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Patient Refusal Of Physician: Institutional Awareness And Hospital Leaders' Perspectives

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**Patient Refusal of Physician:
Institutional Awareness and Hospital Leaders' Perspectives**

A Thesis Submitted to the
Yale University School of Medicine
in Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

By

Natalie Spicyn

2011

ABSTRACT

PATIENT REFUSAL OF PHYSICIAN: INSTITUTIONAL AWARENESS AND HOSPITAL LEADERS' PERSPECTIVES. Natalie Spicyn, Rosana Gonzalez-Colaso, Leslie Curry, Auguste H. Fortin VI, Christopher Guerrero, Thyde Dumont-Mathieu, and Marcella Nunez-Smith. Section of General Internal Medicine, Department of Internal Medicine, Yale University School of Medicine, New Haven, CT.

Patient refusal of physician (PRoP) refers to instances in which a patient refuses to be cared for by a given physician because of the physician's socio-demographic characteristics, such as gender, age, race/ethnicity, religion, national origin, or perceived sexual orientation. Minority physicians experience PRoP more often than non-minority physicians, and thus PRoP may become a growing concern as the healthcare workforce diversifies. Little is known, however, about hospital leadership awareness of and response to these circumstances. This study aims to describe the proportion of teaching hospitals with formal guidance on PRoP and to characterize hospital leaders' perspectives on addressing this issue. The following hypotheses are tested: 1) few hospitals will have formal guidance in place, 2) hospital leaders' opinions about addressing PRoP will vary, correlating with their personal socio-demographic characteristics, and 3) most respondents will report PRoP as an uncommon occurrence at their hospital, but one that nevertheless warrants attention. We used the 2007 American Hospital Association Annual Survey Database to perform a cross-sectional study of chief medical officers (CMOs) at a national sample of teaching hospitals in 2010. Cognitive interviews with hospital administrators informed questionnaire development. CMOs were emailed the online questionnaire with several waves of follow-up. Frequency statistics were used to describe the proportion of responding hospitals with formal statements addressing PRoP,

while bivariate analyses were performed to investigate any association between the existence of a policy and hospital characteristics, as well as CMO perspectives and CMO socio-demographic characteristics. Of the hospital CMOs we contacted (n=426), 221 responded, yielding a response rate of 52%. A majority (88%) of participating hospitals did not have any formal statement (e.g. policy, protocol, procedure) addressing PRoP; lower volume (<10,000 annual admissions) hospitals were more likely than higher volume (10-29,999) hospitals to have formal guidance (23% of low volume vs. 5% of higher volume hospitals). Convening the ethics committee or an ad hoc advisory group was a frequently utilized (14%) response to PRoP at hospitals without formal statements. Nearly half of hospitals typically reassign physicians, whether immediately (7%) or if the patient continues to refuse after further conversation (41%). Overall, while survey respondents were fairly evenly split on whether PRoP is an issue that should be further addressed at their hospital (46% agree, 49% disagree), over half (53%) anticipate enacting formal guidance on PRoP in the future. Because racial/ethnic minority physicians experience PRoP more often than their non-minority colleagues, addressing this issue is a potential strategy for hospitals striving to improve the institutional climate for a diverse workforce. With over three quarters of CMOs indicating that relevant industry guidelines would assist their hospitals in addressing PRoP, professional organizations have the opportunity to provide desired support to hospitals by issuing best practice recommendations.

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TABLE OF CONTENTS

INTRODUCTION.....	1
The Problem of Health Disparities.....	2
Addressing Disparities with a Diverse Physician Workforce.....	4
Challenges in Diversifying the Healthcare Workforce.....	5
Creating an Institutional Climate for Diversity.....	6
Patient Refusal of Physician.....	7
STATEMENT OF PURPOSE.....	10
SPECIFIC AIMS.....	11
SPECIFIC HYPOTHESIS.....	11
METHODS.....	12
Study Design and Sample.....	12
Questionnaire Design.....	13
Data Collection.....	14
Variables.....	15
Data Analysis.....	15
RESULTS.....	16
Sample Characteristics.....	16
Existence and Implementation of Formal PRoP Statements.....	17
Changing Demographics.....	18
PRoP Response in Absence of Formal Guidance.....	19
Institutional Awareness and Inclusion in Strategic Planning.....	20
Hospital Leaders' Perspectives.....	22
Views on Regulatory and Resource Considerations.....	23
Balancing the Interests of Physicians and Patients.....	23
DISCUSSION.....	24
Uncertainty and Variability in Response.....	25
PRoP and Patient Autonomy.....	26
Concordance and the Doctor-Patient Relationship.....	27
Workplace Rights of the Refused Physician.....	28
The British Experience.....	29
Considerations from Other Realms: Patient Refusal of Trainees.....	30
Considerations from Other Realms: Certified Nursing Assistants at Nursing Homes.....	32
Legal Considerations around PRoP.....	33
CMO Awareness, Reporting, and Frequency of PRoP.....	34
Flexibility Desirable in Any Approach to PRoP.....	35
Institutions Welcome Guidance, Consider Future Action.....	37
Limitations.....	37
Implications and Directions for Further Investigation.....	38
REFERENCES.....	41
FIGURES & TABLES.....	45

INTRODUCTION

The demographics of the United States are rapidly changing. Current projections anticipate a “majority minority” population by 2042 (1). Because many racial/ethnic minority groups have poorer health and worse healthcare indicators than Caucasians, the expansion of these minority populations compels the medical community to find new, effective ways to address the health disparities faced by these communities. Several leading groups and organizations have established that diversifying the healthcare workforce is a key component of efforts to confront and mitigate these disparities (2-4).

Successful workforce diversification is a complex process that begins with the recruitment of individuals from historically under-represented racial/ethnic minority groups into pre-medical undergraduate studies, medical school, and clinical, academic faculty, and management positions, and continues with the development and implementation of supportive structures within the healthcare workplace (5, 6). This thesis examines a workplace phenomenon that is potentially relevant to workplace inclusiveness of a diverse physician staff: a patient’s refusal of care from a physician on the basis of the physician’s socio-demographic characteristics, or patient refusal of physician (PRoP). In previous qualitative work, the experience of racially-based PRoP was often recounted as a challenging workplace phenomenon (7); a subsequent national survey established that such refusals of care were not only prevalent, but disproportionately affected black physicians more than their white colleagues (6). Little is known, however, about institutional awareness of and response to PRoP. In order to investigate this institutional perspective, we surveyed hospital leadership across the United States regarding typical response to PRoP situations, whether formal written

guidance exists in these situations, and hospital leaders' awareness and attitudes towards addressing PROp.

The Problem of Health Disparities

Paula Braveman offers a widely-used construct of health disparities (8): "Health disparities/inequalities are potentially avoidable differences in health (or in health risks that policy can influence) between groups of people who are more and less advantaged socially; these differences systematically place socially disadvantaged groups at further disadvantage on health."

A recent Centers for Disease Control and Prevention report provides current information about existing disparities in morbidity, mortality, preventive services and behavioral risk factors (9):

- Non-Hispanic black women continue to experience the highest rate of infant mortality, almost two and a half times higher than the rate of infant mortality amongst non-Hispanic white women. Prematurity, a major contributor to infant mortality, is three times more common amongst non-Hispanic blacks than non-Hispanic whites or Hispanics.
- Diabetes afflicts blacks, Hispanics, older individuals, and individuals with disabilities more often than non-Hispanic whites, Americans under the age of 44, and individuals without disabilities. The racial/ethnic disparity in incidence of diabetes did not decrease between 2004 and 2008, while disparities in incidence by age, disability, and socio-economic status increased during this interval.
- Black men and women fall victim to premature (before age 75) death from coronary heart disease and stroke more often than their white counterparts,

accounting for the greatest proportion of the disparity in life expectancy between whites and blacks in the United States. While interventions aimed at decreasing mortality from cardiovascular disease were successful in decreasing overall death rates, blacks and men were two subgroups that did not reach the lower death rate goals set in *Healthy People 2020*.

- Hypertension, which contributes to mortality from heart disease and stroke as well as carrying its own risk of grave complications, also demonstrates disparities in both disease prevalence and disease control. Blacks have higher rates of hypertension than whites, and individuals with disabilities have higher rates than those without disabilities; Mexican Americans were less likely to have their blood pressure well-controlled on medications than either non-Hispanic blacks or whites.
- Blacks, Hispanics, and other racial/ethnic minorities (with the exception of Asians) carry a disproportionate burden of HIV infection compared to their white counterparts: the relative percentage difference in HIV diagnosis rates compared with whites above 13 years of age was 799% for blacks, 205% of Hispanics, and 178% of Native Hawaiians/Other Pacific Islanders (NH/OPI). Women within these groups experienced larger disparity in diagnosis rates than their male counterparts: 1,830% for black women compared with white women, 359% for Hispanic women, and 266% for NH/OPI women. While analyses based on sexual orientation, identity, and behavior were limited by data collection, men who have sex with men (MSM) had HIV diagnosis rates 6,408% higher than all other men, and infection rates among MSM are rising.

- Lesbian, gay, bisexual, and transgender (LGBT) individuals as well as American Indian/ Alaska Native individuals exhibit higher rates of cigarette smoking and other tobacco use, while the American Indian/Alaska Native population also suffers from the highest prevalence of youth smoking.
- Rates of influenza vaccine coverage (combined seasonal or H1N1) for those age 6 months and older are lower among Hispanics and non-Hispanic blacks than among non-Hispanic whites.

The CDC report notes that weaknesses of the analyses include lack of data regarding certain demographic groups. There is a particular paucity of data regarding individuals with disabilities, individuals of various sexual orientations, and racial/ethnic minorities which were not purposefully over-sampled in all data collection, which will be critical to address if health disparities amongst these populations are to be investigated and confronted (9).

