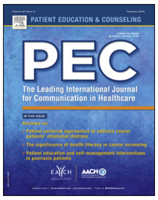
Patient Education and Counseling xxx (2015) xxx–xxx

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou



Race/ethnicity and Americans' experiences with treatment decision making

Meng-Yun Lin[a,b,1], Nancy R. Kressin[a,c,*]

[a] *Section of General Internal Medicine, Boston University School of Medicine, Boston, USA*
[b] *Health Policy and Management Department, Boston University School of Public Health, Boston, USA*
[c] *VA BostonHealthcare System, Boston, USA*

ARTICLE INFO

Article history:
Received 28 January 2015
Received in revised form 16 July 2015
Accepted 17 July 2015

Keywords:
Shared decision-making
Disparities
Survey research

ABSTRACT

Objective: Despite widespread documentation of racial/ethnic disparities in medical care, population-wide variation in Americans' experiences with care are not well understood. We examined whether race/ethnicity is associated with information received from physicians regarding treatment recommendations.

Methods: We conducted a secondary analysis of cross-sectional survey data from a nationally representative sample ($N = 1238$). We assessed patients' personal experiences of receiving information about the rationale for treatment recommendations from their physicians.

Results: Overall, respondents of minority race/ethnicity received less information from their doctors about the rationale for treatment recommendations. After adjustment for possible confounders, doctors talked less often with patients of 'other' race/ethnicity about reasons for treatment recommendations. Both Blacks' and Hispanics' doctors less often cited their own experiences, or scientific research as a reason for treatment recommendations.

Conclusion: Americans' experiences with information communicated by physicians regarding treatment rationale varies significantly on some dimensions by race/ethnicity, suggesting that differences in key elements of shared decision making are evident in the care of racial/ethnic minorities.

Practice implications: Physicians should evaluate the extent to which their communication with patients varies by patient race/ethnicity, and make efforts to ensure that they share equally with all patients regarding the rationale for treatment recommendations.

1. Introduction

Racial and ethnic disparities in health care are widely documented [1], yet the process by which they occur is not fully understood. One potential mechanism is through the process of treatment decision making, and racial/ethnic variations in that communication process. Shared decision making (SDM) is being promoted for its potential to improve the health of populations and individual patients. Clinicians and patients establish a partnership through SDM in which they go through all phases of the decision-making process together, share treatment preferences, and reach an agreement on treatment choice. Enhanced SDM, or use of some of the elements of SDM, might be an antidote to disparities which occur when clinicians' engagement in rapport-building communication varies by patients' race or ethnicity [2,3].

Several studies defined the act of informing patients as a main element of SDM [4–7], which might occur when clinicians explicitly communicate their rationale for treatment recommendations in order to help patients better understand the considerations in making diagnostic and treatment decisions. Physicians' communication with patients generally varies with patients' race and ethnicity [8–10], but less is known about the extent to which such variations extend to doctors sharing their rationale for treatment recommendations. We and others have queried racially diverse groups of patients sharing a common condition about their experiences with

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[*] Corresponding author at: Boston University School of Medicine, Section of General Internal Medicine, 801 Massachusetts Avenue, Crosstown Center, Boston MA 02118, USA. Fax: +1 617 638 8026.

E-mail addresses: mylin@bu.edu (M.-Y. Lin), nkressin@bu.edu (N.R. Kressin).

[1] Backup contact: Research Data analyst and PhD Candidate in Health Services Research, Boston University School of Medicine, Section of General Internal Medicine, 801 Massachusetts Avenue, Crosstown Center, Boston MA 02118, USA. Fax: +1 617 638 8026.

http://dx.doi.org/10.1016/j.pec.2015.07.017

Please cite this article in press as: M.-Y. Lin, N.R. Kressin, Race/ethnicity and Americans' experiences with treatment decision making, Patient Educ Couns (2015), http://dx.doi.org/10.1016/j.pec.2015.07.017

treatment decision making [11–15], but there is a paucity of data about experiences among the American population as a whole.

A recent article conceptualized three pathways through which clinician bias can lead to disparities in health care: explicit biases lead to disparities in health, and implicit biases lead to disparities in medical decision making or clinical communication [16]. Most prior research has focused on the possible effects of bias on disparities in treatment decisions concerning minority patients [17–20]. Thus, more evidence is needed about the potential effects of biases on clinical communication, which may further influence building of trust and partnership during medical encounters. Additionally, findings of previous studies were limited to patients with particular clinical conditions or specific providers, so more needs to be understood as to whether bias might also lead to disparities in the general course of conversation and communication with patients, in addition to prior findings of bias' effects on treatment recommendations.

