Cayla R. Teal, Ph.D.

Cayla R. Teal, Ph.D., is currently an Assistant Professor in the Section of Health Services Research, Department of Medicine, Baylor College of Medicine, and a research investigator with the Houston Center for Quality of Care and Utilization Studies (a Health Services Research and Development Center of Excellence with the Michael E. Debakey Veterans Administration Medical Center-Houston). Dr. Teal is a Community Psychologist with quantitative (e.g., latent variable analysis), qualitative (e.g., focus groups, cognitive interviews, etc.) and psychometric (e.g. questionnaire development) methodological interests and experiences. Her research experiences have been primarily in applied settings and have included work with community-based and volunteer associations, law enforcement, mental health facilities and educational institutions. In more recent years, her research interests have focused on health organizations, and particularly racial and ethnic health disparities. Dr. Teal's research agenda focuses on the cross-cultural measurement of cultural influences on health practices and decisions, as well as the interaction between health care consumers and providers. She is a 2004-2006 Kellogg Foundation Health Disparities Scholar, which recognizes individuals who demonstrate potential to contribute creatively to the understanding of the determinants of health disparities and influence health policy. Her research is financially supported by the receipt of a three-year career development award (K01), *Cultural Influences on Health,* from the Centers for Disease Control and Prevention.

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Abstract

"Culture Clash: The Medical Encounter as a Source of Health Disparities"

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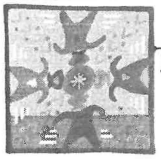
In 2002, the Institute of Medicine (IOM) issued its landmark report entitled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." The report identified three potential sources of healthcare disparities for minority and other underserved communities – patient-level factors, healthcare system-level factors, and care process-level factors. Care process-level factors included issues such as bias, stereotyping, prejudice and clinical uncertainty on the part of healthcare providers. Recommendations to address these factors included a call for additional research, interventions to enhance patient-provider communication, and integration of cross-cultural education into the training of all current and future health professionals.

In this presentation, I will briefly review models of health disparities and the role of provider beliefs in these disparities. I will describe various forms of bias (e.g., stereotypes, prejudice, implicit, explicit) and patient-level outcomes of experiencing bias. I will discuss the current research into provider bias and its limitations. Finally, I will discuss the relationship of cultural competence to bias. Specifically, I will propose a model for Culturally Competent Communication and how the use of the model for assessing and training provider behavior could serve as a framework for addressing provider bias as a cause of health disparities.

Learning Objectives:

- Become familiar with the role that provider beliefs may have in creating or maintaining healthcare disparities
- Learn types of bias and how they are manifest in the medical encounter
- Understand current research regarding provider bias, both strengths and limitations
- Introduce the Culturally Competent Communication Model
- Consider provider communication with culturally diverse patients as model for addressing healthcare disparities related to provider bias



Culture Clash:
The Medical Encounter as a Source of Health Disparities

Disparities in Health in America: Working Towards Social Justice
June 25, 2008

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  - Charla Clark, PhD Candidate
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- Community Participants: Focus Group Hosts, Facilitators, Translators, Participants
- Project Advisory Council

Objective for Today - to Discuss:

- Medical Encounter as a source of health disparities
- Provider beliefs
  - Biases: Stereotypes, prejudice
  - Biases: Implicit vs. explicit
- Outcomes of experiencing bias
- Assessment of provider bias
- Provider bias & cultural competence
  - Provider communication
  - Culturally Competent Communication model

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IOM Report

"Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare"

www.nap.edu

"Unequal Treatment" – Selected Specific Findings

- Occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination…
- Many sources – health systems, health care providers, patients – contribute to racial and ethnic disparities in healthcare.
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare.

Patients who Experience Bias have Poorer Outcomes.

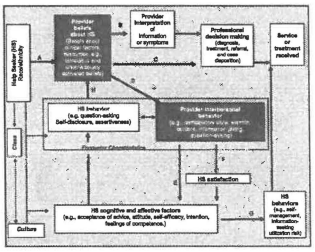
- Everyday experiences of bias are associated with poor health outcomes
  - "Minorities who perceive or report individual-level ethnic discrimination have more physical and psychiatric symptoms and problematic health behavior than Whites and their no-discrimination minority cohorts." (Landrine, 2006)
- Perceptions of bias in healthcare
  - Healthcare system bias (Johnson, JGIM, 2004; LaVeist, 2003)
  - Poorer routine healthcare (Friedman, 2005)

Patients who Experience Bias have Poorer Outcomes.

- Perceptions of biased providers
  - Discrimination in interactions with healthcare providers (Bird, 2001)
- Bias in communication behaviors
  - Variability in provider interactions with patients: Taking a history – asking different questions of minorities than Whites. (James, 2006)
  - More verbally dominant and engaged in less patient-centered communication with African American patients than with White patients. (Johnson, AJPH, 2004)
  - Diabetes patients' reports of health care discrimination are strongly linked to the quality of their interactions with providers as well as multiple health outcomes. (Piette, 2006)

Provider Belief/Bias is Difficult to Measure Directly.

Most studies of provider contribution to disparities have focused on differential provision of care.