Addressing Disparities with a Diverse Physician Workforce

Amongst the many approaches geared at reducing health disparities, the Institute of Medicine has affirmed the connection between addressing racial/ethnic disparities in healthcare and diversification of the healthcare workforce. While Hispanics make up 14% of the U.S population, they represent 5.5% of the U.S. physician workforce; black physicians represent 6.3% of the workforce while African Americans constitute 12.7% of the population (10, 11).

In its 2004 report on diversification of the healthcare workforce, the Institute of Medicine (IoM) briefly outlined the importance of diversifying the physician workforce: racial/ethnic minority physicians are more likely to practice in minority and underserved

areas, thus increasing access to care in high-need areas; racial/ethnic minority patients are likely to select racially-concordant physicians when given the opportunity, and have improved communication and health outcomes in the context of these concordant doctor-patient relationships; and the cultural competency of all physicians is benefited through interactions with colleagues from varied racial/ethnic and cultural backgrounds, during medical school as well as in later stages of training (2). Additional benefits to increasing workforce diversity include diversifying the ranks of leaders in health management, administration and policy with individuals sensitive to the needs of a multicultural patient population, as well as an expanded research agenda set by investigators with a unique perspective, increased investigation into health disparities related issues, and increased ability to recruit minority patients to participate in research studies (12).

Challenges in Diversifying the Healthcare Workforce

Diversification of the healthcare workforce requires attention to recruiting, training, and supporting historically underrepresented minorities (URM) within the health professions. Many factors are often cited as contributing to the dearth of URM students training to become physicians, including unequal educational opportunities earlier in life, as well as legal and judicial challenges to affirmative action in admissions and race/ethnicity-based financial aid support (2). The IoM put forth several recommendations for revising admissions procedures to improve both the quality and diversity of applicants accepted into training programs, including a de-emphasis of test scores of academically qualified candidates, with greater attention to applicants' professionalism and humanistic qualifications. Beyond, this, the IoM also suggests bolstering and coordinating the efforts of public and private funding entities to improve

financial support for URMs to pursue medical training and using accreditation standards to establish and reinforce institutional values and goals around diversity.

Creating an Institutional Climate for Diversity

An institutional climate which supports diversity is a key component of efforts to create an inclusive environment for URM students and faculty (2, 13). Underrepresented minority students stand to benefit from diverse faculty members to serve as role models and mentors; these faculty members, in turn, should receive post-hiring support in order to address the professional challenges of an academic career (14). Diversity goes beyond simply the numbers or proportion of URM students and faculty at an institution, however, and the IoM also urges increased focus on the culture of interactions between members of various groups as well as the integration and quality of curricular elements pertaining to disparities, cultural competency, and other diversity-related issues.

In order to improve the campus climate for diversity, institutions must target interventions for the unique challenges that URM students, physicians, and faculty experience. In addition to more frequently experiencing racial/ethnic discrimination over the course of their careers, minority physicians report various unique challenges at work, such as being asked to take on various tasks because of their race/ethnicity, as well as difficulty finding mentorship and experiencing greater scrutiny at work (6).

Previous qualitative work demonstrates that issues related to race permeate the professional experience of physicians of African descent in the health care workplace (7, 15). In-depth interviews reveal that these minority physicians perceive that their interpretations of potentially offensive race-related work experiences often differ from those of non-minority colleagues, and that the health care workplace is frequently silent

on issues of race with the effect of normalizing or minimizing some of these experiences. At times, this normalization is as challenging to the affected individual as the particular recounted incident; one pediatrician, describing the experience of being dismissed by a patient's parents from the child's care, underscores the subsequent silence about what had occurred:

“I was [removed from] taking care of a [white] individual. We talked later, the division chief and I. The parents were uncomfortable with me taking care of their child. . . [T]hey told him they didn't think I would be capable because of race. That ended our conversation. What about next time?” (7)

These situations – having patients refuse their care – are experienced more frequently by black physicians than their white colleagues and can be challenging to address; such conversations might be particularly difficult given that black physicians are also less likely than white physicians to feel comfortable communicating about race/ethnicity at work (6).

Patient Refusal of Physician

Patient refusal of physician (PRoP) is a term we have coined referring to instances in which a patient refuses to be cared for by a physician because of the patient's perception of any physician socio-demographic characteristics; these socio-demographic characteristics include gender, age, race/ethnicity, national origin, religion and sexual orientation. Throughout this paper, when we use the term “patient refusal of physician” or its acronym “PRoP,” we always refer specifically to refusals on the basis of socio-demographic characteristics. There has been little published regarding PRoP on the basis of race/ethnicity, and the literature is largely silent on the experiences of minority groups

other than African Americans in medicine. Although much of the introduction presents data and literature focused on racial/ethnic diversity, we felt it was appropriate and relevant to extend our investigation to refusal based on several socio-demographic characteristics.

The proper response to such incidents has been much debated in medical trade journals(16-19), and even taken up by the lay press (20). The majority of the published work on this topic is commentary, without an empirical basis. These pieces usually recount an anecdote about a patient refusing to be cared for by a minority physician, followed by a discussion of the moral dimensions of the decision about whether to accommodate the patient's desire for a white doctor. Several themes emerge from these commentaries. The majority of authors label the patient's refusal of a minority physician and request for a white physician as "racist" or "prejudiced" and use this presupposition as they discuss the ethical issues raised by such situations. Several writers frame these rejections using the vocabulary of assault and abuse, labeling such behavior "verbal assault and... emotional abuse" of the physician (19) or "racial abuse" comparable to physical assault by belligerent patients (21). Others acknowledge that PRoP explicitly based on race may constitute poor behavior, but feel that the physician's professional responsibility is to put the patient's needs first and accommodate the request, and caution physicians to avoid differential treatment of patients whose views they might find disagreeable.(18, 19) A few tie such refusals into the concept of cultural competency, and emphasize the importance of good communication skills in these interactions (16, 22). Another idea raised in these discussions is that the response to PRoP is a reflection of the hospital's institutional values, and that a "duty of care" is owed by the employer to the

physician employee in these circumstances (16, 21). Beyond this, some suggest that it would be beneficial for healthcare institutions to clearly delineate policies in advance which can be followed by staff when such circumstances arise (21, 23).

One commentary focuses not on refusal of a non-white physician, but rather a minority patient's specific request for a non-white physician who shares her ethnic background (22). This is not, in a strict sense, a scenario of PRoP as no refusal has taken place, but it does raise questions regarding the accommodation of patient preference for physicians of a given socio-demographic background – in this case, one concordant with the patient's own ethnic and religious background. In addition to reviewing the relevant cultural issues and questioning the parameters by which decisions to accommodate requests would be made, the impact of resource limitations on the hospital's ability to supply concordant physicians was also raised.

A single study has examined physician attitudes towards accommodating patient requests for gender, race, or religion-concordant physicians, specifically in the Emergency Department (ED) setting (24). Physicians completed a brief survey which included vignettes in which patients with non-emergent medical problems requested concordant physicians upon presentation in the ED; the demographics of the patient were altered in each vignette. Overall, patients from minority racial or religious backgrounds were more likely to have requests for concordant physicians (hypothetically) accommodated, as were female patients, with Muslim females receiving the highest accommodation scores of any group. The influence of physician demographics on survey responses was also examined, although the survey respondents were overwhelmingly white and male. Female physicians were more likely to want to accommodate a same-

gender request than male physicians; race, practice duration and location did not influence likelihood to accommodate these requests. Of note, this study gauged the attitudes of Emergency Medicine physicians but did not investigate how these attitudes correlated with actual behavior. Additionally, while the question of accommodating patient requests for physicians of a particular socio-demographic background is salient to consideration of PRoP, it is a distinct scenario from refusals of care on this basis. Beyond this paper and the commentaries on PRoP scenarios reviewed above, the literature to date is silent on the institutional response to PRoP, and how administrative leaders view addressing this issue on a hospital-wide level.

STATEMENT OF PURPOSE

This thesis will examine the phenomenon of patient refusal of physician based on socio-demographic characteristics at teaching hospitals in the United States. The focus will be on the formal and informal manners in which hospitals address patient refusal of physician, as well as hospital leaders' perspectives on implementing formal guidance on this issue at institutions which do not have any formal statement guiding response currently in place.

SPECIFIC AIMS

1. To describe the proportion of teaching hospitals with formal written statements (e.g. policies or protocols) guiding staff response in instances of patient refusal of physician on the basis of socio-demographic characteristics and examine any correlation with hospital level characteristics such as number of beds, number of annual admissions, ownership type and geographic region
2. To characterize the perspectives of hospitals leaders on addressing patient refusal of physician, including their views regarding the desirability and feasibility of implementing formal guidance at institutions where it does not exist

SPECIFIC HYPOTHESIS

1. Few teaching hospitals surveyed will have formal guidance in place. The existence of a policy will be correlated with the geographic region the hospital is located in, but not other hospital characteristics.
2. Hospital leaders' opinions about addressing patient refusal of physician will vary. Most respondents will have had minimal experience addressing PRoP and will report it as an uncommon occurrence at their hospitals. Hospital leaders' perspectives will correlate with their personal socio-demographic characteristics, with women, foreign-born, and racial/ethnic minority respondents more likely to believe PRoP is an issue which hospitals should address than will male, U.S.-born, and racial/ethnic majority respondents.

METHODS

Study Design and Sample

We conducted a national cross-sectional study, electronically surveying the Chief Medical Officers (CMOs) or equivalent at teaching hospitals in the United States. We chose to contact CMOs because we sought to survey individuals who were involved in both the administrative and clinical realms at their hospital. We elected to focus on teaching hospitals because patients are likely to be randomly assigned a previously-unknown physician in this setting. Data were collected between November 2009 and January 2011.

