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Provider Factors in Healthcare Disparities

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Several factors related to healthcare providers may be associated with healthcare disparities. Communication is fundamental to the healthcare process. Patient–provider communication is a multidimensional concept relating in part to both providers and patients. This chapter will discuss those aspects of patient–provider communication more closely related to the provider. Chapter 3 will discuss those patient–provider communication issues more closely related to patients.

Provider Communication

Most of the research being conducted prior to 1990 on the relationship between communication and healthcare outcomes came from European (British, Dutch, and American) studies with relatively little work conducted on other populations. In addition, the medical and communication models originating with these ethnic traditions considered the ideal doctor–patient relationship as somewhat paternalistic with the patients receiving and obeying medical instructions (Ong, de Haes, Hoos, & Lammes, 1995; Roter & Hall, 1993). Early investigators studied the technical or medical competency aspects of the doctor–patient visit, the degree to which the physicians responded to nonsomatic or psychosomatic issues and the degree to which open, secure, and workable relationships were established (Roter & Hall).

The motives underlying physician communication have also been studied. Provider motives have been defined as instrumental or socioemotional. Instrumental communication is communication that is focused on the so-called “cure” aspects of treatment (i.e., signs, symptoms, tests, treatments, side effects). Socioemotional communication is that communication that is focused on the so-called “care”-oriented behaviors (i.e., feelings, emotions, daily functioning, coping) (Ong et al., 1995). Most of the communications and health quality literature have focused on instrumental communication and particularly the information giving and seeking behaviors of doctors. These studies suggest that the amount of information given during the medical visit appears to increase as patient expressions of questioning and concern

increase (Ong et al.). Also, increased physician-affective behaviors, including listening without interruption and use of first names, are associated with improved patient-provider communication.

Both verbal and nonverbal communications have been investigated in relation to healthcare outcomes. Nonverbal communication refers to tone of voice, eye contact, facial expressions, touch, and physical distance. Unfortunately, no single systematic approach has been used to codify these interactions and thus conclusions derived from this literature are difficult (Ong et al., 1995).

The study of the physician's vocabulary in the medical encounter is an area of active research. One study by Hadlow and Pitts demonstrated that common medical terms used by physicians and medical professionals are often misunderstood by patients (Roter & Hall, 1993). More recently a national survey conducted by the Commonwealth Fund found that problematic communication between physicians and patients occurred more often among English-speaking African-Americans, Hispanics, and Asian-Americans than Whites (Collins et al., 2002). These problems are heightened among patients who do not speak English as their primary language. This study also found that compared to White patients, African-Americans, Hispanics, and Asian-Americans were less likely to have great confidence in their doctors, less likely to be as involved in their own care as they would like and less likely to have as much time with their doctors as they would like (Collins et al.). Unfortunately, these problems are not unique to minority populations. This same study found that approximately 18% of all adults with healthcare visits in the recent past reported problems communicating with their doctors (Collins et al.).

Provider Communication and Select Healthcare Outcomes

Studies investigating the influence of language and communication on patient outcomes have largely been focused on three major areas – satisfaction, compliance, and physiologic outcomes. While the vast majority of the work has been in the satisfaction and compliance areas, each category will be briefly discussed below.

Patient Satisfaction

Many studies have been done investigating the relationship between information seeking or provision by a physician and patient satisfaction (Williams, Weinman, & Dale, 1998). Most, but not all, studies of physician information sharing found that provision of information by doctors to patients is associated with increases in patient satisfaction. In contrast though, a physician's spending increased amounts

of time on a patient's history was associated with decreases in patient satisfaction (Williams et al.).

Studies have also been conducted evaluating the link between patient satisfaction and the nature of the doctor-patient relationship. The personal manner (bedside manner) has been associated with patient satisfaction. Physicians displaying behaviors such as being friendly, approving, engaging in social nonmedical conversation with patients, those who use encouraging, empathetic behaviors, and those physicians who engage in partnership building during the consultation are physicians who tend to have higher satisfaction rates among their patients (Roter & Hall, 1993; Roter, Hall, & Katz, 1987). It is unclear if physician's tone of voice or physician's affect significantly impacts patient satisfaction. Among the studies investigating this idea, the results are mixed with some studies finding a positive association and others finding a negative association with patient satisfaction (Roter & Hall; Roter et al.).

Finally, communication style and its relationship to patient satisfaction have been evaluated. In general, a disease-focused approach is perceived by patients as being doctor-led and an approach in which the doctor is focusing on his own agenda. On the other hand, a patient-centered approach is perceived by patients as being patient led and one where the doctor is listening and responding to the concerns of the patient. Many studies in this area find that higher rates of patient satisfaction are associated with higher degrees of patient-centered communication.

