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Disparities in Surgical Care: Strategies for Enhancing Provider–Patient Communication

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Abstract Patient–provider communication is critical to eliminating disparities in healthcare. Both the patient and the physician bring a variety of assumptions to the therapeutic partnership. As illustrated in a surgical case, these are based not only on race and ethnicity but also on a host of other factors, which may affect both partners' perceptions of reality and their subsequent behavior. Communication is an essential component of quality and is necessary to improve patients' understanding of the content of their care, their ability to make informed choices, and their ability to adhere to recommended therapies. There are a variety of practical strategies to enhance awareness of these issues and improve communication that we need to begin to incorporate into surgical culture.

Although the 2005 conference, Disparities in Surgical Care: Access to Outcomes, at which this work was presented, focused primarily on the roles of access and processes of care in surgical disparities, there is increasing evidence to suggest that differences in the interpersonal aspects of healthcare may contribute in a variety of contexts. These issues have received the most attention in the primary care disciplines, where a set of principles and approaches has been developed, focusing primarily on patient–provider communication. As illustrated in the case report that follows, these strategies are equally relevant in the context of surgical care.

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Case report

A 47-year-old African-American man was transferred to an academic medical center for 3rd degree burns over 70%–80% of his body. He sustained the burns in a house fire of unknown origin. His family arrived at the burn unit and met with the attending physician, resident, and nurse to learn about the care he would receive and his prognosis.

After 48 h he developed sepsis leading to multiorgan failure, and he required increasing amounts of narcotics to maintain his comfort. The team of physicians caring for the patient met with the family and explained that his prognosis was extremely poor and that he had virtually no hope for recovery. They asked permission to withdraw life support and keep the patient comfortable. The family became angry, suggesting that the patient would have received different care had he been white. They refused to withdraw life support. The burn unit team called an ethics consult.

Discussion

This case report illustrates the range of interpersonal issues that can arise in the setting of surgical care and that may contribute to disparities in outcomes. This was not so much an ethical issue but a disagreement between the patient's family and his physicians that arose out of problems with communication. It was the family's perception that

withdrawing treatment was equivalent to giving up and would amount to second-rate care. The physicians failed to understand the family's perceptions and lacked the interpersonal skills to clarify and resolve this end-of-life conflict. The skill set necessary to address these issues has not traditionally been part of physician training, particularly in surgery. However, if we are to begin to address disparities in care, we need to increase awareness of an evolving group of strategies to improve communication and promote patient-centered care.

These strategies suggest that the initial step in enhancing patient–provider communication is to begin to understand the filters that both the patient and the physician bring to the therapeutic relationship. As shown in Figure 1, these filters create a set of assumptions, and it is these that determine the perceived reality and the subsequent behavior of each member of the partnership. Only by recognizing and addressing these assumptions, by developing "cultural competence" or the ability to interact in a fashion that supersedes cultural differences [1], can the relationship realize its true potential for improving health quality and outcomes. These filters include race and ethnicity but a host of personal, social, community, and environmental factors. Sex, culture, language, socioeconomic factors, educational status, and health care literacy all play important roles. For the physicians, similar personal factors and, in addition, their cultural competence, communication skills, medical knowledge, technical skills, and biases may all influence the relationship. There is increasing evidence that patient socioeconomic status has an even more significant effect on physician perceptions than race [1]. The interaction of these factors is also important; considerable evidence suggests that concordance of sex, race, and a myriad of other factors between the patient and provider may significantly influence the success of the physician–patient partnership.

Although much of the literature on the subject relates to primary care, there is accumulating evidence to suggest that similar issues are important in explaining surgical disparities. For example, a survey investigating the role of cultural difference in health benefits among potential thoracic surgical candidates found that 61% of blacks and 31% of whites believed that exposing a cancer to air during surgery increases the risk of spread [2]. Nineteen percent of blacks as opposed to 10% of whites believed it was a reason to avoid operation. Similarly, blacks are less likely than whites (76% of black women versus 79% of white women, 80% of black men versus 85% of white men) to want a kidney transplant [3], and physicians are less likely to believe that transplantation improves survival for blacks (69%) than whites (81%) [4]. We clearly need more research to identify other such biases and their impact on surgical care.

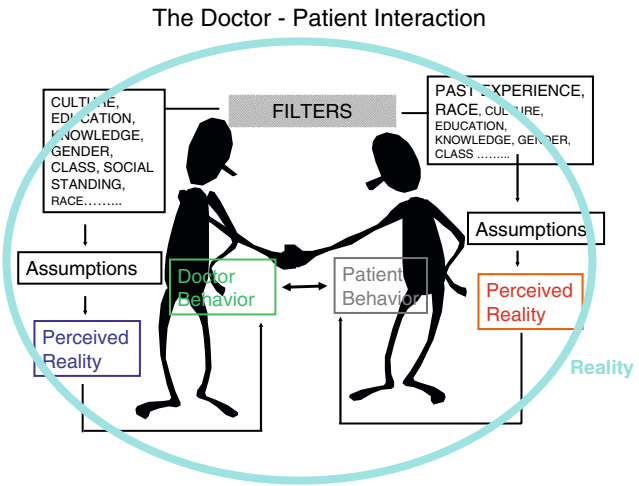

Fig. 1 Both the physician and patient bring a variety of filters to the physician–patient relationship, and these determine their perceived reality and subsequent behavior