A random sample of 550 teaching hospitals was generated using the American Hospital Association (AHA) Annual Survey Database (Fiscal Year 2007). The initial sampling frame included all 6,312 hospitals in the 2007 AHA database. Of these, 1,086 responded that they had residency training programs approved by the Accreditation Council for Graduate Medical Education (ACGME). This subset was determined to comprise 68% “minor” and 32% “major” teaching hospitals, defined by the latter’s membership in the Council of Teaching Hospital of the Association of American Medical Colleges (COTH). Random selection of 550 hospitals, approximately half of the total sample of teaching hospitals in the AHA database, was performed using a random number generator in Microsoft Access 2007. This work was done by our collaborator at the University of Iowa (CG). A research assistant (KMB) placed telephone calls using a standardized script to each of the 550 teaching hospitals in our sample in order to obtain electronic contact information for the CMO or the CMO’s administrative assistant.

Of the 550 hospitals called, we were unable to obtain contact information from 51

hospitals (did not respond to 4 phone calls, could not be connected to appropriate department, etc.), 25 refused to provide the requested contact information, 9 did not have a CMO or Chief of Staff or the position was vacant, and 4 reported that they were not in fact teaching hospitals. We also excluded 35 hospitals which provided only non-electronic (fax or mail) contact information, bringing the final sample to 426 hospitals (Figure 1).

Questionnaire Design

The survey instrument was developed based upon previous qualitative work (6, 7, 15), literature review, and input from a multidisciplinary research team with expertise in relevant content areas. Four face-to-face cognitive interviews, each one to one and a half hours long, were performed with administrators from local hospitals. The aim of the cognitive interviews was to assess clarity and relevance of draft items, as well as identify additional potentially relevant content. Both think-aloud and verbal probing cognitive interviewing techniques were used. Input from the cognitive interviews was incorporated into final survey revisions. Literature review, item drafting and revision, and cognitive interviews were conducted by NS, with input from the entire research team as indicated.

The survey, as initially administered, included 45 questions and required 15-20 minutes to complete. We shortened the survey after receiving 139 complete responses as well as direct correspondence from CMOs recommending the survey be briefer. We eliminated questions to which the responses trended unambiguously in one direction. We kept core questions regarding primary outcomes of interest, as well as questions to which responses were fairly split. The final version of the survey contained 33 questions and required 5-7 minutes to complete. Both versions included 8 questions about respondent

socio-demographic characteristics. After shortening the survey, we received an additional 82 responses, for a total of 221, bringing the response rate to 52%.

Data Collection

We used an on-line data collection service with encryption capabilities to post the electronic questionnaire. We sent an initial email explaining the study and requesting participation, along with an information sheet and a unique URL to the electronic questionnaire, to each CMO in our sample. The unique URL, assigned to each institution, allowed us to link responses to hospital level characteristics available in the AHA database. CMOs were instructed that they may choose to delegate the survey to other personnel they deemed appropriate. The majority of CMOs did not elect to delegate the survey and completed it on their own; they typically worked within departments of Medical Affairs and Administration at their hospitals. The small minority of surveys which were delegated to other hospital leaders were completed by directors of Social Work, Human Resources, Patient Services/Advocate, Hospitalist Services, and Accreditation, Licensing, and Regulatory Affairs.

Outreach emails were sent and responses tracked by NS. A second email was sent to non-responders two weeks after the first email, with a third email following one week later as necessary. We then pursued a “peer email” strategy, obtaining support for the project and permission to send emails soliciting participation from our institution’s CMO to the CMOs in our study sample. This email was followed by a hand-written postcard to non-responders, and finally with further outreach via email and telephone directed only at individuals who initiated, but did not complete, the questionnaire. All data collection was performed by NS.

Variables

Table 1 summarizes the variables of interest. The primary outcome of interest was the existence of a formal statement (e.g. policy, protocol, or bylaws) addressing response to PRoP at the hospital. Other secondary outcome variables included typical response to PRoP, including likelihood that PRoP results in the reassignment of physicians, the CMO's estimate of the frequency of occurrence of PRoP at his/her hospital, and the CMO's experience with PRoP (having been notified of instances of PRoP, having witnessed PRoP, or having experienced it personally). Further secondary outcome variables included the CMOs perspective on the likelihood of the hospital addressing PRoP in the future, as well as on the rights of patients and physicians in circumstances of PRoP.

Hospital characteristics used as associated variables were drawn from the AHA annual survey database; these included bed size, number of annual admissions, ownership type (government, not-for-profit, investor-owned for profit), geographic region, whether the hospital gathers data regarding patient race/ethnicity, and whether they the institution was either considering or currently enacting a diversity plan.

For other analyses, CMO socio-demographic characteristics collected using our online questionnaire were used as associated variables. These included CMO gender, age, race, ethnicity, and national origin. Data was also collected regarding religion and CMO physician specialty training.

Data Analysis

We used descriptive statistics to characterize the study sample, describing both the socio-demographic characteristics of responding CMOs as well as the hospital

characteristics of the institutions at which they work. Frequency statistics were employed to describe the proportion of responding hospitals that have a formal statement addressing PRoP (the primary outcome of interest), as well as secondary outcome variables such as hospital leaders' perspectives regarding addressing PRoP and the typical response to such patient requests at a given institution. We performed bivariate analyses (unadjusted and adjusted odds ratios) to investigate associations between the outcomes of interest and associated variables, including hospital characteristics such as bed size, number of annual admissions, and region of the country, as well as CMO socio-demographic characteristics and their professional experience with PRoP (having previously been notified of PRoP, witnessed PRoP, or personally experienced PRoP in the past). Bivariate analyses were performed by CG and RGC.

RESULTS

Sample Characteristics

Our overall study sample (n=426) was drawn from the population of all teaching hospitals in the AHA annual survey database (n=1086). Our sample did not differ significantly from the population of teaching hospitals in the AHA annual survey database with regards to bed size, number of annual admissions, ownership type (government, not-for-profit, investor owned for-profit), geographic region, whether patient race/ethnicity data is gathered, and whether the institution is considering or enacting a diversity plan (Table 2).

Of the hospital CMOs we contacted, 221 responded, yielding a response rate of 52%. Overall, just over half of responding hospitals have more than 300 beds, with 10%

having less than 100 beds. Just under 40% have less than 10,000 annual admissions, while about 50% have between 10,000 and 30,000. Just under two-thirds of responding hospitals are not-for-profit, with 5% being investor owned for-profit. The geographic distribution of responding hospitals mirrors that of the overall sample, with 8% in the Northeast, 20% Mid-Atlantic, 32% in the South, 23% Midwest, and 17% in the West. Over 70% of hospitals gather patient race/ethnicity data, and 65% are considering or enacting a diversity plan. The characteristics of responding and non-responding hospitals are compared in Table 3.

The majority of individuals responding to the questionnaire were male, 50 years of age or older, born in the United States and self-identified as white, non-Hispanic or Latino (Table 4). Of physician respondents, 43% trained in internal medicine, 9% in psychiatry, 8% in family medicine, and 7% each in pediatrics and general surgery; 4% of total respondents were not physicians. The majority of respondents had been employed at their current hospital (85%) and in their current position (58%) for over 5 years.

Existence and Implementation of Formal PRoP Statements

A vast majority (88%) of participating hospitals did not have any formal statement (e.g. policy, protocol, procedure, practice guideline, medical staff bylaw) addressing PRoP on the basis of patient perception of a physician's socio-demographic characteristics. The number of annual admissions was the only hospital-level characteristic associated with the existence of a formal PRoP statement; hospitals with greater volume were less likely to have a formal response in place compared with hospitals with lower volume. While over a fifth of hospitals with <10,000 annual admissions had formal PRoP statements, only 5% of hospitals with 10,000-29,999 annual

admissions had such statements (unadjusted OR 0.19, CI 0.07 to 0.50; p=0.004 in the adjusted analysis) (Table 5).

At hospitals with formal statements addressing PRoP (n=26), a variety of departments and offices were cited as responsible for developing the document, including Human Resources, Quality, the medical staff office, the chief of staff office, legal, the ethics committee, the executive committee, Performance Management, Compliance, patient advocates, and patient relations. Many (44%) of these statements have been written since 2005.

No single factor stood out as commonly influencing the development of PRoP statements at hospitals which have formal statements in place. Patient requests were reported to be the most influential factor, cited as “very” or “extremely” influential by over a third of responding hospitals. A single precipitating event was a “somewhat” or “very” influential factor influencing the development of such statements at under a third of hospitals (n=8); none indicated that a single precipitating event was “extremely influential,” while two-thirds cited it as having no influence. Over half reported that PRoP document development was not at all influenced by requests from community representatives, recommendations by professional or trade organizations, hospital-wide diversity planning, or research findings. Almost half reported that neither increased frequency of PRoP incidents nor recommendations by staff organizations or internal committees had any influence.

Changing Demographics

In response to questions about the racial/ethnic diversity of the hospital’s patient populations, CMOs were evenly split in noting no change (48%) or increased diversity

(48%) in the past 5 years, while projecting increasing diversity (52%, vs 42% responding “no change”) in the next 5 years. Over half of respondents noted increased diversity of resident physician (56%) and attending physician (59%) populations in the past 5 years, while slightly less projected continued increases in the diversity of these physician populations (44% replying “no change” in resident physician populations, 42% for attending physicians, and the remainder selecting “I don’t know”).

Five hospitals with formal statements report collecting data on the frequency of occurrence of PRoP (18.5%); 4 of the 5 collect data on patient socio-demographic characteristics, while 2 of 5 collect data of physician characteristics for individuals involved in the care refusal scenarios. CMOs at these hospitals estimated between 0 and 6 incidents of PRoP during the 2008 calendar year.

PRoP Response in Absence of Formal Guidance

Nearly half of hospitals typically reassign physicians, whether immediately (7%) or if the patient continues to refuse after further conversation (41%). A handful of hospitals decline to reassign physicians, either immediately (1%) or even if refusal continues after further conversation (4%). Response to PRoP was reported to be highly variable at nearly a quarter of responding institutions. At some hospitals, the subject is typically discussed and decided by the entire medical team (7%), while at other hospitals PRoP was noted not to occur (12%).