Patient Compliance

Early studies of patient compliance were only able to demonstrate weak associations between enhanced communication and patient compliance (Roter, 1989). More recently it has been suggested that patients with language barriers may be *less* likely to receive a follow-up appointment, but if given one, patients with language barriers are equally likely to keep a follow-up appointment as those without language barriers (Sarver & Baker, 2000).

The term "adherence" is increasingly used to reflect the patient perspective. Adherence is defined as a collaborative effect of healthcare providers and consumers to achieve mutually agreed health goals (Rose, Kim, Dennison, & Hill, 2000). It is estimated that only 50% of patients in the general population are adherent to long-term medical regimens (Charles, Good, Hanusa, Chang, & Whittle, 2003).

Although studies directly investigating adherence across racial and ethnic groups are few, some studies suggest that African-Americans and other special populations may have lower rates of adherence (Charles et al., 2003) as compared to Whites. On the other hand, increased adherence is associated with patient satisfaction and increased physician-affective behaviors (Hill et al., 1999; Rose et al., 2000).

Physiologic Outcomes and Healthcare Utilization

Few studies evaluating the association between communication and physiologic outcomes have been done. Yet, the available evidence suggests that less physician-controlling behavior during the visit, more expressions of affect, and more information given by the physician are associated with improvements in blood pressure, glucose control, and functional status (Kaplan, Greenfield, & Ware, 1989; Orth, Stiles, Scherwitz, Hennrikus, & Vallbona, 1987). Additionally, a few studies have linked enhanced physician communication with improvements in recovery from surgery, decreased utilization of pain medicines, and decreased length of stay in hospital (Mumford, Schlesinger, & Glass, 1982; Roter & Hall, 1993).

Provider Communication and Healthcare Disparities

It has been hypothesized that communication-related factors may contribute to healthcare disparities in potentially three ways. They are (1) disparate care may be provided by doctors in the context of total ignorance, (2) disparate care might be appropriate given the medical nature of populations of patients, and (3) doctors might be affected by the same biases and stereotypes that affect others in the population (Roter & Hall, 1993). Admittedly though, there is no consensus on these issues and the relative importance of these factors is hotly debated (Smedley, Stith, & Nelson, 2003).

A study by Cooper-Patrick et al. suggests that African-American patients experience shorter, more physician-dominated, less patient-centered visits than White patients (Smedley et al., 2003). As previously stated, other studies investigating the role of race/ethnicity and communication have largely been done in Eurocentric groups (Smedley et al.). While these studies do not include minorities of African, Caribbean, or North American descent, they still generally demonstrate health-related differences between European subgroup social classes (Roter & Hall, 1993; Smedley et al.). Negative stereotypes, bias, and prejudices of disadvantaged populations may affect the way doctors interact with individuals from those population groups (Smedley et al.).

Bias and Discrimination Among Healthcare Providers

Several studies suggest that while physicians, like other members of society, may find prejudice unacceptable and contradictory to personal and professional values, providers may not always recognize prejudice in their own behavior (Smedley et al., 2003). As outlined in Chap. 1, the Harvard Medical Practice Study (Brennan, Leape, et al., 1991; Brennan, Leape, Laird, Localio, & Hiatt, 1990; Leape et al.,

1991) was based on more than 30,000 medical records from 51 randomly chosen hospitals in New York (Brennan, Hebert, et al., 1991). This study revealed that a significant amount of injury to patients from medical practice occurred in this sample of healthcare system. It also found that these adverse events were not randomly distributed in the sample and that many injuries were the result of substandard care (Brennan, Leape, et al., 1991; Brennan et al., 1990; Leape et al.). In addition, a significantly higher risk of adverse events was found among hospitals serving large proportions of minority patients. In fact, in multivariate analysis, the only factor that remained significantly associated with an increased risk of adverse events due to negligence was the treatment of a large proportion of minority patients (Brennan, Hebert, et al.). Although the authors could not explain the cause of these findings, they suggested that the findings of the study and, in particular, the findings related to adverse events due to negligence reflected the quality of care delivered by doctors to patients, and not patient-behavioral factors or other clinical factors related to the natural history of patient's disease (Brennan, Hebert, et al.).

More recently, in a highly publicized study, Schulman studied physician recommendations for the management of chest pain (Schulman et al., 1999). In this study, physicians were shown video vignettes of patients who were actually trained actors portraying the same symptoms of coronary artery disease. The patients varied only by race (Whites vs. Black), sex, age (55 vs. 70), coronary risk, and results of an exercise test. Schulman found that physicians were less likely to recommend cardiac catheterization for women and African-Americans (Schulman et al.). While the magnitude of the findings and the statistical tests used in the analyses has been criticized, the existence of a difference is generally accepted. In two related studies, LaVeist demonstrated that White cardiac patients are more likely to receive a special referral for coronary angiography (LaVeist, Arthur, Morgan, Plantholt, & Rubinstein, 2003) or cardiac rehabilitation (Gregory, LaVeist, & Simpson, 2006) than similar African-American cardiac patients.

