

# Physician Cultural Competence and Patient Ratings of the Patient-Physician Relationship

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**OBJECTIVE:** To determine the association of patients' ratings of the patient-physician relationship with physicians' self-reported cultural competence (CC).

**METHODS:** Physicians completed a survey assessing their CC in three domains: motivation to learn about other cultures (motivation attitudes), awareness of white privilege and acceptance of a racial group's choice to retain distinct customs and values (power assimilation attitudes), and clinical behaviors reflective of CC. Their African-American and white patients completed interviews assessing satisfaction with the medical visit, trust in their physician, perceptions of their physician's respect for them and their participation in care. We conducted regression analyses to explore the associations between CC and patient ratings of the relationship.

**RESULTS:** Patients of physicians reporting more motivation to learn about other cultures were more satisfied (OR=2.1, 95% CI=1.0–4.4), perceived their physicians were more facilitative ( $\beta=0.4$ ,  $p=0.02$ ) and reported seeking and sharing more information during the medical visit ( $\beta=0.2$ ,  $p=0.03$ ). Physicians' power assimilation attitudes were associated with patients' ratings of physician facilitation ( $\beta=0.4$ ,  $p=0.02$ ). Patients of physicians reporting more frequent CC behaviors were more satisfied (OR=3.1, 95% CI=1.4–6.9) and reported seeking and sharing more information ( $\beta=0.3$ ,  $p=0.04$ ).

**CONCLUSIONS:** Attitudinal and behavioral components of CC are important to developing higher quality, participative relationships between patients and their physicians.

**KEY WORDS:** cultural competence; primary care physician; disparities; interpersonal relationship; quality; patient participation.

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Efforts to better understand the underlying causes of racial disparities in health-care delivery have moved beyond studying the more obvious sources of inequities, such as poor access, to examining disparities emanating from the patient-physician relationship. Once minority patients gain entry to a system of care, poorer physician communication with patients<sup>1</sup> and less actively engaged patient-physician partnerships<sup>2</sup> have been identified as contributing factors to health disparities. Satisfaction,<sup>3</sup> trust in physicians<sup>4</sup> and perceptions of being treated with respect by physicians<sup>5</sup> are lower among minority patients than whites, and minorities are less participatory during the medical visit.<sup>6</sup> The patient-provider relationship is one of the most important health service factors affecting the course of patient care,<sup>7</sup> including patient adherence with recommendations for care.<sup>8</sup> Cultural competence (CC) training is suggested as one strategy for better preparing physicians to serve diverse groups of patients.<sup>9</sup> CC at the patient-physician level of care has been defined as “the ability of individuals to establish effective interpersonal working relationships that supersede cultural differences.”<sup>10</sup> The goals of CC training are to increase physician awareness of health-care disparities and their attitudes contributing to disparities, increase knowledge of health-care issues unique to minority populations and increase behaviors that will enhance physicians' ability to build rapport, communicate effectively with patients who culturally differ and develop a plan of care acceptable to the patient.<sup>9</sup>

Knowledge about the relationship between greater physician CC and improved patient-physician interpersonal outcomes is limited. The purpose of this study was to determine if patients' rate their involvement in their care and the quality of their relationship with their primary care physicians (PCPs) more favorably when their physicians are more culturally competent. We hypothesized that patients of physicians with more culturally competent attitudes and behaviors would perceive

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that their physicians were more respectful toward them, would have more satisfaction with and trust toward their physicians and would report greater involvement in their care.

