Medical Student Attitudes About Quality of Care and Training of Minority Persons

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Ninety-five first year medical students agreed that there was differential medical treatment of minority vs majority persons. Implicated reasons for this phenomenon were lack of personal treatment of members of minorities, distrust of medical workers by minority members, and majority perceptions that minority persons are not good patients. Integrated treatment and training facilities, preferential academic treatment, special training for majority students, and philosophy of medical care are discussed in terms of improving medical care for all.

The purpose of this paper is to present systematic data from medical students concerning their attitudes about medical services and training for minority persons. Attitudes of majority and minority medical students about the quality and quantity of services and about training facilities are most important since these students are the physicians of the future. As they perceive the issues and needs, they will act to shape and hopefully improve medical services and training for all. As practitioners and faculty, we have an obligation to know what the physicians of the future believe, for we in fact influence them by what we say and what we do, by what we do not say and what we do not do.

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Method

Sample

In 1974, the entire first year class of 124 students at the University of Southern California School of Medicine was asked to respond to a questionnaire. Ninety-five students, including 80 "Anglo" Caucasians, not including Mexican-Americans (77 percent of the majority students), and 15 minority group students (75 percent of minority students) responded. The minority respondents consisted of two blacks, seven Mexican-Americans, four Asians, and two persons who classified themselves as "Other." Eighty-two percent of the 98 males responded while only 58 percent of the 26 females responded ($X^2 = 6.57$, $p<.02$). Anglo males did not differ from Anglo females in their attitudinal responses. The minority males could not be compared to the minority females because of the small sample. Given the lack of relationship between sex and attitudes, it was appropriate to combine the sexes in the statistical analyses.

Instrument

The attitude questionnaire consisted of 23 Likert-type items divided into the following general categories: quality of care, integrated treatment facilities, integrated training facilities, preferential academic treatment, and health care: right or privilege. In the questionnaire itself, the items were not grouped but were presented in a random order. Four alternatives were available for response: agree very much, agree somewhat, disagree somewhat, and disagree very much. In presenting the findings in

Table 1, the four categories have been condensed into: agree and disagree.

Each item, except those concerned with health care: right or privilege, was responded to in terms of blacks and Mexican-Americans. Both majority and minority students responded substantially the same to both ethnic groups. Because of this similarity and for the sake of clarity, only the data concerned with blacks are presented. Several items were responded to in terms of Anglos as well as the minorities. These data are also presented.

Results

Care of Minority and Majority Patients

Quality of Care—The responses to item 1 set the stage for the rest of the data. Over 80 percent of the majority and over 90 percent of minority students disagreed that adequate medical services are currently available to the minority communities. Further, both majority and minority students thought that significantly better medical care was available to the Anglo community than to the minority communities. Despite the nearly unanimous agreement that medical services are inadequate for minorities, the students showed much less consensus concerning a particular aspect of the delivery of health services (Item 2). A significantly larger proportion of minority students compared to majority students agreed (73 vs 40 percent) that inadequate personal treatment was involved in behavior of minority persons seeking health care.

Integrated Treatment and Training Facilities—Two items concerned a possible method of increasing personal treatment facilities. Twenty percent or less of both minority and majority students agreed with the statement, "It is probably better to have physicians treat only patients of their own ethnic group." On the other hand, a significantly greater proportion of minority students agreed that it was only natural for physicians to give better, more personal services to members of their own ethnic group (57 vs 18 percent). The responses to these two statements suggest that the minority students are caught between an egalitarian ideal and perception of reality that is contradictory and perceive differential treatment on the basis of ethnicity.

The two items (5 and 6) concerned with ethnically integrated or separated training facilities received very little support from majority students but significantly more support by a small percentage of minority students. Only about 25 percent of the minority students wanted separate training facilities or agreed that it was reasonable to have different graduation standards for different ethnic groups, if they treated their own ethnic group exclusively, compared to less than ten percent of the majority students.

Good/Bad Patients—One explanation of the lack of personal attention to minority groups is that they are perceived as being "bad" patients. Four items concerning good and bad patients were completed concerning Anglo patients. The minority students did not differ from the majority in evaluating Anglo patients ($t = 0.55$, p is NS). However, the majority students thought that whites were significantly better patients than either Mexican-Americans or blacks (correlated t's = 3.56, $p<.001$, 2.97; $p<.01$ respectively) and that the minority groups were about the same (correlated $t = 0.25$). On the other hand, the minority students did not rate the Anglo patients as significantly better or worse than black or Mexican-American patients (correlated t's = 1.37 and 1.10 respectively).