Unadjusted and adjusted analyses revealed a correlation between likelihood that a hospital typically reassigns physicians in PRoP cases and both the hospital’s geographic region and annual admissions: Mid-Atlantic and Western hospitals were over 4 times more likely to reassign physicians than hospitals in the Northeast (OR 4.7 p=0.04, OR

4.67 $p=0.04$). The likelihood that a hospital typically reassigns physicians in PRoP cases did not correlate with other hospital characteristics in either the unadjusted or adjusted analyses (Table 6).

A fifth of hospitals without formal PRoP guidelines in place reported that PRoP is covered by their Patient Bill of Rights, suggesting that these hospitals strive to honor such patient requests. Convening an existing ethics committee or creating a special ad hoc advisory group was another frequently utilized (14%) response to PRoP. A variety of other approaches were cited by respondents, including informal discussion at staff meetings, cultural sensitivity training through Human Resources, resident orientation and teaching sessions, ad hoc discussions on a per-patient basis, utilizing the formal procedures for all general patient requests for an alternate provider, informal department policies which reassign physicians on any grounds in non-emergent situations, medical ethics didactics, grand rounds, CME, and the “usual supervisory chain” with decisions ultimately left to the discretion of the chief of service.

Institutional Awareness and Inclusion in Strategic Planning

All hospital CMOs, regardless of existence of a formal statement or data collection regarding PRoP at their hospital, were asked to estimate the frequency with which such refusals occur at their hospital. At hospitals with a PRoP document, 55.6% of CMOs estimate that PRoP occurs a few times a year, while 4% estimate it occurs more frequently than that (once a month) and 37% estimate it occurs less frequently (once a year to never). At hospitals without a PRoP document, 40.3% of CMOs estimate that PRoP occurs a few times a year, while 8.4% estimate that it occurs more frequently than that (once a month or once a week) and 38.8% estimate that it occurs less frequently

(once a year, a few times a decade, or never). Hospitals without formal PRoP statements in place rarely collect data about frequency of occurrence (n=4, 3.3%) or socio-demographic characteristics (n=2, 1.6%) of individuals involved.

CMOs were asked about how often they encountered PRoP in their professional capacity, and in what context – having been notified of an incident, having personally witnessed an incident, or having personally experienced a refusal based on socio-demographic characteristics. More CMOs report having witnessed PRoP than having it reported to them: while 29% had never witnessed an incident of PRoP, 40% report never having been notified. Similar proportions (14%) have often or very often witnessed PRoP as have been notified of it. Over two-thirds of CMOs have never personally had their own care refused, while 5% reported sometimes or often personally experiencing PRoP.

At hospitals without formal PRoP statements in place, previous institutional consideration of the issue had infrequently occurred. A minority of CMOs reported having previously considered establishing formal guidance addressing PRoP at the hospital (13%). These CMOs reported lower levels of such consideration at the hospital staff or administrative level (8%), and only 3 institutions (2.4%) had previously had an unsuccessful experience trying to establish formal guidance addressing PRoP.

A majority (53%) of hospitals anticipate enacting formal guidance on PRoP in the future, although action would be unlikely in the next five years. No hospital characteristics were associated with increased likelihood of implementing formal PRoP guidance within 5 years (Table 7). Respondents most frequently identified Medical Affairs as the most likely office or department which would be charged with leading any future efforts to address PRoP with a formal statement. Other common replies included

the ethics committee, medical board, risk management, legal, Patient Relations/Advocacy, Compliance, equal employment opportunity (EEO) or diversity officer, Quality, Human Resources, bylaws committee, and clinical resource management.

Hospital Leaders' Perspectives

Nearly three quarters of respondents felt that current response to PRoP at their hospital was adequate, agreeing that hospital staff members successfully manage incidents of PRoP without formal guidance. At the same time, they overwhelmingly agreed (84%) that staff members would be receptive to formal guidance on how to respond when the issue arose, and most felt that their hospitals would implement formal guidance in the future (53%). Many CMOs considered the lack of existing evidence-based outcomes research (49%) and the lack of consensus regarding the appropriate response to PRoP (60%) to be barriers to addressing the issue with a formal statement. Furthermore, the majority of respondents acknowledged that attending physicians would expect the flexibility to handle PRoP at their discretion (78%).

CMOs were fairly evenly split on the importance of a formal statement, such as a policy or protocol, as part of any hospital plan to address PRoP, with 48% agreeing that such a statement would be a central aspect of any approach, and 43% disagreeing. Queried about how frequency of PRoP may influence decisions to develop formal guidance, over 95% of CMOs agreed that PRoP is a situation which arises infrequently, but over 40% of respondents felt that it is necessary for hospitals to provide guidance regardless. Many disagreed, with 55% asserting that PRoP arises infrequently and it is thus not necessary for hospitals to provide formal guidance.

Overall, survey respondents were fairly evenly split on whether PRoP is an issue that should be further addressed at their hospitals, with 46% agreeing and 49% disagreeing. There was no correlation between CMO perspectives on the desirability of addressing PRoP further and CMO socio-demographic characteristics (Table 8). Having been notified of, witness to, or personally experienced PRoP did not correlate with belief that PRoP should be further addressed, regardless of whether CMOs had those experiences never, rarely, sometimes, often, or very often (Table 9).

Views on Regulatory and Resource Considerations

Asked about appropriate involvement of accreditation bodies or regulatory agencies in addressing PRoP, nearly two-thirds did not want to see mandated adoption of a specific statement addressing PRoP, while one-third believed such a mandate should be put in place. Despite this opposition to specific mandates, over three quarters of CMOs agreed that the establishment of relevant industry or professional organization guidelines would increase the likelihood of their hospitals addressing PRoP.

Nearly two-thirds of CMOs felt that staffing limitations would not be a barrier to consistently granting patient requests for a different provider. The same proportion did not feel the hospital would be prepared to further diversify its staff in order to accommodate PRoP requests. CMOs were fairly evenly split on whether implementing a written PRoP statement would present any difficulties in terms of resources.

Balancing the Interests of Physicians and Patients

We were interested in eliciting hospital leaders' perspectives on the tension between the rights and expectations of patients and physicians which may arise in

instances of PRoP. Just over half of CMOs agreed that refusing to grant any patient request for a new physician violates the patient's health care rights, while roughly 40% disagreed that refusing requests made for any reason compromises the patient's rights. About a third of CMOs agreed that removing a physician from the care of a patient because of refusal on socio-demographic grounds violates the physician's right to equal treatment in the workplace. Just over half disagreed that honoring patient refusals in PRoP constituted a violation of the refused physician's expectation of equal treatment at work.

Neither CMO gender nor ethnicity correlated with CMO perspectives on these issues (Table 10). Respondents 60 years of age and older were more likely to believe that any denial of a patient request for a new physician violates patient health care rights than respondents less than 50 (OR 2.52, $p=0.03$). Foreign-born respondents were more likely to believe that removing a physician in instances of PRoP represents a violation of the physician's right to equal treatment in the workplace compared with US-born respondents (OR 3.16, $p=0.008$). Non-white respondents were also more likely to see this as a violation of equal treatment compared with white respondents (OR 2.55, $p=0.05$). No correlations were found between CMO perspectives on these issues and their experience with PRoP (Table 11).

DISCUSSION

This study is among the first to examine patient refusal of physician on the basis of perceived socio-demographic characteristics, using a national survey of US hospitals. We found that very few participating hospitals did have any formal statement (e.g. policy,

protocol, procedure) addressing PRoP, although some hospitals without formal statements have utilized other mechanisms to address this issue, including cultural competency didactics, resident orientation, and ethics committee consults. Nearly half of hospital leaders surveyed indicated that at their hospital, physicians are typically reassigned when PRoP arises, although very few hospitals collect data about incidents of PRoP or the demographics of patients and physicians involved.

Uncertainty and Variability in Response

As expected, most teaching hospitals surveyed did not have a formal statement addressing PRoP. In the absence of guidance from an institutionally endorsed policy or protocol, the response to PRoP was ad hoc; while many hospitals tended to discuss the situation and then reassign physicians, some would reassign immediately, while others favored whole-team discussions about the proper course of action. Almost a quarter of hospitals indicated that response at their institution is highly variable. This variability in response, both within and between institutions, creates an inconsistent environment for individual providers, who face uncertainty about what might constitute the most appropriate response within their particular context. The uncertainty that exists in the absence of institutional guidance itself constitutes one of the barriers to implementing a formal response, as evidenced by hospital leaders' agreement that the lack of consensus in these circumstances limits the hospital's ability to address PRoP with a formal statement.

This variability is consistent with findings in a survey of Emergency Room physicians (24) presented with hypothetical scenarios of patients requesting race, religion, or gender concordant providers. Physician gender influenced the likelihood of

accommodation, with female physicians accommodating requests for same-sex providers more often than male physicians. Furthermore, the race, religion, and gender of the patient in a given vignette also affected the likelihood that physicians would choose to accommodate a concordance request. This lack of uniformity contributes to the uncertainty around responding to these scenarios, as well as raising questions of consistency and fairness.

PRoP and Patient Autonomy

Another important area of uncertainty, as highlighted by the disagreement amongst respondents to our original research survey, is whether patient healthcare rights are violated if any request for a new physician is denied. CMO open-ended response comments outlined two distinct varieties of concerns about this issue: that refusing such request runs counter to patient autonomy and informed consent, and that refusing such requests causes irreparable damage to the patient-physician relationship.

The linked concepts of patient autonomy and informed consent in medical ethics grew out of a concern for paternalism and exploitation, asserting the centrality of the patient's values and their rights to maintain ultimate control over medical decisions influencing their bodily integrity. Such autonomy might extend beyond selecting particular therapeutic interventions to the selection of the individual performing those interventions on any grounds which the patient values. In this view, even blatantly discriminatory requests for a new physician must be honored, as the autonomous patient may withhold consent for their care from physicians of a certain socio-demographic profile.