Thus, the goal of this study was to examine racial/ethnic differences in the types of information communicated by physicians regarding their rationale for recommendations for care, using national data collected from a diverse group of respondents. We hypothesized, given the widely documented disparities in clinician–patient communication, that racial/ethnic minority respondents would be more likely to report receipt of less information from their doctors regarding the rationale for treatment decision making. In contrast, we posited that given prior literature about Whites' better communication with clinicians [8–10] they might receive more information from their physicians about their rationale for recommended care.

2. Methods

2.1. Overview

Using publicly available data from a nationally representative sample of American adults, we examined the extent to which race/ethnicity was associated with information communicated by physicians during treatment decision making, before and after adjusting for covariates which might also influence such associations.

2.2. Data

We used national telephone survey data from "The Public and the Health Care Delivery System", which examined numerous aspects of the public's attitudes and experiences [21]. This effort was jointly sponsored by National Public Radio (NPR), the Kaiser Family Foundation (KFF) and the Harvard School of Public Health (HSPH). Survey fieldwork was done by telephone in March, 2009 by Social Science Research Solutions, of a nationally representative sample of 1238 randomly selected respondents ages 18 and over. Interviews were conducted in English and Spanish. In the data file, all groups were weighted to reflect their actual distribution in the nation.

We accessed the data in May, 2013 through the Roper Center for Public Opinion Research at the University of Connecticut's iPOLL Databank, to conduct analyses to address different scientific questions than those originally examined or reported by the study's sponsors. The Boston University Institutional Review Board determined that this study was exempt from human studies review.

The funding source had no role in the study.

2.3. Study variables

2.3.1. Independent variable

Race/ethnicity was classified as non-Hispanic White (hereafter "White"), non-Hispanic Black ("Black"), Hispanic, and non-Hispanic Others ("Others"), obtained via respondent self-report.

2.3.2. Outcomes

We examined types of information communicated by physicians during treatment decision making—specifically, the extent to which doctors discussed various aspects of their rationale for treatment recommendations. Respondents were also asked five questions about information communicated by their doctors regarding the rationale for treatment recommendations. First, they were asked, "1. How often does your doctor discuss with you his or her REASONS for recommending a particular treatment?" (response categories: often, sometimes, rarely, never, do not know (latter 2%, deleted)). Respondents who responded often, sometimes, or rarely were then asked, "2. Has your doctor ever talked with you about his or her own experience using the same treatment for other patients as a reason for his or her recommendations?" (Yes/no, do not know (latter 1.78%, deleted)); "3. Has your doctor ever talked with you about scientific research about how well the treatment works as a reason for his or her recommendations?" (Yes/no, do not know (latter 1.34%; deleted)); "4. Has your doctor ever talked with you about the cost of the treatment as a reason for his or her recommendations?" (Yes/no, do not know (latter 0.8%; deleted)) and, "5. Has your doctor ever talked with you about how well a treatment works compared to other less expensive treatments as a reason for his or her recommendations?" (Yes/no, do not know (latter 2.67%; deleted)).

2.3.3. Covariates

We assessed sociodemographic factors which might affect individuals' perceptions or experiences of care, or which might modify the association between race and the outcomes, including age (categorized as 18–29, 30–49, 50–64, 65 and over), gender, education (grouped into attended high school, graduated high school, attended college, and graduated college), family income (all-source income before taxes in 2008, dichotomized as <\$50,000 and \$50,000+), self-reported health status (categories: excellent, very good, good, fair or poor (latter two combined)), and presence/absence of insurance coverage ('insured' category including both private and government insurance (e.g., Medicare, Medicaid)).

2.4. Statistical analysis

We first conducted bivariate analyses to explore the associations of race and other sociodemographic factors with the outcomes. Significance of associations between dependent and independent variables was determined by Pearson chi-square statistics if responses were dichotomous or by Mantel–Haenszel chi-square statistics for ordinal responses. All selected covariates were significantly associated with one or more of the outcomes, so all were later included in multivariate analyses. We then performed multivariate logistic regression analyses to examine whether race was significantly associated with the outcomes, after adjusting for covariates. Questions with more than two response options were recoded as dichotomous, as indicated above. To address issues of nonresponse bias, sampling weights were developed using US Census data, to reflect respondents' actual distribution in the nation, which were supplied with the dataset and used in the analyses. Statistical significance was estimated at the level of $p < 0.05$. All analyses were performed using SAS, version 9.3.1.

3. Results

Demographic characteristics of the 1238 respondents showed that the majority of respondents were White (75%), with about 12% Black and 10% Hispanic, and 58% female (Table 1). More than 90% of respondents were aged ≥30. About two-thirds of the participants

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