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How doctors' communication style and race concordance influence African–Caribbean patients when disclosing depression☆

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ABSTRACT

Objective: To determine the impact of doctors' communication style and doctor–patient race concordance on UK African–Caribbeans' comfort in disclosing depression.
Methods: 160 African–Caribbean and 160 white British subjects, stratified by gender and history of depression, participated in simulated depression consultations with video-recorded doctors. Doctors were stratified by black or white race, gender and a high (HPC) or low patient-centred (LPC) communication style, giving a full $2 \times 2 \times 2$ factorial design. Afterwards, participants rated aspects of doctors' communication style, their comfort in disclosing depression and treatment preferences
Results: Race concordance had no impact on African–Caribbeans' comfort in disclosing depression. However a HPC versus LPC communication style made them significantly more positive about their interactions with doctors ($p = 0.000$), their overall comfort ($p = 0.003$), their comfort in disclosing their emotional state ($p = 0.001$), and about considering talking therapy ($p = 0.01$); but less positive about considering antidepressant medication ($p = 0.01$).
Conclusion: Doctors' communication style was shown to be more important than patient race or race concordance in influencing African Caribbeans' depression consultation experiences. Changing doctors' communication style may help reduce disparities in depression care.
Practice Implications: Practitioners should cultivate a HPC style to make African–Caribbeans more comfortable when disclosing depression, so that it is less likely to be missed.

1. Introduction

This paper aims to shed light on aspects of primary care practice which can improve the experiences of UK African–Caribbeans presenting with depression, and help reduce racial disparities in care. It explores the impact of different consultation conditions on African–Caribbeans' ability to disclose symptoms of depression. Specifically, it examines whether doctor–patient race concordance or a patient-centred communication style is important in facilitating the disclosure process.

1.1. Background

Depression is acknowledged to be difficult to diagnose, and is missed in about 50% of primary care consultations [1]. Reasons for this are due to a complex mix of patient and doctor factors, a key one of which is patients' difficulty in disclosing their symptoms [2].

Patients' ability to disclose symptoms of depression is affected by numerous factors, such as stigma and time constraints in primary care consultations which militate against their ability to create a full and coherent account of a phenomenon both difficult to understand and describe, particularly when experiencing low mood [3,4]. Worryingly, non-disclosure can occur more frequently amongst those whose need for help is greatest. Bushnell et al. [3] found that younger patients, those consulting more frequently and those with greater psychiatric disability were more likely to report non-disclosure. The most frequently given reasons for non-disclosure were beliefs that a general practitioner is not the 'right' person to talk to, and that mental health problems should not be discussed at all. Other studies suggest that patients contribute to non-detection by presenting their distress as somatic rather than

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emotional [5], and by normalising psychologically distressing symptoms [4].

Disclosing depression is difficult for anyone, but has long been recognised as particularly difficult for people of black African race compared with white people in developed countries, where primary health care is provided predominantly by white clinicians [6–9]. In the US, Cooper et al. [10] argued that ethnic-cultural differences in communication contribute to racial disparities in depression detection and treatment. This can arise because of racial differences in patients' modes of communication. UK African–Caribbeans are often misinterpreted [11], and this has been associated with poorer experiences and outcomes of care [6,12].

Doctors' modes of communication with patients of African race also contribute to the problem. Johnson et al. [13] observed differences in doctors' communication styles with African American compared with White American patients, finding them to be more verbally dominant (by 23%) and engaging in 33% less patient-centred communication. More specifically, Ghods et al. [14] found doctors less likely to discuss depression, respond to emotional disclosures or recognise the significant emotional distress of their African American relative to their white patients, despite them screening positive for depression. Similarly in the UK, African–Caribbeans are less likely than white patients to receive a diagnosis of depression [15–17], and consequently are at risk of not getting the help they need. This is compounded by the fact that people of black African race living in predominantly white societies are also often wary of formal mental health care and the treatments used [18–21].

Race concordance between doctors and patients, i.e. where doctors and patients are of the same race, appears to be important for improving the experiences of black African race patients. Cooper-Patrick et al. [22] found that African American patients reported primary care consultations were more participatory under conditions of doctor–patient race concordance; and in prospective testing, race concordant consultations proved to be longer, and characterised by more satisfied patients displaying more positive affect [23]. Street et al. [24] explain that where patients see themselves as similar to their doctors in terms of personal beliefs, values and ways of communicating: trust, satisfaction and concordance with treatment are more likely.