An alternate perspective on patient refusal based on socio-demographic grounds is akin to a patient who demands a certain treatment or intervention which the physician or medical team does not believe is indicated. A conception of patient autonomy which is consistent with the physician declining such requests is that autonomy is “a negative freedom, a freedom from interference” rather than a positive freedom in which certain treatment is demanded (25). In this conception, the patient may decline to accept the care of a given physician, but the hospital is under no moral obligation to provide a physician from a different background, provided that the medical team does not believe the demanded “intervention” (a new physician) is urgently medically necessary. This is the approach taken in the policy of the British National Health Service (26).

Concordance and the Doctor-Patient Relationship

One possible harm that might arise from declining a patient’s request for a new physician is the degradation of the doctor-patient relationship. Several surveyed CMOs felt that change-of-physician requests must be honored in order to preserve this trusting relationship at the core of the provision of high-quality healthcare. Not only might distrust interfere with communication between a physician-patient pair forced to remain in a relationship, but a patient’s health might benefit from the increased comfort and trust he or she feels with a provider from a common background. Indeed, much research has demonstrated the benefits associated with racial concordance, including increased patient satisfaction (27), participatory decision-making (28), and decreased delays in seeking care along with improved utilization of needed services (29). While many physicians do not share patients’ views about the benefits of one-on-one concordance, they are often willing to accommodate specific requests on the basis of race, religion, or gender (24).

Along these lines, however, honoring a potentially-discriminatory request for a change in physician may increase concordance in one instance while decreasing opportunities for concordance overall. Racial/ethnic minority physicians, who experience refusal more frequently than white physicians (6), may feel that their work is devalued when they are removed from a patient's case; the cumulative effect of repeated small instances of disrespect, also termed "microinequities," (30) leads to an erosion of the individual's workplace experience, with potentially detrimental effects on their confidence and job performance. Beyond decreased professional satisfaction, such experiences influence an individual's decisions to exit a specific institution or the workforce. Attrition of minority physicians from any socio-demographic group decreases the opportunity for minority patients to be cared for by a concordant physician. Perhaps equally importantly, attrition of minority physicians creates a less diverse institution, which may be harmful to a patient's sense of connection to and representation by the hospital's medical staff overall even if not by their direct care providers, decreasing the opportunity for such institutional concordance.

Workplace Rights of the Refused Physician

While about a third of CMOs believed that reassigning a physician faced with refusal of their care based on socio-demographic characteristics constituted a violation of their right to equal treatment in the workplace, just over half of CMOs surveyed did not agree. As in the literature, perspectives regarding what type of protection is owed to physicians in the hospital vary: while some argue that physicians can rightfully expect a "duty of care" from their employers and draw parallels between assault, which is not tolerated, and racial abuse on the part of the patient (21), others believe it to fall within

the physician's responsibility to put the patient's needs above their own (18), and their professional obligation to treat patients regardless of their values and opinions (19). We found socio-demographic characteristics of respondents to be an uneven predictor of their perspective on physicians' expectations of equal treatment: while ethnicity did not correlate, race and foreign-born status did correlate with the belief that physician's rights are violated when PRoP leads to reassignment. One possible explanation of the foreign-born correlation might be that views within the medical profession about the limits of what constitutes reasonable patient autonomy vary internationally. We do not know, however, if these foreign-born respondents trained abroad as well, or how long they have been residing in the United States. Given the qualitative literature with descriptions of PRoP by physicians of African descent, and evidence that PRoP is more frequently experienced by minority physicians, it seems consistent that race other than white correlates with the belief that reassignment violates the physicians rights in circumstances of PRoP.

The British Experience

The issue of PRoP has been studied and addressed by the British National Health Service (NHS). Nearly one third of doctors and nurses employed by the NHS in Great Britain are racial/ethnic minorities; these minority staff (particularly blacks and Asians) experience bullying or harassment more often than their white colleagues, and are less likely to report it (31). This harassment comes from patients and patients' families, as well as colleagues and superiors. A study of racial harassment experienced by minority staff in the NHS revealed that while verbal abuse was the most common type of

harassment experienced by minority staff, refusals of care – particularly of black providers – were the second most commonly experienced form of racial harassment (32).

In 2005, the NHS implemented a policy (26) addressing PRoP on the basis of race, ethnicity, sexual orientation, disability and age. This “Policy for handling patients, their families and carers who refuse care from the PCT (Primary Care Trust) staff on racial or discriminatory grounds” outlines a stepwise course of action for staff faced with PRoP from informal to formal actions, while acknowledging that some patients may request a particular physician on the basis of “faith, religion, or culture.” The importance of completing an incident report form is heavily stressed.

The NHS PRoP policy explicitly defines a “racist incident [as]... any incident perceived to be racist by the victim or any person” and states that a refusal on discriminatory grounds is tantamount to a refusal of services. The document reinforces the NHS’ commitment to its “Zero Tolerance Policy” regarding verbal and physical abuse of staff, and explicitly states that “patients and service users do not have the right to request to be treated by a particular staff member for discriminatory reasons and no... staff will facilitate such requests.” A physician may only be reassigned with the agreement of the individual whose care was refused. Any efforts to adapt policy content would have to take into account important differences in the organization and financing of the British and American healthcare systems, as well the unique dynamics of the socio-demographic issues in each culture.

Considerations from Other Realms: Patient Refusal of Trainees

Because this investigation represents the first comprehensive analysis in this area of which we are aware, it is necessary to consider potential parallels to PRoP from both

medical and non-medical domains. Below, we consider PRoP within the context first of patient refusal of medical trainees, and then in the context of patient refusal of certified nursing assistants at nursing homes.

Patient refusal on the basis of physician training level is one important parallel to PRoP based on socio-demographic characteristics; in fact, several surveyed CMOs drew comparisons to patient refusal of trainees. There are various similarities in these situations, as well as key differences. When patients refuse trainees at a teaching institution, there is conflict between the concern for the individual patient's comfort, privacy, and autonomy and the mission of the teaching hospital as a training grounds for the next generation of medical professionals (33). The concern for protecting patient autonomy and for the impact of patient comfort and preference on the patient-physician relationship is common to both types of refusal scenarios.

Various ethical arguments have been articulated regarding the patient's potential moral obligation to allow trainees to participate in their care. One such argument posits that if patient refusals cannot be universalized (e.g. if all patients opted out of receiving care from trainees, medical education could not continue), such refusals may not be morally permissible (34). While the utilitarian position puts forth that more overall good comes from having a trainee participate in medical care than having a fully trained physician deliver that care, the communitarian position broadly holds that patients who benefit from the medical system have an obligation to contribute to that system as well (34, 35). Such social obligation arguments might also find a parallel in the realm of PRoP based on socio-demographic characteristics. Given that diversifying the healthcare workforce is one approach to addressing health disparities and is thus a societal good, it

could be argued that hospitals have an obligation to consider the benefit of the broader patient population alongside the benefit conferred to any individual patient having their preferences honored.

However, the particular harms to which a patient being cared for by a trainee might be exposed (risk of pain and complications due to inexperience, a weaker relationship with the supervising physician because of the various levels of medical trainees interacting with the patient) (35) are distinct from those harms which might come to a patient who would prefer to decline care from physicians of a certain socio-demographic background (discomfort and distrust adversely affecting the patient-physician relationship). In refusals based on socio-demographic characteristics, patients are not seeking to avoid the harms of being cared for by novices honing their clinical skills. Taking a competency-based view of patient refusal of trainees (36), then, arguments against the patient's moral obligation to participate in clinical teaching would not extend to patient refusals to be cared for by competent physicians of a given background.

Considerations from Other Realms: Certified Nursing Assistants at Nursing Homes

Although the empirical literature is thin on this issue, trade journals and online sources reveal that certified nursing assistants (CNAs) at nursing homes experience patient refusal of their care based on socio-demographic characteristics. The American Journal of Nursing's *Off the Charts* blog recently covered the story of a black CNA who sued the nursing home at which she worked because of the nursing home's acquiescence to a patient's demands to not have black healthcare workers involved in her care (37). In addition to race-based refusals, incidents of gender-based refusals of CNAs are reported,

particularly amongst male CNAs. One such case involved a male CNA, hired for the night shift, who was fired due to the nursing home's concerns that female residents had heightened fear of sexual assault from male CNAs during the evening hours (38). Both of these cases were tried in court, where the CNAs' claims of discrimination were held to be valid.

Legal Considerations around PRoP

Beyond considering how race-preference and provider refusals are handled in other realms, hospitals developing and implementing guidance around PRoP will certainly explore the legal context for any such document. Although it is beyond the scope, and not the intention, of this thesis to comprehensively review the potential legal arguments pertaining to PRoP, it is interesting to consider how the law treats employer actions based on socio-demographic characteristics. Such actions fall under Title VII of the Civil Rights Act of 1964, which makes it illegal for an employer "...to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment...[or] to limit, segregate, or classify his employees... in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race, color, religion, sex, or national origin." The only exception to this is a situation in which the employer can establish that a given socio-demographic characteristic may be considered a "bona fide occupational qualification" (BFOQ), meaning that the characteristic is somehow necessary for the individual to carry out the responsibilities of a given job – for example, airline pilots being forced to retire by age 60, or women being excluded from certain guard positions at maximum security prisons. While age, sex,

national origin and religion-based discrimination can sometimes be justified using the BFOQ defense, race or color discrimination cannot. Furthermore, employers may not simply cite customer preference as a BFOQ, as this would dilute the protection that the Civil Rights Act was intended to confer. This raises questions regarding to the similarities and differences between “customer preference” and patient preference, given the relationship between patient preference and the doctor-patient relationship. Since part of claiming a BFOQ is factual proof that the discrimination being sanctioned is related to a business’s “essence” or “central mission,” is there evidence that a physician cannot provide a reasonable level of care to a patient despite any damage to that relationship, or that outcomes for patients’ acute hospitalizations would be significantly worsened? The matter is further complicated by the fact that patient preference in the medical context also involves consent, and by the frequent (gender-asymmetrical, and questionably consistent) manner in which “privacy” is cited as justification for sex-based BFOQ claims (39) (40).