A vicious circle is entered into when one combines the perceived lack of personal attention for minorities and the belief that minorities are poorer patients with the finding that more than half of the majority students (52 percent) and 79 percent of the minority students indicated that distrust of medical workers by minority persons is a problem.

Selection of and Standards for Medical Students

Preferential Admissions and Academic Treatment—It has been suggested that one method of improving the quality of medical services to minorities is to increase the number of minority members admitted to medical school. The notion of preferential admissions to medical school has been an extremely passionate issue. In Table 1 about 50 percent of the majority students and about 60 percent of the minority students are for preferential admissions for minorities. The responses to four of five items concerned with this issue indicated that a greater percentage of minority students than majority students was in favor of preferential treatment for minorities. Two of the items tended towards statistical significance and one was significant.

On four of the five items, about half of the majority students were for preferential selection of minority persons. However, on the item that presented the history of discrimination as the reason for preferential treatment, only one third of the majority students indicated a propreferential admissions response. Thus, for Anglo students, history seems to be the weakest argument for preferential treatment. The other presented arguments are about of the same importance for majority students. On the other hand, the minority students seemed much more sensitive to the different reasons presented. That is, the percent of minority students for preferential treatment ranged from 40 to 79 percent depending on the reason given. Further, the fewest number of minority propreferential responses occured on item 11 with no argument for preferential treatment.

Four items concerned other types of preferential academic treatment. The majority and minority students did not differ significantly on any of the four items. Of most interest is item 18 which states that persons, including minorities, should be graduated only if they meet traditional criteria. Over 90 percent of both majority and minority students agreed that traditional standards should be maintained for all those who are graduated. The other items did not elicit such consensus. Slightly more than 70 percent of both majority and minority students were for giving compensatory education to those students who do not have the educational background for medical school. The two other items concerned with preferential academic treatment indi-

Table 1. Percent of Minority and Majority Students Agreeing with Attitude Items

	Majority Students (N=80)	Minority Students (N=15)	X^2
Quality of Care			
1. Adequate medical services are, for the most part, currently available to the black community.*	16	7	0.82
2. The inadequate personal treatment received is the best explanation of the apparent lack of health-seeking behaviors of blacks.*	40	73	5.67***
Integrated Treatment Facilities			
3. It is probably better to have physicians treat only patients of their own ethnic group, for example, blacks treating only blacks.*	12	20	0.80
4. It is only natural that physicians would give better, more personal treatment to members of their own ethnic group; for example, physicians would give better care when blacks treat blacks.*	18	57	10.23****
Integrated Training Facilities			
5. There is a need for more physicians, but because of their special problems and interests, blacks* should be trained in their own facilities.	6	27	6.02***
6. Although changing medical school graduation standards for minorities may be debatable, it is reasonable to have different graduation standards for the following groups, if they treat their own ethnic groups exclusively.*	4	20	5.34***
Good/Bad Patients			
7. Because they do not follow instructions, it is extremely difficult to treat black patients.*	26	21	0.15
8. Distrust of medical workers is extremely high among blacks.*	52	79	3.36**
9. Once a decision is reached to see a physician, the doctor's instructions are very likely to be followed by black patients.*	57	62	0.11
10. The lack of personal cleanliness and bad eating habits create unique medical problems for blacks.*	55	43	0.66
Preferential Admissions to Medical School			
11. The same selection standards for medical school met by nonminority students should be met by blacks.*	51	60	0.57
12. It is unfair to those who have expended effort and successfully met the traditional admission criteria for professional schools to accept students who do not meet the traditional criteria even if they are black students.*	54	50	0.07
13. Given the deprived and disadvantaged background of most minorities, special criteria for selection for medical school should be used for blacks.*	51	79	3.75**
14. Providing the number of nonminority students stays the same it would be fine for medical schools to accept more black students.*	51	79	3.51**
15. To make up for years of discrimination and exclusion, preference for acceptance to medical and other professional schools should be given to blacks.*	33	67	6.08***
Preferential Academic Treatment			
16. Since many students do not have the academic background for medical school, compensatory education should be given to black students.*	75	71	0.06
17. Although minorities have been discriminated against in the past, that is no reason for preferential treatment today for blacks.*	44	27	1.62
18. Even students who are admitted to medical school using nontraditional standards should be graduated only if they meet traditional criteria even if they are blacks.*	96	93	0.30
19. Given equal financial need and academic ability, preferential scholarship support should be given to blacks.*	36	50	0.93
Health Care: Right or Privilege?			
20. A compulsory federal health program would destroy a most important aspect of American medicine, namely, the doctor-patient relationship.	38	27	0.70
21. A compulsory federal health program is the best way to provide health care to the American people.	62	64	0.04
22. In this country, health services should be a right, not a privilege.	83	93	1.02
23. Health services should be distributed on a fee for service basis, with better services going to those who are able to pay for it.	3	0	0.37

*Basically, the same results were obtained for Mexican-Americans.
** = $p < .10$, two-tail.
*** = $p < .05$, two tail.
**** = $p < .01$, two-tail.

cated that slightly, but not significantly, more majority students than minority students were in favor of nonpreferential treatment.