In this study we do not examine how doctors and patients communicate with each other, but instead examine the *impact of doctors' communication on patients*. We explore a number of hypotheses. Firstly, that African–Caribbean (hereafter called 'black') compared with White British (hereafter called 'white') patients will find it more difficult to disclose depression to primary care doctors (Hypothesis 1); and secondly, that they will feel less comfortable overall in consulting with doctors about depression (Hypothesis 2). Hypothesis 3 is that all patients will rate their consultation experiences more positively when doctors have a high patient-centred (HPC) style compared with when doctors have a low patient-centred (LPC) style. Hypothesis 4 is that black patients will rate their consultation experiences with black doctors more positively than those with white doctors.

2. Research methods

We sought to recruit three hundred and twenty analogue patients (APs) aged 21–65 years, with an equal gender mix. (An analogue patient is defined as a research subject who simulates being a patient). Half of the sample was to be from the African–Caribbean population and half White British, mainly from the West Midlands. To enhance the study's validity, half of the sample was to have been previously treated for depression, whilst the other half was not. APs with a history of depression were to be identified via primary care practices' and improving access to psychological therapies services' past patient lists. Those meeting the study criteria were sent letters and information sheets, inviting them to contact the research team if they would like to participate. APs who had not previously been diagnosed with depression were recruited using study posters and flyers, in-person presentations and by word of mouth via relevant community organisations and networks.

The study procedure involved APs being asked to envision themselves as a patient consulting with a primary care doctor during a time in their lives when things were especially difficult for them. This was a time when they felt sad and upset and/or emotionally and physically exhausted for more than a couple of weeks. They were then oriented to an interactive computer program in which a simulated doctor engaged them in a conversation about their symptoms.

Four actors were used in the production of the simulations. They were filmed in the US to facilitate a comparative US/UK study, with actors employing both US and UK accents. Actors' performances and scripts were reviewed by US and UK research teams, to ensure the ecological validity of simulations for both country contexts. The race (black versus white), gender and communication style (low versus a high patient-centred style) of the video doctors were experimentally manipulated to produce 8 conditions. (See Appendix A for communication scripts, highlighting differences between HPC and LPC styles). This constituted a full $2 \times 2 \times 2$ factorial design, to explore the independent contribution of doctor communication style, as well as gender and race, on APs' responsiveness and receptivity to depression care, and their ability to disclose their experiences of depression. This paper focuses only on race and doctors' communication style. Gender effects are reported elsewhere [25].

The computer program randomly selected two simulations for each AP to interact with, thus assuring that the sequence in which simulations were presented was balanced (i.e. whether they encountered a male/female, or black/white doctor, with either a HPC/LPC style first or second). The program was also designed to ensure an overall equal balance of factor combinations, to provide the required systematic dataset. APs were instructed to respond directly back to the video doctor as naturally as possible, as if talking to their own doctor. The only caveat was that no questions should be asked. Patient disclosures were captured through the computer's video cam. A practice exchange with a video receptionist welcomed the AP to the surgery and asked about the weather. After verifying the program was being used correctly, the research assistant left the room, but remained available nearby if help was needed.

The program presented a series of nine brief video segments (average duration 30 s) portraying a doctor during a depression–focused primary care consultation. At the end of each segment the doctor asked a question to which the AP responded directly. The next segment began with a response scripted to be general enough to appear reasonably responsive to most patient statements, followed by a new topic, thus simulating a clinical conversation. Each simulation comprised an initial conversation with a practice nurse, exploring the nature of the patient's problem and how they had dealt with it. The patient then 'saw' the doctor who explored: why they had come; their symptoms and how these impacted their life; whether this could be depression; family history of depression; treatment options (medication or talking therapy); ability to concord with treatment; and follow-up care. Each simulation ended after an exchange with a video receptionist asking the AP to talk candidly about what they liked or disliked about the consultation.

Afterwards, APs completed assessment measures of verisimilitude (5 items), doctors' affective demeanour (12 items) and