CMO Awareness, Reporting, and Frequency of PRoP

Despite the variety of perspectives regarding patient and physician rights in PRoP, a majority of hospital leaders felt that staff members successfully manage incidents of PRoP without formal guidance. Our survey did not probe each respondent’s understanding of “success” in this context, but likely it was broadly taken to imply that a resolution was found which was acceptable to all parties involved. Given that only a minority of hospitals reported collecting data about PRoP, the CMO might only learn of an incident if the hospital’s formal or informal policy requires the involvement of the CMO, or if the incident escalated beyond settlement by the medical team and the patient

involved. In the absence of a data collection mechanism and requirement, incidents of PRoP successfully managed on an ad hoc basis by the medical team are likely to go underreported to hospital leadership by physicians who may wish to avoid being labeled as sensitive, or who may be concerned about professional retribution for filing complaints. The likelihood of underreporting of PRoP might suggest that the frequency estimates we present may represent an underestimation of the phenomenon. It is also notable that CMOs report having witnessed PRoP more often than having been notified of it in their professional capacity, again possibly suggesting underreporting. While using CMO estimates as an indirect measure for PRoP frequency is imperfect, it is valuable data representing the best guess of hospital leaders. Furthermore, a sizable minority of hospital leaders indicated that despite the relative infrequency of PRoP, they felt it merited formal guidance regardless.

Flexibility Desirable in Any Approach to PRoP

There are many formats in which hospitals might choose to address PRoP; respondents were fairly evenly split on whether a formal statement should necessarily be part of any official institutional approach to addressing PRoP, often expressing concern that rigid protocols would not be appropriate for a sensitive, highly individual matter. Similarly, a desire to preserve physician discretion was revealed by CMO aversion to regulatory agencies mandating adoption of a specific PRoP statement, and by their opinion that attending physicians would expect flexibility to handle PRoP at their discretion. Accordingly, any form of formal PRoP guidance, written or otherwise, must preserve some measure of provider discretion in order to be acceptable to hospital administrators.

With CMOs divided on whether a formal statement, per se, is necessary or even desirable, some may find other approaches of addressing PRoP more palatable. Various hospitals report addressing PRoP through existing structures— resident orientation, medical staff meetings, grand rounds – which might accomplish similar goals to the implementation of a formal written statement. Such activities could be used to train staff in how to approach the patient, what resources and support are available to them, and help open a conversation around what would constitute an appropriate or desirable response that is sensitive to the local context and preferences of individuals involved. Such sessions, in addition to providing relevant training, create a forum within which the hospital can provide some official acknowledgement about the personal and professional challenge that such situations pose, counterbalancing the microinequity that affected individuals may experience.

Previous work on racial concordance may provide some insight into how individuals might be trained to have productive conversations with patients around their refusal to be cared for by a given physician. LaVeist and Nuru-Jeter put forth three hypotheses about why patients are more satisfied with care rendered by a racially-concordant physician: 1) increased comfort and ability to relate culturally with the physician, 2) negative attitudes about members of a culturally-unrelated group stemming from internalized racism or historical discrimination and distrust, and 3) experiential trust derived from previous negative encounters with others along with previous positive encounters with members of their own cultural group (27). Similarly, any of these 3 possibilities may form part of an explanatory model for why a patient would refuse a physician of a particular socio-demographic background, and this framework could

provide an overall structure with which to approach the patient. Many survey respondents who worried that a formal statement would be too prescriptive to allow physicians to account for the particulars of a patient's history which might have led to their refusal of a given physician cited experiential factors in particular. Several leaders from Veterans' Administration hospitals described combat veterans refusing care from physicians who resembled populations against whom they had engaged in warfare. Others wished to reserve special consideration for patients who had experienced sexual trauma or presented with other mental health issues.

Institutions Welcome Guidance, Consider Future Action

Despite being averse to having regulatory agencies mandate a particular approach to PRoP, CMOs indicated that they would welcome industry or professional organizations guidelines assisting hospitals in addressing this issue. They also projected that staff members would be receptive to formal guidance on how to respond to PRoP. Our survey results indicate that PRoP has not been an issue highly prioritized by hospital administrators, as indicated by the unlikelihood that formal guidance would be issued in the near future. Yet, while very few CMOs reported that they or their hospitals have ever considered addressing PRoP in the past, many more agreed that PRoP is an issue that should be further addressed at their hospital.

Limitations

This study is vulnerable to non-respondent bias, as hospital leaders who are interested in workplace diversity issues may have been more likely to elect to participate in our survey than CMOs who are not interested in, or perhaps uncomfortable with, these

issues. By excluding data from incomplete surveys, we may further introduce withdrawal bias. Both of these biases might tend to skew our sample towards respondents with a particular interest in workforce and diversity concerns. Finally, social-desirability bias may influence subjects to select responses they suspect to be more favorable to the investigators, or more broadly.

Non-respondents and withdrawal bias were addressed through an intensive data collection effort, including specifically targeting individuals who did not complete the survey to address their concerns, technical or otherwise. In order to minimize social-desirability bias, the questionnaire was developed with much attention to neutral wording of questions and response choices. Cognitive interviews were used to assess and confirm the semantic neutrality of the questionnaire, as well as to uncover any other issues of bias that the administrator interviewees perceived. Finally, we highlighted the confidentiality of all responses by reinforcing our protocol to de-identify all submitted surveys.

Finally, CMOs were asked to estimate frequency of PRoP as well as characterize the typical ad hoc response at their hospitals, when these data are not systematically collected at their hospitals. Although other methods (direct observation, surveying physicians) might yield more accurate estimates, we chose to survey CMOs regarding this data because their perception of frequency and typical response would be likely to inform the institutional approach to PRoP, given their role within the hospital.

Implications and Directions for Further Investigation

This study represents a first attempt to characterize the experiences and views of key hospital administrators on a potentially important workforce-related phenomenon – patient refusal of physician on the basis of socio-demographic characteristics. A minority

of teaching hospitals has already implemented formal written guidance to guide staff response to PRoP. Further investigation into the content of these policies may contribute to future efforts to develop national practice guidelines for these circumstances. We found hospital leaders to be receptive to utilizing guidance put forth by professional organizations. Furthermore, we identified the roles and departments that would be responsible for developing and implementing any such guidelines at the hospital level.

While we wish to be explicit that we do not present addressing PRoP as a panacea for healthcare workplace diversity challenges, we believe that findings from this novel, national survey will inform future research directions, with implications for pertinent policy initiatives. Hospital administrators have varied views on addressing PRoP, including whether a formal statement is the best approach to this issue. Their hesitation is not related to resource limitations, but rather to ambiguity on the appropriate response in these circumstances, and doubts regarding whether a formal statement would allow an acceptable amount of flexibility in adapting response to each particular situation. Thus, any future guidelines around PRoP must incorporate mechanisms to preserve physician discretion and reinforce the centrality of the doctor-patient relationship. Additionally, further research might build on previous work focused on accommodations of requests for concordance by investigating physicians' perspectives and decision-making in circumstances of patient refusals; although requests and refusals lay along a spectrum of actions by patient who desire a physician of a particular background, not all refusals are actually requests for concordance, and the accommodation of a refusal may carry different implications than the accommodation of a request. It will be important to examine the various outcomes of different approaches to resolving situations of PRoP,

and to gauge the acceptability of those outcomes to the individuals involved and the impact on overall job satisfaction and satisfaction with the workplace culture for diversity. Furthermore, similar investigations should be undertaken in the realm of nursing, where similar patient refusal scenarios arise, possibly with greater frequency than physician refusals.

As the healthcare workforce diversifies, hospitals may find the physician staff increasingly challenged with PROp and other situations that arise in the multicultural setting of American teaching hospitals. Addressing PROp through formal guidance – policy, protocol, or otherwise – allows hospitals an entry point into the multifaceted problem of implementing effective diversity initiatives, while demonstrating institutional commitment to a creating a inclusive culture. Supporting and retaining a diverse physician workforce is a pivotal aspect of addressing ongoing health disparities in the United States.