Treatment Provision as a Proxy for Provider Bias

- Chest pain emergencies: Blacks waited longer than whites for an EKG and were less likely to receive cardiac catheterizations but more likely to receive echocardiography.
  (Bell, *Am J Health Behav*, 2001)
- Pain control for cancer: 65% of minority patients did not receive guideline-recommended analgesic prescriptions vs. 50% of non-minority patients.
  (Cleeland, *Annals of Internal Med*, 1997)
- Recommendation for renal transplantation: Asian males were less likely than white males to be recommended for transplantation.
  (Thamer, *Transplantation*, 2001)

Treatment Provision as a Proxy for Provider Bias

- ER analgesic for isolated long-bone fractures: Hispanic and Black patients with isolated long-bone fractures were less likely than white patients to receive analgesics
  (Todd, *JAMA*, 1993; *Ann.Emer.Med*, 2000; Cone, *Acad.Emerg.Med*, 2003)
- Review of invasive cardiac procedures: Racial differences in invasive cardiac procedure use were found even after adjustment for disease severity. Physician bias was also associated with racial variation in recommendations for treatment.
  (Kressin & Petersen, *Annals of Internal Medicine*, 2001)

Treatment Provision or Provider Bias?

- These studies definitely demonstrate disparities in treatment related to provider decisions and behavior.
- These studies may (indirectly) demonstrate provider bias.
  - If so, the nature of the bias or the mechanisms by which it occurs are not captured by these types of studies.

Is Other Evidence of Provider Belief/Bias Available?

- Other data available, such as verbal and non-verbal communication behavior in the medical encounter could offer some insight.
  - Numerous studies have demonstrated the importance of communication to the patient-perceived quality of the medical encounter and satisfaction with the medical encounter.
- Bias could potentially be detected in communication, though no studies have identified communication correlates of perceived bias.

through a Lens of Cultural Competence?

- Much attention has been paid to improving culturally competent communication among physicians and medical students, specifically to reduce bias in the form of both stereotyping and prejudice.
- Achieving cultural competence does not necessarily assume that bias has been eliminated, but instead successfully identified and managed:
  - Increasing physician awareness of how patients' cultural norms might differ from their own and how physician assumptions about these differences can implicitly guide the care they offer
  - Teaching skills to help physicians navigate and resolve cultural misunderstandings in the medical encounter.

through a Lens of Cultural Competence?

- Few definitions or models of culturally competent communication exist.
  - Culturally competent communication must be patient-centered
  - Patient-centered interviewing and communication assesses and integrates the biological, psychological and socio-cultural aspects of the patient's illness, and to involve the patient as an active participant in the diagnostic and treatment processes, with shared understanding and decisions.

Stewart, CMAJ, 1995

through a Lens of Cultural Competence?

- Most models of culturally competent interactions with patients lack specific behavioral markers and skills by which a culturally competent physician who was engaging in one of the elements could be recognized.
- Development of the physician Culturally Competent Communication model

(Teal & Street, under review)

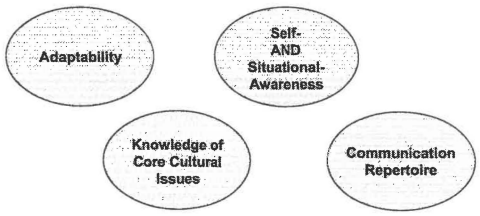
Communication (CCC) Model

- Emphasizes physician sensitivity to cultural variation in patients, without relying on cultural, race/ethnic, or other categorizations to select behaviors for interacting with patients
- An explicit integration of aspects of communication that are considered fundamental to any physician-patient exchange
- Comprehensive coverage of the 3 functions of the medical encounter
- Patient-centered communication skills
- Level-specific behavioral markers

(Teal & Street, under review)

Communication (CCC) Model

Four critical elements for carrying out culturally competent communication



(Teal & Street, under review)

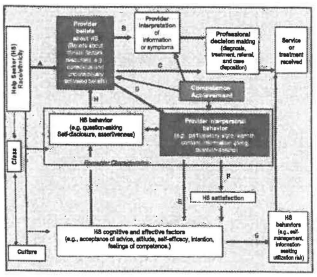
Context: Language Discordance

Use of Interpreter

- Physicians have been shown to be less empathetic to and establish less rapport with patients who have limited English proficiency.
  Ferguson & Candib, 2002
- Because language discordance appears to increase the likelihood of physician bias, knowing how to work with interpreters is essential for the physician working with diverse populations, and to the demonstration of higher levels of cultural competence when working with patients who speak another language.
  - Guidelines: Levin, 1998

Effecting Change in Provider Belief through Training

The CCC model extends van Ryn's model by specifying how interpersonal communication behaviors displayed by the physician are related to the provider's conscious and unconscious beliefs about a help-seeker and to degrees of achieved competence.



Significance

- Communication behaviors that have been associated with definitions and degrees of culturally competent skill could serve as effective proxy measures for detecting bias in the physician.
- Physicians who demonstrate higher levels of culturally competent communication skill will also demonstrate lower levels of perceived bias.

Significance

- Help identify providers who appear biased or may be at risk for (conscious or unconscious) biased behavior
- Help identify those patient-situations that are mostly likely to result in biased behavior.
- Offers a pragmatic framework for teaching and evaluating CCC and the potential or presence of bias among physicians or medical students.

Significance

- Culturally competent communication training would aid a physician in transcending their biases, by offering reflection skills that would bring bias to light and communication skills to guide in the successful management of situations where cultural bias is likely to be present.

Significance

- CCC can be explicitly explored as a mechanism for eliminating, reducing, or managing bias, by connecting achieved levels of competency to the absence of biased behavior, such that patients experience fewer disparities and enhanced outcomes.

Disparities in Health in America:

Working Toward Social Justice

A Sociocultural Approach to Understanding Racial Disparities in Late-Life Physical Function

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