Racial Concordance as a method to decrease healthcare disparities among African Americans

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This chapter will examine the differences between race and attitudes toward the healthcare delivery system and answer the research questions, Do African Americans prefer healthcare providers that look as they do? And are African Americans’ beliefs about racism in the healthcare system linked to how healthcare is accessed and experienced?

For example there is a well-documented history of racial discrimination toward African Americans in medical research and in the clinical settings. Most notably is the 1932 U.S. Public Health Service Tuskegee Syphilis Study on Untreated Syphilis in the Negro Male. (Gamble, 1997). Recent research has illustrated that African Americans are aware of this discrimination and are reluctant to participate in clinical trials and distrustful of medical researchers and clinicians. (Shavers, Lynch & Burmeister, 2002). This distrust has been associated with racial disparities in health and lower rates of satisfaction with physician visits among African Americans than among other population groups. (Doescher, Saver, Franks & Fiscella, 2000).

Definition

Concordance is defined as a state of agreement such as harmony. (Merriam-Webster, 2003). In healthcare, the meaning is basically the same, healthcare providers in racial concordance as the people they care for. This concept of concordance has been extensively studied in healthcare and has lead to several published studies.

What we know

Data from the 2000 census document that African Americans (AA) make up about 13% of the US population, but less than 3% of practicing physicians are African American. (US Census Bureau, 2000). These disparities in AA physician numbers mirror the health disparities prevalent in AA populations. The Institute of Medicine report Unequal Treatment confirmed that racial and ethnic disparities are not entirely explained by differences in access and that disparities in healthcare exist in broader contexts such as social, economic and systematic bias. (Institute of Medicine, 2003). This report has generated new hypotheses and models of understanding healthcare disparities. Concordance is a new concept in the complex disparity arena. Recent studies have shown that ethnic-concordant relationships with healthcare providers are documented as being longer and more satisfying than ethnic-discordant relationships. This finding was independent of patient-centered communication suggesting that patient/physician attitude and bias may contribute to the relationship. (Cooper, Roter, Johnson, Ford, Steinwachs &
Powe, 2003). Boulware, Cooper, Ratner, Laveist & Powe (2003) in a separate study, reported that 43% of AA respondents trusted their physician compared to 80% of White respondents. A majority of all respondents trusted their physicians (71%) and trusted hospitals (70%). After adjustment for potential confounders, black respondents were less likely to trust their physicians (37%, p=0.01). Boulware et al. concluded that patterns of trust in healthcare reflect cultural experiences and expectations of care among AA.

We also know that few observational studies of healthcare use have report sufficient information to support the claim of provider bias; however a study conducted by Park et al. (2006) reported that most internal medicine residents gain cross-cultural skills through informal training and most stated that delivery of high-quality cross-cultural care was important, but were skeptical about the expectation of learning every little detail about all cultures. (Park, 2006). Barriers to cross-cultural care included lack of time, not knowing enough about the religion or ethnic group of the patient they were caring for and or dealing with beliefs systems which are different than their own. Van& Burke (2000) found that physicians rated minority patients more negatively than white patients; the study also reported that physicians viewed minorities as non-compliant and more likely to engage in risky health behaviors. These views can be perceived by AA via nonverbal and verbal cues. The American College of Physicians stated in a 2004 position paper that a diverse workforce of health professionals is an important part of eliminating disparities in the United States, (American College of Physicians, 2004). The paper also stated that concordance is associated with better patient-reported outcomes and that patients were more satisfied with their care.

Concordance as an indicator of satisfaction

A salient element of concordance is that the patients perceive the value of their relationship with their physician. Most patients are happy to discuss their health concerns when encouraged to do so by their healthcare provider. Cooper et al, in 2003 designed a cohort study to compare patient-physician communication in race-concordant visits and race-discordant visits to examine whether communication styles explained differences in patient ratings of satisfaction and participatory decision making. Figure 1 depicts the effect of race on patient-physician communication. From the model, one can see that the patient-provider communication is effected by social class of both the patient and the physician, and cultural competence of the institution. The outcomes of successful patient-physician communications are increased satisfaction and quality of life of the patient.