Student Philosophical Attitudes Towards Health Care

The final section of the questionnaire concerned the students' attitudes towards the general philosophy of providing health care in the United States. Almost all students, both majority and minority, believed that health services should be a right and not a privilege in this country and that health care should not be delivered solely on the basis of ability to pay for it. In terms of method of implementing this philosophy, 60 percent of the students agreed that a compulsory federal health program is the best way to provide health care to the American people. About one third of the students, however, thought that such a compulsory federal health program would destroy a most important aspect of American medicine, the doctor-patient relationship.

Discussion

The responses to each individual item in Table 1 are of intrinsic interest. A coherent theme, however, may be developed.

Almost all students agreed that health services should be available to all persons as a right, not a privilege only for those who are able to pay for it. Over 60 percent of the students agreed that a compulsory federal health program is the best way to implement this philosophy and provide health services to the American people.

Despite the belief and desire for equal health care, both majority and minority students thought that significantly better medical care was available to the white community compared to the minority communities. Almost three quarters of the minority students and almost one half of the majority students implicated inadequate personal treatment as being involved in the lack of health-seeking behaviors in minority persons. Intertwined with the perceived lack of personal treatment of minority persons was the opinion of 80 percent of the minority students and more than 50 percent of the majority students that distrust of medical workers is extremely high among minority persons. In addition, the majority students thought that whites were significantly better patients than were minority patients. These attitudes and preconceptions, then, are some of the reasons explaining the differential medical treatment of minority patients.

An often suggested method of improving the treatment of minority patients is to increase the personal element and eliminate the barrier of distrust by using medical care workers of the same ethnic group as the patients. However, about 80 percent of both majority and minority students disagreed with this proposition. Despite the consensus denying the efficacy of an ethnic group treating members of its own group, 57 percent of the minority students agreed that it was only natural for physicians to give better, more personal services to members of their own ethnic group (as compared to less than 20 percent of the majority students). Thus, almost 60 percent of the minority students are caught between an egalitarian ideal and a perception of reality reflecting differential treatment on the basis of ethnicity.

The desire for ethnically integrated treatment and training facilities comes across fairly strongly although the differential treatment of ethnic groups still remains. To maintain ethnic integration, to reduce the minorities' distrust of medical workers and increase the personal treatment they receive, many have proposed that the number of minority physicians be increased. Implementing this proposition has been interpreted by many as preferential admissions of minority groups to medical schools. About one half of the majority students and about 60 percent of the minority students agreed with items concerned with preferential admissions. The lack of consensus over this issue among the students reflects the lack of consensus within society about these complex issues. The data suggest that the minority students pay much more attention to the different reasons for preferential admissions than do the majority students. On the other hand, among the majority students, one argument for preferential treatment stood out as the weakest; namely the long-term history of discrimination. It should be reemphasized that despite the percentage of students wanting preferential admissions, very few agreed with preferential graduations, that is, that almost all students agreed that the traditional criteria for graduation should be met by all.

In addition to increasing the number of minority professionals, another important, even crucial method of improving the quality of care received by minority persons is to increase the sensitivity and awareness of majority students and professionals of their own feelings, attitudes, and behaviors that tend to stimulate distrust by minority persons and lessen the personal nature of the services given to minorities. The methodology of such training is difficult, complex, and beyond the scope of this paper. But even before such a training program is designed, much attention must be paid to recruitment of majority students into such a program. For example, included in the questionnaire was an item asking, "Would you like some sort of organized course concerned with understanding minority groups in relation to medical care?" Eighty-five percent of the respondents checked "yes." Yet when an elective meeting was scheduled for such a course, only nine students appeared. There are, of course, many reasons for the first year medical students not committing themselves to spending additional time in their already overcrowded schedules. Nonetheless, the lack of behavioral follow-through of the students stated intention is interpreted as indicating that this issue has low priority for them. Indeed, if such issues are to be considered high priority by students, they must be so considered by the role models of the students (ie, faculty, administration, and practicing physicians). Courses or experiences that focus on the patient as a whole person, rather than as a case, are major steps in the right direction. Explicit attention, however, must be directed towards the feelings, attitudes, and behaviors of both faculty, students, and clinicians towards minority patients and colleagues.

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