

Educational support materials for ABIM's *Care for the Underserved* Module

Module #17

There is increasing evidence that racial and ethnic minority patients receive lower quality interpersonal care than white patients. In 2002, the Institute of Medicine report *Unequal Treatment* confirmed that racial and ethnic disparities in healthcare are not entirely explained by differences in access, clinical appropriateness, or patient preferences and suggested that these differences in healthcare emerge from discriminatory processes within the healthcare system or from bias and prejudice, stereotyping, and uncertainty in communication and clinical decision-making on the part of providers. (1)

Disparities in care may be attributable, in part, to racial or cultural differences between patients and their physicians. Ethnic minority patients are frequently treated by professionals who differ from them in racial or ethnic background in so called, "race-discordant" relationships. The term, "concordance", has been used to indicate shared identities between patients and clinicians. Several studies suggest that racial/ethnic concordance between patients and physicians is positively related to partnership, respect, and communication. (2-5) A telephone survey of adults attending primary care practices in a large urban area found that patients in race-concordant relationships rated their physicians as significantly more participatory than patients in race-discordant relationships. (2) A nationally representative survey found that black respondents with black physicians were more likely than those with non-black physicians to rate their physicians as excellent in treating them with respect, explaining problems, listening, and being accessible to them. (3) Another study showed that patient-provider racial concordance accounted for the gaps in ratings of respect and satisfaction between whites and African Americans. (4) A study that used measures of actual communication behaviors of physicians and patients found that race-concordant visits were longer and had higher ratings of patient positive affect by independent observers than race-discordant visits. (5) Patients in race-concordant visits were also more satisfied and rated their physicians as more participatory. Similarly, in a European study, patient-provider ethnic discordance was associated with less social talk and less positive physician affect, lower patient ratings of mutual understanding with physicians, satisfaction and self-reported compliance. (6) Differences in interpersonal care for race-concordant and race-discordant relationships may identify intervention targets for training programs in intercultural communication skills or programs to enhance diversity among health professionals. (7)

For further information, see the following:

1. Smedley BD, Smith AY, Nelson AR, editors, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care*. Washington, D.C.: The National Academies Press, 2002.

This educational support material was created by the Society of General Internal Medicine's Disparities Task Force. For more information, visit www.sgim.org/qo/disparities

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3. Saha S, Komaromy M, Koepsell TD, Bindman AB: Patient-physician racial concordance and the perceived quality and use of health care. *Arch Intern Med* 1999;159(9):997-1004.
4. Malat J. Social distance and patients' rating of healthcare providers. *J Health Soc Behav* 2001; 42(4):360-372.
5. Cooper LA, Roter DL, Johnson RL, et al: Patient-centered communication, ratings of care, and concordance of patient and physician race. *Ann Intern Med* 2003;139(11):907-915.
6. van Wieringen JC, Harmsen JA, Bruijnzeels MA. Intercultural communication in general practice. *Eur J Public Health* 2002; 12(1):63-68.
7. Cooper LA, Beach MC, Johnson RL, Inui TS. Delving below the surface. Understanding how race and ethnicity influence relationships in health care. *J Gen Intern Med*. 2006 Jan;21 Suppl 1:S21-7. Review.