The results of this study reported that race-concordant visits were longer [95% CI, 0.60 to 3.71] and had higher ratings of patient positive affect [95% CI, 0.04 to 1.05] compared with race-discordant visits. Patients in race-concordant visits were more satisfied and rated their physicians as more participatory. [95% CI, 3.23 to 13.60]. She concluded that race-concordant visits were longer, more satisfying and resulted in more positive patient outcomes. Patients reported greater ease in discussion problems and make healthcare decisions during longer medical visits. Ethnic-discordant visits were characterized by less social talk and had lower ratings of physician positive affect than
were race-concordant visits. She added that increasing ethnic diversity among physicians may be the most direct strategy to improve healthcare experiences of minority groups. This supposition may also directly decrease disparities via increasing healthcare utilization by AA by increasing trust in the healthcare system.

LaVeist, Nura-Jeter & Jones, (2003) examined a national sample of AA, white, Hispanics and Asian-American respondents to test their hypothesis that when patients are race concordant with their medical doctor, they are more likely to utilize health services. The study compared patients whose regular doctors were of a different race with patients who were of the same racial group as their physicians. They found that race-concordant pairs were more likely to use health care services. (OR = 2.68; 95% CI 2.07, 3.45). This pattern was most consistent among white and AA groups. In 2002, LaVeist and Carroll studied the predictors of concordance and found that patient income and having a choice in the selection of the physician were significant predictors of concordance, and patients who were race concordant reported higher levels of satisfaction with care compared with AA patients that were not race concordant.

Saha, Taggart, Komaromy & Bindman (2000) in an effort to explain why minority health consumers tend to seek race-concordant physicians, analyzed data from the Commonwealth Fund 1994 National Comparative Survey of Minority Health Care, a telephone survey of a random sample of 3,789 adults. For AA and Hispanics there was a significant correlation between patients’ ability to choose their physicians and choosing a race-concordant physician. 23% of AA with racially concordant physicians reported that they explicitly considered the race or ethnicity of the physician when selecting their doctor. Saha et al. suggested that minority physicians are more culturally sensitive and organize healthcare more congruent with the needs of the minority patient.

Chen, Fryer, Phillips, Wilson & Pathman (2005) concluded from their study that AA who perceive racism in the healthcare system where more likely to prefer a race-concordant physician. Chen et al. believe that shared languages and social experiences may drive some preference. Data was collected from the 1999 Kaiser Family Foundation Survey of Race, Ethnicity and Medical Care: Public Perceptions and Experiences. This survey was based on a national sample of telephone interviews. 3,884 telephone interviews were conducted. AA and Latinos were purposely over sampled. The primary focus of the interviews was to assess public awareness and perceptions of racism in healthcare. Results revealed that AA had stronger beliefs about racism in health care than Latinos (12.4 vs. 11.0, P<.001). The study also demonstrated a strong relationship between racial concordance and patient satisfaction. AA who preferred an AA physician were 3 times more likely to rate their physician as excellent and highly rated their satisfaction with healthcare. Chen et al. states that patients’ beliefs about racism and discrimination in healthcare are deep-seated and complex. One solution he recommends is to improve the ways that patients to choose physicians. Race-concordant patient-physician relationships are often reported as trusting, which validates Chen et al. perception that shared languages and social behavior are important to patients when choosing a physician.
Concordance as an indicator of trust

Petersen (2002) stated that trust is a key element in a therapeutic alliance and facilitates open communication. She described two different aspects of trust: interpersonal trust and social trust. Interpersonal trust or trust in other persons is an important concept when conceptualizing how one might trust their physician but not the healthcare system and is significantly related to continuity and adherence. This study emphasized that trust and continuity in the physician-patient relationship are correlated with positive health outcomes. Hill & Garner (1991) found that patients tend to choose physicians based on their perception of the physician being knowledgeable and interested in their concerns. They also reported that these attributes were more commonly found in physicians of their same race and ethnic group.