Several studies suggest that physicians prescribe pain medications differentially among White and minority patients. Among patients discharged from an urban ER, Knox et al. demonstrated that Hispanics and Whites were less likely to be prescribed certain pain medicines than similar White patients (LaVeist, 2002). Similar findings have been documented among cancer patients (Bernabei et al., 1998; Cleeland, Gonin, Baez, Loehrer, & Pandya, 1997). A study by Morrison et al. suggests that the problem with prescription pain medications may go beyond that of the physician. In this study of New York City pharmacies, Morrison found that of 347 pharmacies, 51% did not have adequate supplies of certain pain medicines needed for patients with severe pain (Morrison, Wallenstein, Natale, Senzel, & Huang, 2000). In addition, those pharmacies with inadequate drug supplies were more likely to be in predominately non-White neighborhoods. According to the interviews with the pharmacists involved in this study, fear of theft, low demand, additional paperwork demand, regulatory oversight, and monitoring of these medicines were the major reasons for the inadequate supply of pain medicines (Morrison et al.). In sum then, these studies appear to indicate that racial and ethnic disparities in health care are related to differential patterns of physician's prescription and/or referral for

appropriate care. It also suggests that the problem may go beyond that of physicians to include other healthcare practitioners.

Provider Cultural Competency and Healthcare Disparities

Cultural competence has been defined as a set of behaviors, attitudes, and policies that enable effective work in cross-cultural situations (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003). Culture refers to integrated patterns of behavior including language, thoughts, customs, and beliefs of religious, ethnic, or social groups (Anderson et al.). Competency refers to the capacity to function effectively as an individual within the context of cultural beliefs, beliefs and needs of consumers, and their communities (Anderson et al.). Interest in the role of cultural competency continues to grow as does the realization of the increasing diversity of the US populace. While the need for cultural competency is most often discussed as a need of providers, health care and medical practice are being provided increasingly by a team or mix of individuals. Because minorities are significantly underrepresented in the healthcare workforce, the need for cultural competency is heightened, but will only occur with the support, and in the context, of the broader healthcare system (Brach & Fraser, 2000). In addition, if long-term institutionalization is to occur, cultural competency will need to be addressed at the institutional level. As such, this section will briefly outline the issue of cultural competency only as it relates to providers. The concept will be more broadly developed in the chapter on healthcare systems.

Much of the cultural competency literature is focused on cultural awareness, knowledge attitudes, and skills of providers. Indeed, the potential need for this focus is suggested by studies that document significant proportions of minorities reporting that they believe they would have received better care if they had been seen by a doctor of a different race or ethnicity (Collins et al., 2002). As many as 16% of African-Americans and 18% of Hispanics indicate that they had been treated with disrespect during a healthcare visit. The reasons for these beliefs were often attributed to communications-related factors such as being spoken to rudely, talked down to, or otherwise ignored (Collins et al.). Asian-Americans are least likely to feel that their doctors understand their beliefs and values and they are the most likely group to report that their doctors looked down on them (Collins et al.). Interestingly though, one-third of all adults report using complementary or alternative therapies and remedies within the past 2 years, with the highest rates being reported among White adults (Collins et al.). On the other hand, African-Americans, Hispanics, and Asians who use alternative remedies are less likely to tell their doctors about it than White patients (Collins et al.). Finally, in a recent classic study by Lillie-Blanton et al., a representative sample of US citizens were asked to indicate their thoughts regarding whether the average African-American receives lower quality care, about the same quality care, or higher quality care as the average White person? The results indicated that while a majority of White Americans (68%) believed that African-Americans

receive the same or higher quality care than most Whites, most African-Americans (64%) believed that they receive lower quality care than most Whites (Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000).

Summary

From the discussion above it can be seen that culture and ethnicity often create unique patterns of beliefs, behaviors, and perceptions regarding health, illness, providers, patients, and the provision of care. These patterns influence the provider's ability or likelihood in recognizing certain patient symptoms. They also influence what patients choose to tell providers about their health. These factors impact provider interpretations of symptoms and patient adherence to therapy (Anderson et al., 2003). The evidence also suggests that racial and ethnic minority patients do not receive the appropriate and recommended care as clinically similar White patients for those services that require provider referral. As such, the evidence suggests that several factors related specifically to providers likely contribute to differential outcomes and the persistence of healthcare disparities.

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