## METHODS

### Study Design

We analyzed survey data from 26 PCPs located in 15 Baltimore practices serving low-income to middle-class communities and 123 of their patients. The data were collected as part of a clinical trial evaluating a patient coaching intervention and physician communication training to enhance patient-centered, but not culturally specific knowledge, attitudes or skills.<sup>11</sup> PCPs were eligible to participate in the trial if they practiced at least 20 hours per week and planned to stay at the clinical site for at least 12 months. In order to be part of this analysis, physicians had to have at least one patient complete a 12-month interview, have one encounter or more with that patient within 9 months of the patient interview, and complete an Internet-based survey at the end of the study. Physicians' patients were eligible if they self-identified as African-American or non-Hispanic white race, were diagnosed with hypertension and had visited their physician within the 9 months prior to their 12-month interview. The study procedures were approved by the Institutional Review Board and are described extensively elsewhere.<sup>12</sup>

### Study Measures

Three components of CC—two attitudes (motivation and power/assimilation) and behaviors—were evaluated using summary measures that were self-reported.<sup>12</sup> Physicians selected their level of agreement on a 5-point Likert scale (strongly disagree to strongly agree) to two items assessing "motivation" to learn about cultures within their practice and society, and three items assessing "power and assimilation" attitudes reflecting awareness of white advantage and acceptance of a cultural group's choice to retain distinct customs and values. Physicians also reported the frequency, in 25% increments, of how much they performed four behaviors that are commonly identified as culturally competent: seeking information about a patient's culture; asking patients to tell about their own explanations of illness; receptivity to co-workers' feedback concerning cross-cultural patient-provider interactions; and adapting care to patients' preferences.

The quality of the patient-physician relationship was evaluated using items commonly found in the literature. Patients' level of agreement was measured on a 5-point Likert scale to statements concerning overall satisfaction with the visit (one item), their physician's respect toward them (five items)<sup>13</sup> and their trust in their physician (five items derived from two lengthier scales).<sup>14,15</sup> Respect items included global respect, caring about the patient as an individual, respecting privacy during the exam and when asking questions, addressing patient by their preferred name and acknowledging the patient's presence when talking to him/her. Patient trust in their physician was assessed by asking patients if they felt confident in their doctor's knowledge and skills, and if their physician looked out for their best interest, always told the truth, maintained their confidentiality and put their medical needs first. Trust and respect items were summed and

averaged to create mean scores for each concept. Patient participation was assessed using the patient's Perception of Involvement in Care Scale (PIC), a self-report questionnaire divided into three subscales: Doctor Facilitation, Patient Information and Decision-making.<sup>16</sup> The CC measures and quality of the patient-physician relationship measures were positively skewed with few responses in the lower categories, so we dichotomized the responses based on the distribution of the mean scores (Table 1). Physician cultural motivation attitudes,

Table 1. Physician and Patient Characteristics

| Characteristics   | n (%)       |
|---|-------------|
| <b>Physicians, (N=26)</b>                                   |             |
| Age, mean years (SD)  | 43.6 (7.9)  |
| Race  |             |
| White   | 11 (42)     |
| African-American  | 7 (27)      |
| Other   | 8 (31)      |
| Gender  |             |
| Female  | 17 (65)     |
| Specialty   |             |
| Internal medicine   | 22 (85)     |
| Family medicine   | 4 (15)      |
| Cultural competence*  |             |
| Motivation attitudes  |             |
| Lower   | 9 (35)      |
| Higher  | 17 (65)     |
| Power assimilation attitudes                                |             |
| Lower   | 18 (69)     |
| Higher  | 8 (31)      |
| Behavior  |             |
| Lower   | 18 (69)     |
| Higher  | 8 (31)      |
| <b>Patients, (N=123)</b>                                    |             |
| Age, mean years (SD)  | 61.9 (10.9) |
| Race  |             |
| White   | 38 (31)     |
| African-American  | 85 (69)     |
| Gender  |             |
| Female  | 78 (63)     |
| Income <sup>†</sup>   |             |
| <\$35,000   | 73 (64)     |
| >\$35,000   | 41 (36)     |
| Education <sup>† ‡</sup>                                    |             |
| Less than high school diploma                               | 36 (30)     |
| High school diploma or higher                               | 85 (71)     |
| Self-reported health status <sup>‡</sup>                    |             |
| Poor/fair   | 41 (33)     |
| Good  | 52 (42)     |
| Very good/excellent   | 30 (24)     |
| <b>Patient-physician relationship measures*</b>             |             |
| Satisfaction  |             |
| Lower   | 66 (53)     |
| Higher  | 57 (46)     |
| Trust   |             |
| Lower   | 19 (15)     |
| Higher  | 104 (85)    |
| Respect   |             |
| Lower   | 63 (51)     |
| Higher  | 60 (49)     |
| Perceived involvement in care (PIC), mean (SD) <sup>§</sup> |             |
| Physician facilitation                                      | 3.9 (0.8)   |
| Patient information   | 3.9 (0.8)   |
| Patient decision-making                                     | 2.7 (0.8)   |