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FIGURES & TABLES

FIGURE 1: Study Sample

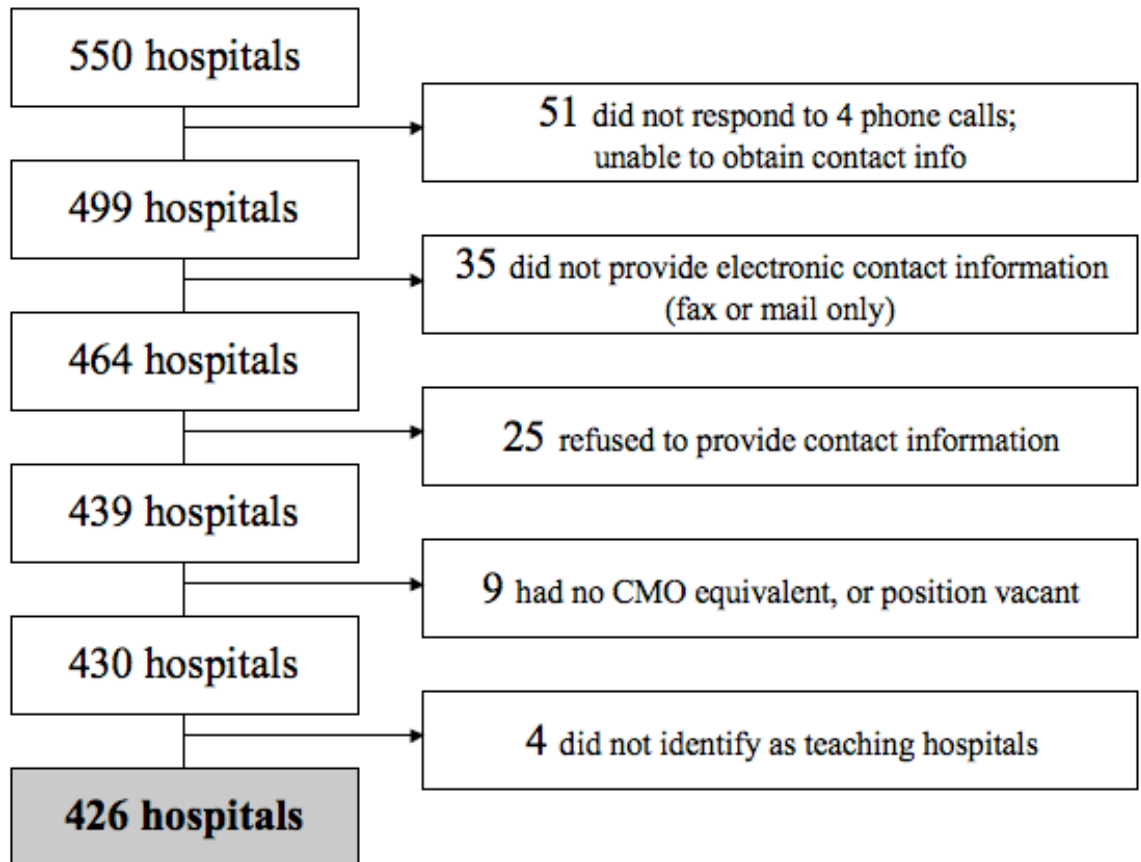


TABLE 1: Variables of Interest

Primary Outcome of Interest	Secondary Outcome Variables
Existence of a formal statement (e.g. policy, protocol, bylaws) addressing response to PRoP	Typical response to PRoP Frequency of PRoP CMO experience with PRoP Likelihood PRoP will be addressed in the future CMO perspective on patient and physician rights
Hospital Characteristics	CMO Socio-demographic Characteristics
Bed size Number of annual admissions Ownership type Geographic region Collection of patient race/ethnicity data Enactment of hospital diversity plan	Gender Age Race Ethnicity National Origin

TABLE 2: Comparison of Study Sample Characteristics with Complete AHA Survey Teaching Hospital Population Characteristics

Hospital Characteristic	Study Sample n (%)	All Teaching Hospitals n (%)	p- value
	N=426	N=1086	
Bed Size			0.18
0-99	41 (10)	131 (12)	
100-299	156 (36)	415 (38)	
>300	229 (54)	540 (50)	
Annual Admissions			0.49
0-9,999	160 (38)	415 (38)	
10-29,999	223 (52)	552 (51)	
30,000+	43 (10)	119 (11)	
Ownership Type			0.16
Government	137 (32)	312 (29)	
Not-for-Profit	267 (63)	696 (64)	
Investor Owned For-Profit	22 (5)	78 (7)	
Geographic Region			1.00
Northeast	33 (8)	79 (7)	
Mid-Atlantic	72 (17)	180 (17)	
South	137 (33)	355 (33)	
Midwest	106 (25)	270 (25)	
West	72 (17)	185 (17)	
Gathers Patient Race/Ethnicity Data*			0.10
Yes	314 (74)	774 (71)	
No	12 (3)	50 (5)	
Considering/Enacting Diversity Plan*			0.07
Yes	284 (67)	685 (63)	
No	36 (8)	131 (12)	

* Percentages of responses to these fields do not sum to 100 because missing data is excluded from the table. These items had 23% (gathers patient race/ethnicity data) and 25% (considering/enacting diversity plan) missing data in the 2007 AHA Annual Survey Database. All other variables in this chart had less than 2% missing data.

TABLE 3: Comparison of Characteristics of Responding and Non-Responding Hospitals Within The Study Sample

Hospital Characteristic	Respondents n (%)	Non-respondents n (%)	p-value
	N=221	N=205	
Bed Size			0.68
0-99	23 (10)	18 (9)	
100-299	77 (35)	79 (38)	
>300	121 (55)	108 (53)	
Annual Admissions			0.96
0-9,999	82 (37)	78 (38)	
10-29,999	116 (53)	107 (52)	
30,000+	23 (10)	20 (10)	
Ownership Type			0.59
Government	76 (34)	61 (30)	
Not-for-Profit	134 (61)	133 (65)	
Investor Owned For-Profit	11 (5)	11 (5)	
Geographic Region			0.66
Northeast	18 (8)	15 (8)	
Mid-Atlantic	43 (20)	29 (15)	
South	71 (32)	66 (33)	
Midwest	51 (23)	55 (27)	
West	37 (17)	35 (17)	
Gathers Patient Race/Ethnicity Data*			0.38
Yes	157 (71)	157 (77)	
No	6 (3)	6 (3)	
Considering/Enacting Diversity Plan*			0.53
Yes	143 (65)	141 (69)	
No	18 (8)	18 (9)	

* Percentages of responses to these fields do not sum to 100 because missing data is excluded from the table. These items had 23% (gathers patient race/ethnicity data) and 25% (considering/enacting diversity plan) missing data in the 2007 AHA Annual Survey Database. All other variables in this chart had less than 2% missing data.

TABLE 4: Socio-demographic Characteristics of Responding Chief Medical Officers (CMOs)

CMO Characteristics	n (%)
Gender	
Male	178 (81)
Female	38 (17)
Decline to Respond	5 (2)
Age	
Under 50	43 (19)
50-59	97 (44)
60 and over	75 (34)
Decline to Respond	6 (3)
Race	
White	188 (85)
Black or African-American	7 (3)
Asian	10 (5)
Other	6 (2)
Decline to Respond	10 (5)
Ethnicity	
Hispanic or Latino	11 (5)
Non-hispanic or Latino	203 (92)
Decline to Respond	7 (3)
National Origin	
US-born	190 (86)
Foreign-Born	27 (12)
Decline to Respond	4 (2)

TABLE 5: Existence of a Formal PRoP Statement by Hospital Characteristic

Hospital Characteristic	Formal Response in Place	Unadjusted OR (95% CI)	P-value	Adjusted OR (95% CI)	P-value
	n/N (%)				
Bed Size		0.22		0.61	
0-99	5/23 (22)	1.00		1.00	
100-299	10/77 (13)	0.54 (0.16-1.77)		1.21 (0.28-5.16)	
>300	11/121 (9)	0.36 (0.11-1.16)		2.17 (0.38-12.3)	
Annual Admissions		0.003*		0.004*	
0-9,999	18/82 (22)	1.00		1.00	
10-29,999	6/116 (5)	0.19 (0.07-0.50)		0.08 (0.02-0.36)	
30,000+	2/23 (9)	0.34 (0.07-1.58)		0.12 (0.02-0.94)	
Ownership Type		0.98		0.19	
Government	9/76 (12)	1.00		1.00	
Not-for-Profit	17/134 (13)	1.08 (0.46-2.56)		3.1 (0.91-10.6)	
Investor Owned For-Profit	0/11 (0)	#		#	
Geographic Region		0.69		0.35	
Northeast	3/18 (17)	1.00		1.00	
Mid-Atlantic	4/43 (9)	0.51 (0.10-2.59)		0.43 (0.07-2.51)	
South	9/71 (13)	0.73 (0.18-3.01)		0.56 (0.12-2.69)	
Midwest	10/51 (20)	1.22 (0.30-5.04)		1.58 (0.34-7.45)	
West	0/34 (0)	#		#	
Gathers Patient Race/Ethnicity Data		0.9		1	
No	0/6 (0)	1.00		1.00	
Yes	18/157 (11)	##		##	
No Response	8/58 (14)	##		##	

Considering/Enacting Diversity Plan		0.36		0.84	
No	4/18 (22)	1.00		1.00	
Yes	15/143 (10)	0.41 (0.12-1.41)		0.61 (0.12-3.13)	
No Response	7/60 (12)	0.46 (0.12-1.81)		#	

indicates SAS output OR <0.001(<0.001 - >999.999) with warning regarding questionable validity of model fit

indicates SAS output OR >999.999(<0.001 - >999.999) with warning regarding questionable validity of model fit

TABLE 6: Likelihood PRoP Will Result in Physician Reassignment, by Hospital Characteristic

Hospital Characteristic	Likely to Reassign	Unadjusted OR (95% CI)	P-value	Adjusted OR (95% CI)	P-value
	n/N (%)				
Bed Size		0.33		0.49	
0-99	6/18 (33)	1.00		1.00	
100-299	31/67 (46)	1.72 (0.58-5.13)		2.06 (0.58-7.23)	
>300	57/110 (52)	2.15 (0.75-6.14)		2.27 (0.57-8.96)	
Annual Admissions		0.29		0.47	
0-9,999	27/64 (42)	1.00		1.00	
10-29,999	54/110 (49)	1.32 (0.71-2.46)		1.09 (0.46-2.61)	
30,000+	13/21 (62)	2.23 (0.81-6.12)		2.04 (.57-7.33)	
Ownership Type		0.75		0.96	
Government	30/67 (45)	1.00		1.00	
Not-for-Profit	59/117 (50)	1.03 (0.29-3.70)		1.05 (0.53-2.09)	
Investor Owned For-Profit	5/11 (45)	1.13 (0.69-2.30)		1.25 (0.27-5.70)	

Geographic Region		0.13		0.11	
Northeast	4/15 (27)	1.00		1.00	
Mid-Atlantic	23/39 (59)	3.95 (1.06-14.65)	0.04*	4.70 (1.10-20.07)	0.04*
South	25/62 (40)	1.85 (0.53-6.50)		2.24 (0.55-9.17)	
Midwest	23/41 (56)	3.51 (0.96-12.89)		4.67 (1.12-19.53)	0.04*
West	19/37 (51)	2.90 (0.781-10.80)		3.67 (0.85-15.79)	
Gathers Patient Race/Ethnicity Data		1		0.86	
No	3/6 (50)	1.00		1.00	
Yes	67/139 (48)	0.93 (0.18-4.77)		0.63 (0.11-3.63)	
No Response	24/40 (48)	0.92 (0.17-5.02)		#	
Considering/Enacting Diversity Plan		0.6		0.88	
No	5/14 (36)	1.00		1.00	
Yes	62/128 (48)	1.69 (0.54-5.32)		1.36 (0.39-4.73)	
No Response	27/53 (51)	1.87 (0.55-6.32)		##	