Boulware et al. (2003) reported that differences in trust of health care providers have been implicated in racial disparities and access to healthcare and in lower rates of satisfaction with physician visits. Boulware et al. hypothesized that racial differences in trust may contribute insight into racial disparities in health care. The cross-sectional study surveyed people about their trust in physicians, health insurers and hospitals. To assess trust in physicians the respondents were asked to rate their agreement with two statements derived from the Trust in Physician Scale (Anderson & Dedrick, 1990). AA respondents were less likely to trust their physicians, but more likely to trust their health insurance plans. Age and exposure to medical facilities were associated with trust and attitudes toward hospitals. Older respondents were more likely to report having trust in their medical doctors. AA respondents were more likely to express concern about harmful experiments in hospitals. This can be directly related to more AA being cognizant of the Tuskegee Syphilis study than whites. Racial anonymity may also be related to high percentages of AA who trust their healthcare plan, distrust of the physician can not be as easily hidden in a private office, but insurance companies are so large and rarely have personal contact with patients. The strong associations of trust and satisfaction with physicians is bidirectional: patients are more likely to see a physician that they trust, this continuity of care can directly influence health promotion and illness prevention of the patient, which cycles back with patients reporting more satisfaction with their physicians.

Concordance and respect

Research is beginning to expose how the healthcare encounter is related to disparities in healthcare. Blanchard, J. & Lurie, N. (2004) hypothesized that patients who report negative experiences with the healthcare encounter are less likely to seek care or return for follow-up. The researchers tested this hypothesis using data from the Commonwealth Fund 2001 Health Care Quality Survey. The sampling was based on random-digit dialing, using telephone numbers with higher than average numbers of minority households. The found that over 14% of AA reported that they had been treated with disrespect by their doctor. These respondents were also less likely to have had a physical
exam within the prior year. Those respondents who believed they would have received better care if they had been of a different race were also less likely to receive optimal care for chronic diseases.

Hicks, Ayanian, Orav, Soukup, Mcwilliams et al. (2005) analyzed survey results and hospital administrative data after hospitalization at an urban teaching hospital. Association of patient race and ethnicity with reporting problems and with their hospital experience was assessed. AA were found to have an odds ratio of 1.8 [95% CI, 1.3-2.6] of reporting problems with respect during their hospitalization compared to whites. Stratifying for hospital services, (medical, obstetrical or surgical) analyses demonstrated that AA were 2.21 likely to experience disrespect during an obstetrical hospitalization compared to whites and 1.74 more likely to experience disrespect during a surgical hospitalization compared to whites. Hick et al. established that racial differences in respect may contribute to the perception among AA that their care is less participatory than for whites. AA are more likely to perceive bias and lack of trust in the health system overall than whites. So, would recruiting more minorities to enter into the medical profession decrease healthcare disparities? The position paper from the American College of Physicians argues that an important part in eliminating health disparities is to have a diverse workforce. Policy implications include retention and recruitment of minority physicians and mandatory diversity courses throughout medical school. Community-based opportunities that would allow healthcare practitioners to become more familiar with minority patients may decrease bias and pre-conceived judgments against minority patients. Incorporating public health constructs in medical school curriculum and mandates of community service hours will expose medical students to a population of patients they may not otherwise have the opportunity to serve. The encounters can be taped and reviewed for constructive criticism.

What can be done?

The American college of Physicians in 2004 composed a position paper that supports more minority physicians in the US, however there are no clinical trial results that confirm the assumption that more minority physicians will result in a decrease in healthcare disparities. What is known that race concordant visits are more satisfying that discordant physicians visits. One solution ala Oprah Winfrey would be to recruit talented minority students, preferably within the first three years of grade school, and expose these students to study skills, state- of- the-art science and math courses and foster self esteem. Surround these students with positive role models, affirmations that empower and healthy foods and expect excellence. These students will become healthcare professionals and scientists, pass on their toolkit for life and success to their offspring which will again be passed on to where it is viewed as uncommon not to become an educated valuable part of society.

For more information, please go to www.cdc.gov/omh.
References


FIGURE 1. The effect of race and ethnicity on patient-physician communication.