\*"Higher" indicates more of the characteristic vs. "lower," which indicates less of the characteristic

<sup>†</sup>Numbers do not add up to 123 due to missing data

<sup>‡</sup>Percent does not add up to 100 due to rounding

<sup>§</sup>Response choices: 1, strongly agree; 2, disagree; 3, neither agree nor disagree; 4, agree; 5, strongly agree

patient satisfaction, patient trust and patient perceptions of physician respect toward them were dichotomized as strongly agree, labeled as “higher,” versus agree or less, identified as “lower.” Physician power and assimilation attitude scores were divided into agree and strongly agree (“higher”) versus all other responses (“lower”). Cultural behavior was dichotomized into greater than 50 percent of the time (“higher”) versus 50 percent or less of the time (“lower”).

**Statistical Analysis**

Robust logistic and linear regression models with generalized estimating equations were developed to evaluate the hypotheses. A two-sided P value of  $\leq 0.05$  was considered significant. Adjusted analyses were performed controlling for physician characteristics that were associated by chi-square or t-test statistics with at least one of the CC measures and at least two of the dependent variables at a significance level of 0.10 or less. Physician gender and race (white versus non-white) were controlled for in the multivariate regressions because they met these criteria. Patient characteristics and intervention group status were not controlled for since they were not significantly associated with physician ratings of their CC. Data analyses were performed in STATA version 8.2 (STATA Corp., College Station, TX).

**RESULTS**

Physician and patient characteristics can be found in Table 1. There were no differences in personal characteristics between participating and nonparticipating physicians and patients.

Patients of physicians who were more motivated to learn about cultures within their practice and society were more satisfied with the medical visit (OR=2.1, 95% CI=1.0–4.4), perceived their physicians were more facilitative ( $\beta=0.4$ ,  $p=0.02$ ) and reported seeking and sharing more information ( $\beta=0.2$ ,  $p=0.03$ ) (Table 2). Physicians’ power/assimilation attitudes (awareness of white advantage and acceptance of a cultural group’s choice to retain distinct customs and values)

were associated with patients’ perception that their physician was more facilitative ( $\beta=0.4$ ,  $p=0.02$ ). Patients of physicians reporting more frequent culturally competent behaviors were more satisfied (OR=3.1, 95% CI=1.4–6.9) and reported seeking and sharing more information with their physicians ( $\beta=0.3$ ,  $p=0.04$ ). These relationships were attenuated after adjustment for physician gender and race (white vs. non-white).

**DISCUSSION**

This study is one of the first to examine the association of physician self-reported CC with the quality of the patient-physician relationship and patient participation in care. Patients of physicians with more culturally competent attitudes and a greater frequency of self-reported culturally competent behaviors were more satisfied, perceived their physicians were more facilitative, and sought and shared more information with their physicians. Physician CC, as measured in our study, was unrelated to patients’ trust in their physicians, their perception of physician respect for them or patient reports of their own participation in decision-making. The data suggest that both attitudinal and behavioral components of CC are important to developing higher quality, participative relationships between patients and their physicians.