Responding hospitals were designated as “Likely to Reassign” if the CMO indicated that the typical response to PRoP was either “Patient will immediately be assigned a new physician, whenever another physician is available” or “Patient’s intention will be clarified and the physician’s credentials will be reiterated to the patient; if the patient continues to refuse, he/she will be given a new physician, whenever another physician is available.”

indicates SAS output OR <0.001(<0.001 - >999.999) with warning regarding questionable validity of model fit

indicates SAS output OR >999.999(<0.001 - >999.999) with warning regarding questionable validity of model fit

TABLE 7: Hospital Characteristics Associated with Self-Reported Likelihood of Formally Addressing PRoP within 5 Years

Hospital Characteristic	Likely to Implement Formal Response	Unadjusted OR (95% CI)	P-value	Adjusted OR (95% CI)	P-value
	n/N (%)				
Bed Size		0.37		0.2	
0-99	6/18 (33)	1.00		1.00	
100-299	26/67 (39)	1.27 (0.42-3.80)		1.92 (0.55-6.74)	
>300	52/110 (47)	1.79 (0.63-5.12)		3.20 (0.81-12.64)	
Annual Admissions		0.77		0.59	
0-9,999	29/64 (45)	1.00		1.00	
10-29,999	45/110 (41)	0.84 (0.45-1.56)		0.63 (0.26-1.55)	
30,000+	10/21 (48)	1.10 (0.41-2.95)		0.77 (0.22-2.73)	
Ownership Type		0.6		0.48	
Government	32/67 (48)	1.00		1.00	
Not-for-Profit	47/117 (40)	0.73 (0.40-1.35)		0.69 (0.34-1.38)	
Investor Owned For-Profit	5/11 (45)	0.91 (0.25-3.28)		1.23 (0.27-5.55)	
Geographic Region		0.53		0.36	
Northeast	6/15 (40)	1.00		1.00	
Mid-Atlantic	21/39 (54)	1.75 (0.52-5.87)		1.97 (0.53-7.30)	
South	25/62 (40)	1.01 (0.32-3.20)		0.98 (0.28-3.46)	
Midwest	19/41 (46)	1.30 (0.39-4.31)		1.66 (0.46 -6.01)	
West	13/37 (35)	0.81 (0.24-2.80)		0.88 (0.23 -3.36)	
Gathers Patient Race/Ethnicity Data		0.82		0.84	
No	3/6 (50)	1.00		1.00	
Yes	58/139 (42)	0.72 (0.14 -3.68)		0.59 (0.10-3.55)	
No Response	23/50 (46)	0.85 (0.16-4.64)		#	

Considering/Enacting Diversity Plan		0.37		0.72	
No	4/14 (29)	1.00		1.00	
Yes	54/128 (42)	1.82 (0.54-6.12)		1.71 (0.46-6.27)	
No Response	26/53 (49)	2.41 (0.67-8.64)		##	

indicates SAS output OR <0.001(<0.001 - >999.999) with warning regarding questionable validity of model fit

indicates SAS output OR >999.999(<0.001 - >999.999) with warning regarding questionable validity of model fit

TABLE 8: CMO Socio-demographic Characteristics and Correlation with PRoP Perspectives

Characteristic		n/N (%)	Unadjusted OR (95% CI)
GENDER	Male	73/159(46)	1
	Female	13/34(38)	0.68(0.32-1.47)
AGE	<50	14/38(37)	1
	50-59	43/86(50)	1.71(0.78-3.75)
	>59	29/68(43)	1.28(0.56-2.88)
NATIONAL ORIGIN	US-born	72/166(43)	1
	Foreign-born	13/26(50)	1.31(0.57-2.99)
ETHNICITY	Hispanic or Latino	5/10(50)	1.22(0.34-4.37)
	Non-hispanic or Latino	81/180(45)	1
RACE	White	75/166(45)	1
	Other	11/21(52)	1.34(0.54-3.31)

Socio-demographic characteristics of CMOs who chose “agree” or “strongly agree” in response to the statement “*Patient refusal of physician is an issue that should be further addressed at this hospital.*”

*The denominators do not sum equally in each category because individuals who selected “decline to respond” were included in the analysis as a separate group, but the data is not shown in this table and no correlations were statistically significant.

TABLE 9: CMO Experience with PRoP and Correlation with PRoP Perspectives

Experience with PRoP	Frequency	n/N (%)	Unadjusted OR (95% CI)
NOTIFIED of an incident of PRoP	Never or Rarely	72/172 (42)	1
	Sometimes	13/20 (65)	2.58(0.98-6.79)
	Often or Very Often	2/3 (67)	2.78(0.25-31.22)
Personally WITNESSED PRoP	Never or Rarely	69/165 (42)	1
	Sometimes	12/23 (52)	1.52(0.63-3.64)
	Often or Very Often	5/5 (100)	##
Personally EXPERIENCED PRoP	Never or Rarely	78/180 (43)	1
	Sometimes	5/7 (71)	3.27(0.62-17.30)
	Often or Very Often	2/2 (100)	##

PRoP experience of CMOs who chose “agree” or “strongly agree” in response to the statement “*Patient refusal of physician is an issue that should be further addressed at this hospital.*”

*The denominators do not sum equally in each category because individuals who selected “not applicable” were included in the analysis as a separate group, but the data is not shown in this table and no correlations were statistically significant.

indicates SAS output OR >999.999(<0.001 - >999.999) with warning regarding questionable validity of model fit

TABLE 10: CMO Socio-demographic Characteristics and Correlation with Beliefs Regarding Reassigning Physicians in PRoP

Characteristic		Patient health care rights are compromised when requests for a change in physician, for any reason, are refused.		Removing a physician from the care of a patient because of refusal on socio-demographic grounds violates the physician's right to equal treatment in the workplace.	
		n**/N (%)	Unadjusted OR (95% CI)	n**/N (%)	Unadjusted OR (95% CI)
GENDER	Male	88/159 (55)	1	55/159 (35)	1
	Female	17/34 (50)	0.81 (0.38-1.69)	10/34 (29)	0.788 (0.35-1.77)
	Decline to Respond	1/2 (50)	0.81 (0.05-13.13)	0/2 (0)	#
AGE	<50	16/38 (42)	1	13/38 (34)	1
	50-59	44/86 (51)	1.44 (0.67-3.11)	25/86 (29)	0.79 (0.35-1.78)
	>59	44/68 (65)	2.52 (1.12-5.69)* p=0.03	26/68 (38)	1.19 (0.52-2.73)
	Decline to Respond	2/3 (67)	2.75 (0.23-33.01)	1/3 (33)	0.96 (0.08-11.62)
NATIONAL ORIGIN	US-born	92/166 (55)	1	50/166 (30)	1
	Foreign-born	13/26 (50)	0.80 (0.35-1.84)	15/26 (58)	3.16 (1.39-7.37)* p=0.008
	Decline to Respond	1/3 (33)	0.40 (0.04-4.52)	0/3 (0)	#

ETHNICITY	Hispanic or Latino	8/10 (80)	3.58 (0.74-17.32)	3/10 (30)	0.86 (0.21-3.43)
	Non-hispanic or Latino	95/180 (53)	1	60/180 (33)	1
	Decline to Respond	3/5 (60)	1.34 (0.22-8.23)	2/5 (40)	1.33 (0.22-8.20)
RACE	White	88/166 (53)	1	50/166 (30)	1
	Other	12/21 (57)	1.18 (0.47-2.96)	11/21 (52)	2.55 (1.02-6.39)* p=0.05
	Decline to Respond	6/8 (75)	2.66 (0.52-13.56)	4/8 (50)	2.32 (0.56-9.65)

**Respondents who agree or strongly agree with statements at top of each column

indicates SAS output OR <0.001(<0.001 - >999.999) with warning regarding questionable validity of model fit

TABLE 11: Impact of CMO Experience with PRoP on Perspectives on Reassigning Physicians

Experience with PRoP	Frequency	Patient health care rights are compromised when requests for a change in physician, for any reason, are refused.		Removing a physician from the care of a patient because of refusal on socio-demographic grounds violates the physician's right to equal treatment in the workplace.	
		n**/N (%)	Unadjusted OR (95% CI)	n**/N (%)	Unadjusted OR (95% CI)
NOTIFIED of an incident of PRoP	Never or Rarely	96/172 (56)	1	60/172 (35)	1
	Sometimes	8/20 (40)	0.53 (0.21-1.36)	5/20 (25)	0.62 (0.22-1.80)
	Often or Very Often	2/3 (67)	1.58 (0.14-17.79)	0/3 (0)	#
Personally WITNESSED PRoP	Never or Rarely	92/165 (56)	1	56/165 (34)	1
	Sometimes	11/23 (48)	0.73 (0.30-1.74)	8/23 (35)	1.04 (0.42-2.60)
	Often or Very Often	2/5 (40)	0.53 (0.09-3.25)	0/5 (0)	#
Personally EXPERIENCED PRoP	Never or Rarely	100/180 (56)	1	59/180 (33)	1
	Sometimes	2/7 (29)	0.32 (0.06-1.69)	4/7 (57)	2.73 (0.59-12.62)
	Often or Very Often	0/2 (0)	#	0/2 (0)	#

**Respondents who agree or strongly agree with statements at top of each column.

Two individuals selected “not applicable” for witnessing PRoP and 6 for personally experiencing PRoP. “Not applicable” was analyzed as an independent subgroup and no statistically significant correlation was found; data omitted from this table.

indicates SAS output OR <0.001(<0.001 - >999.999) with warning regarding questionable validity of model fit