to make many choices based on their preferences, but requesting clinicians based on their identity characteristics is different since it is founded on personal, not professional, characteristics and can harm clinicians by exposing them to **discrimination**. (We acknowledge that personal and professional characteristics are often closely bound up since the exercise of a profession is not a

“view from nowhere”³ but of necessity subjective. We adopt this division, however, as a first approximation. For example, a clinician who is white and foreign born—both personal characteristics—may prescribe antibiotics less frequently because of her Dutch medical training, a professional characteristic.⁴) If there were no evidence demonstrating effects of concordance, patient requests would need to be scrutinized because of the potential harm to clinicians.

Concordance and Health Outcomes

The challenge is that the evidence of the effects of concordance lies somewhere between these 2 hypothetical cases, perhaps closer to the second: it is inconclusive whether concordance improves health outcomes. Few studies have shown any direct correlation between these 2 variables. The exception is evidence of better outcomes with [language concordance](#) between non-English-speaking pairs,⁵⁻⁸ although other studies discussed below have reported effects of concordance.

One argument for concordance is grounded in evidence that racial minorities receive worse quality care than their white counterparts²; concordance requests could be justified by a motivation to try to remedy this disparity. However, evidence is mixed on whether concordance alone will reduce health care disparities. Some studies found no relationship between racial concordance and improved outcomes, communication, or patient satisfaction.⁹⁻¹¹ Other studies found that both quality and type of treatment and communication are influenced not (or not strongly) by concordance but by patients’ or clinicians’ race or gender.^{10,12-17} Conversely, 2 studies have reported that racially concordant patient-clinician pairs are associated with increased medication adherence^{8,18}—presumably linked to better patient outcomes—and another study reported an association between concordance and reduced cardiovascular events.¹⁹ It is worth noting that all 3 of these studies examined racial concordance for black patients, with 2 of the studies including samples of Hispanic and Asian patients.^{8,18}

More consistently, studies have reported that patients were more satisfied with communication and their visits and had greater trust in their clinicians when they saw either racially or socially (gender-, education-, or age-) concordant clinicians.^{14,20-23} It seems reasonable to conclude that patients who have positive health care experiences and trust their clinicians will adhere to recommendations.²⁴ It could also be the case that clinicians similar to patients in some respects make patients feel more justified in reporting their experience, thereby mitigating epistemic injustice that occurs if patients are not believed because of their race or gender, for example.^{25,26} However, here, too, the concordance evidence is mixed, since other studies have shown that it is not racial concordance but the clinicians’ interpersonal and patient-centered communication that affects satisfaction and trust.^{10,27-29} The evidence thus cuts 2 ways: concordant clinicians may increase patients’ trust and positive feelings about the health care encounter, but clinicians who are well trained in communication and cultural competency can also cultivate patient trust.

Without clear-cut evidence of health benefits of concordance, the reasons to accommodate a patient's request for a certain type of clinician are limited. Although evidence about effects of certain shared characteristics is inconclusive, each patient-clinician relationship is unique, shaped by many preferences and values. In the next section, we examine the acceptability of accommodating some preferences through 2 examples. These examples form the basis of our argument that accommodating patient preferences for concordant clinicians should be dependent on reasonable justifications.

A Case for Accommodation, Sometimes

In this section, we examine 2 situations in which patient requests are motivated by evidence-based reasoning about outcomes and values. One leads to an absurd and unacceptable conclusion, and the other provides a reasonable justification for accommodation and concordance. Consider: several studies have found that, compared to male clinicians, female clinicians have better communication with patients and improved outcomes—from lower 30-day mortality rates and fewer emergency room visits to better detection rates of adenoma during colonoscopies.³⁰⁻³⁶ Assuming those studies capture true effects, which is similar to the first hypothetical case we proposed, it could be that when a patient—male or female—requests a female clinician, the reason is to receive better care. If a female patient requests a female clinician, is it because she feels more comfortable or wants to maximize the likelihood of a good outcome? Without probing the reasons, we lose these distinctions, which matter since clinicians tend to respect some requests but not others; female patients are more likely to be accommodated.³⁷ If female clinicians do indeed have better outcomes, then all patients would be wise to request them. But this is an unacceptable conclusion since the result would be to diminish the role of an entire gender in patient care—a socially and ethically detrimental outcome. These 2 lines of argument thus suggest that the reason someone has for requesting a certain kind of clinician is relevant to decisions about whether to honor such requests—as are the implications of concordance for the health system overall.

Finally, we consider the case of a patient who asks for a specific clinician because of concerns about physician conscientious objection. Whether health care clinicians ought to be able to conscientiously object to providing certain treatments—that is, refusing to offer them on moral grounds—has been the topic of much debate.³⁸ It is our argument that in cases in which patients would be denied a health care service because of conscientious objection, they should be accommodated if they request an alternative clinician. If a patient asks for a clinician who will perform an abortion, for example, then that request should be accommodated. Concordance of values in this instance determines whether a legitimate health care service is a priori available to a patient. Apart from ethical questions conscientious objection itself raises, we should view patient requests for a value-concordant clinician—one who will perform certain services—as reasonable.

Patient-clinician concordance when both patients and clinicians share similar values about the goals of health care and similar personal beliefs is likely to result in improved partnership in the patient-clinician relationship, and it has been linked to greater patient trust in clinicians.²³ To justify a request for concordance, however, the patient should be able to provide a reasonable explanation of the need for concordance. What constitutes “reasonableness” is a difficult question, and it is in judging the reasonableness of the request as it moves from one extreme of the continuum (a clinician’s potential conscientious objection) to fuzzier areas that these requests become ethically challenging. What we have shown is that the grounds for justifying reasonableness on the basis of evidence is limited. The grounds of reasonableness and potential benefits from value-based partnership warrant further exploration. With any benefit of concordance, like communication, whether to accommodate a concordance request means thinking about value tradeoffs within health care—an important but not overriding consideration in deciding on a patient’s clinician and care pathway.

Our argument about whether to accommodate patient requests is based on evidence of clinical benefit. Given the limited evidence of clinical benefit, we should not simply accept reasons for concordance that are grounded in claims about improved health outcomes or reduced health disparities without further probing the basis of such claims. The limited evidence supports our conclusion that concordance for the sake of health outcomes should be accommodated in few circumstances, which depend on the ability of patients to access legitimate health care—as distinct from their preferences and values, which we have not explored. While concordance might be an apparent route to increasing trust, we should focus on the harder task of improving clinician communication and patient-clinician relationships.

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Citation

AMA J Ethics. 2019;21(6):E505-512.

DOI

10.1001/amajethics.2019.505.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

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