The case report given above illustrates the complexity of issues that must be considered. For the African-American community, second-rate care is a very real concern that begins with a history of societal, institutional, and personal misconduct exemplified by the U.S. Public Health Service syphilis experiments [5]. The lack of diversity among medical providers, nowhere more obvious than in surgery, only enhances this concern. Likewise, the family brings a context of cultural, religious, and spiritual beliefs that need to be considered. African Americans have a higher mortality from everything, including homicide, and defying death may be viewed as a healthy attitude in the midst of many cues that their communities are dying. Likewise, religious beliefs may suggest that pain and suffering are to be endured as part of a spiritual commitment. Many families seek aggressive treatment because they value the sanctity of life, not because they don't understand the limitations of technology.

Recognizing these filters, the next step is to build empathy and trust. Table 1 lists a variety of trust-building behaviors. Active listening, nodding, and encouraging are means of developing empathy. It is important for physicians to demonstrate that they are picking up on the patient's concerns with phrases like, "Sounds like you…" Physicians should try to identify the factual content of patients' statements with leads, such as, "What I heard you say was…" and ask about any observed affective response, for example, "I get the feeling that you are angry…" It is also important to request clarification, asking, "Can you say more about…"

Physicians must also recognize the potential pitfalls in this relationship. These include their failure to identify cultural differences, with the medical model as the only paradigm. Stereotyping, bias, and lack of personal

Table 1 Trust-building behaviors

•Eye contact	•Use understandable language
•Don't appear rushed	•Display genuine concern
•Ask personal questions	•Listen to symptoms in the patient's style of telling
•Don't make assumptions	•Hold patient information as confidential
•Attention to cultural beliefs	•Ask if patient is satisfied with appointment
•Respect different perspective	•Ask if patient understands
•Distinguish persons as individuals	•Listen to questions
•Be responsive	•Apologize when there is a problem
•Make an effort to make patient feel comfortable	

Table 2 RESPECT model

•Respect—A demonstrable attitude involving both verbal and nonverbal communications
•Explanatory model—What is the patient's point of view?
•Sociocultural context—Class, race, ethnicity, education, sexual norms and orientation, family and gender roles, for example
•Power—Power differential between patients and providers
•Empathy—Putting into words the significance of the patient's concerns so the patient feels understood
•Concerns and fears—Eliciting the patient's emotions and underlying concerns regarding symptoms
•Therapeutic alliance/Trust—A measurable outcome that will enhance adherence and compliance

Source: Bigby J. Cross-cultural Medicine. Philadelphia, American College of Physicians Press, 2003

awareness on the part of physicians is not unusual. The use of medical jargon and technical language often has a negative effect; physicians need to verify meaning and understanding with the patient and family and inquire frequently about their preferences. Just eliciting a patient's or family's concerns, beliefs, or expectations is often sufficient to resolve the negative situation and avoid conflict. It is also important for patients and physicians with differences of opinion to negotiate, with the goal of understanding each other and working toward an acceptable outcome; sometimes this must be based on compromise. The doctor is typically in the "more powerful" position and therefore should initiate the negotiation, determining shared priorities.

A variety of models for cross-cultural training have been proposed [6, 7]. The RESPECT model, developed by the first author for the Boston University Residency Training Program in Internal Medicine Diversity Curriculum Task Force, is shown in Table 2. This is an approach to the provider–patient encounter that is particularly helpful across cultural and racial barriers. The first element is Respect, which may be particularly important when the power differential is greatest, helping to reduce shame or distrust and increase openness and partnership. If power is the problem, and the biggest challenge in the doctor–patient relationship, respect seems to be a major part of the solution. The next element, the Explanatory model defines the patient and provider's points of view. Why does the patient think he or she is ill? What is the provider's explanation? In this model, all points of view must be elicited and reconciled before progress can be made. The third element, Sociocultural context, goes beyond demographic data gathering to define what is most important to the patient and to recognize how these issues influence the way a patient experiences illness. How is this illness affecting his/her life? How does his/her life affect the illness? The social context of the providers is also important. Are they post-call? Are they hungry or otherwise stressed? Providers' backgrounds affect how familiar they are with people who are different from them. Providers must also be mindful of the Power difference between themselves and their patients. A participatory style of interaction with patients who may perceive themselves as less empowered will likely result in better satisfaction and outcomes for all. Understanding a patient's sociocultural context and individual preference for sharing power may allow for a mutually acceptable medical encounter. Again, Empathy involves verbal recognition of the significance of the patient's concerns so the patient feels understood. This is a skill that takes active practice.

Teachers can begin by modeling empathy with patients and learners alike.

In summary, if we are to begin to address disparities, these approaches need to be incorporated into surgical training and into our Maintenance of Certification process. Communication is an essential component of quality of care and is necessary to improve patients' understanding of the content of their care, their ability to make informed choices, and their ability to adhere to recommended therapies. Attention to these issues is critical if we are to address healthcare disparities in the context of surgical care.

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