Our findings are supported by a limited body of literature evaluating the association of provider CC with patient-provider interpersonal outcomes. In one study, African-American clients treated by counselors who had attended cultural sensitivity training rated their therapists more highly on interpersonal measures than those patients seeing control group counselors.<sup>17</sup> A cross-sectional study of patient-physician dyads demonstrated that physician self-ratings of CC were associated with patients’ perceptions of physician communication behaviors that encouraged patient involvement and sense of empowerment.<sup>18</sup> More recently, a patient-reported measure of physician CC was found to be related to patient satisfaction and trust, while physician self-assessed CC was not.<sup>19</sup>

Limitations of this study should be considered. A standardized measure of CC that was appropriate to our setting and

**Table 2. The Association of Physician Cultural Competence (CC) with Quality of the Patient-Physician Relationship and Patient Perceived Involvement in Care Scale**

| CC and quality of relationship (N=123)     | Satisfaction*       |                 | Trust*              |                 | Respect*                |                 |
|--|---------------------|-----------------|---------------------|-----------------|-------------------------|-----------------|
|  | Unadjusted          | Adjusted        | Unadjusted          | Adjusted        | Unadjusted              | Adjusted        |
|  | OR 95% CI           | OR 95% CI       | OR 95% CI           | OR 95% CI       | OR 95% CI               | OR 95% CI       |
| Motivation attitudes                       | 2.1 1.0–4.4         | 1.5 0.8–2.8     | 2.1 0.9–4.9         | 1.3 0.5–3.3     | 1.7 0.7–4.2             | 1.5 0.5–4.3     |
| Power and assimilation attitudes           | 1.5 0.6–4.2         | 1.2 0.4–4.0     | 2.1 0.4–9.9         | 1.4 0.3–7.4     | 1.2 0.4–3.7             | 1.6 0.5–4.8     |
| Behavior                                   | 3.1 1.4–6.9         | 2.7 1.5–4.8     | 0.9 0.3–2.4         | 0.8 0.4–1.9     | 2.6 0.9–7.4             | 2.1 0.9–5.2     |
| CC and patient involvement in care (N=123) | Doctor facilitation |                 | Patient information |                 | Patient decision-making |                 |
|  | Unadjusted          | Adjusted        | Unadjusted          | Adjusted        | Unadjusted              | Adjusted        |
|  | $\beta$ P-value     | $\beta$ P-value | $\beta$ P-value     | $\beta$ P-value | $\beta$ P-value         | $\beta$ P-value |
| Motivation attitudes                       | 0.4 0.02            | 0.3 0.13        | 0.2 0.03            | 0.3 0.08        | 0.0 0.93                | 0.1 0.71        |
| Power and assimilation attitudes           | 0.4 0.02            | 0.3 0.09        | 0.3 0.06            | 0.2 0.09        | 0.0 0.46                | 0.1 0.50        |
| Behavior                                   | 0.2 0.28            | 0.2 0.26        | 0.3 0.04            | 0.3 0.04        | 0.0 0.95                | 0.0 0.91        |

\*Values signify the odds of patients of physicians with higher vs. lower cultural competence feeling more vs. less satisfied, trusting of their physician and respected by their physician  
The adjusted model is adjusted for physician gender and race (white vs. non-white)

population was not available.<sup>20</sup> Although the measure we developed has not been extensively tested, our study advances earlier studies of CC that have relied on more limited measures. Self-report measures of CC are subject to social desirability bias. This risk was minimized through the use of an Internet survey and the assurance of anonymity. Recall bias may have played a role since patients were surveyed as much as 9 months following their physician visit. The small sample size may have given us inadequate statistical power to detect associations of physician CC with the relationship measures. Finally, the generalizability of our findings to non-urban settings or other geographic areas where physicians and patients are less racially and ethnically diverse is unknown. Despite these limitations, our study provides new evidence that will guide future investigations in the field.

A strong patient-physician relationship is integral to the delivery of high-quality health care to all patients, but may be particularly important in cross-cultural situations where differences in perspectives can lead to misunderstandings and conflict. Our findings indicate that a multifaceted approach to fostering CC that includes influencing provider attitudes and behaviors may be important to strengthening relationships between physicians and their patients.

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**Conflict of Interest:** None disclosed.

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