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The influence of patients' immigration background and residence permit status on treatment decisions in health care. Results of a factorial survey among general practitioners in Switzerland

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ABSTRACT

This study examines the influence of patients' immigration background and residence permit status on physicians' willingness to treat patients in due time. A factorial survey was conducted among 352 general practitioners with a background in internal medicine in a German-speaking region in Switzerland. Participants expressed their self-rating (SR) as well as the expected colleague-rating (CR) to provide immediate treatment to 12 fictive vignette patients. The effects of the vignette variables were analysed using random-effects models. The results show that SR as well as CR was not only influenced by the medical condition or the physicians' time pressure, but also by social factors such as the ethnicity and migration history, the residence permit status, and the economic condition of the patients. Our findings can be useful for the development of adequate, practically relevant teaching and training materials with the ultimate aim to reduce unjustified discrimination or social rationing in health care.

1. Introduction

Investigations of ethnic discrimination in health care have focused largely on patients' subjective perceptions in the medical encounter. Several studies surveying ethnic minorities themselves have demonstrated that these groups perceive high levels of racist behaviour by the health care personnel and that such felt discrimination is associated with ill health among those same patient groups (Hausmann et al., 2008; Paradies, 2006). It can be assumed that patients' subjective perceptions of discrimination may differ from the intention of the health care personnel. Nonetheless, it has been shown that patients' ethnic background can be a significant predictive factor for a number of treatment decisions and outcomes, and that diagnoses and treatment of ethnic minorities may be biased by unconscious stereotypes among physicians (Moskowitz et al., 2012; Smedley et al., 2003). One result of such subtle stereotypes is for example that ethnic minorities may be kept waiting longer for assessments or treatments and thus experience posteriorisation for other than medical reasons (Hall et al., 2015).

To posteriorise patients for non-medical reasons may happen while physicians are reluctant to admit that such a kind of rationing takes place (Ginsburg et al., 2000; Hurst et al., 2006, 2007; Strech et al., 2009; Strech et al., 2008). In his landmark study 'Passing On' David Sudnow described how health care staff made decisions in the process of dying based on the *social value* of patients (Sudnow, 1967). Follow-up studies on this so-called *social rationing* have shown that this effect has not weakened but instead increased over the time e.g. through policy changes that failed to address the broader societal foundations of social inequality (Timmermans and

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Sudnow, 1998; Timmermans, 1999).

Altogether, studies indicate that physicians' decision-making is influenced by a complex simultaneous interplay of social- and situational factors rather than in terms of overarching categories like ethnicity (Babitsch et al., 2008; van Ryn et al., 2006; Stepanikova, 2012).

This paper focuses on this interplay in the medical encounter with ethnic minorities and tries to shed light on possible posteriorisation of patients due to social factors such as immigration background or residence status. Prominently discussed additional or related social factors are socioeconomic status (SES), time pressure and language barriers. Their influence on medical decision making in ethnic minority patient groups can be summarized as follows:

1.1. Socioeconomic status

Van Ryn et al. (2006) reported an interconnected interplay of socio-demographic variables in physicians' perceptions of black and white candidates for coronary artery bypass graft surgery (CABG). Recommendations for CABG were significantly influenced by patients' ethnicity among male, but not female patients. Physicians' perceptions of patients' education level and physical activity preferences mediated the effects of ethnicity on CABG recommendations. Van Ryn and Burke (2000) reported similar findings regarding physicians' perceptions of social attributes. Their findings showed that physicians' perceptions of patients were influenced by patients' socio-demographic characteristics. Black patients (even after controlling for patient sex, age, income and education) and members of low and middle SES groups were more likely to be perceived negatively on a number of dimensions than white and upper SES patients. McKinlay et al. (2013) found significant influences of patients' ethnicity on the diagnosis of diabetes. According to their study patients with higher SES were more likely to receive essential foot exams and suggestions according to diabetes guidelines than patients with lower SES.

1.2. Time pressure

Stepanikova (2012) found significantly fewer specialist referrals and less serious diagnoses for black patients only in physicians under high time pressure. This finding corresponds to the assumption that heuristics such as stereotyping serve as simplifications for decision-making in complex environments. Such simplifications have been described to be cognitive shortcuts for the decision-maker, which may be particularly useful in the context of medical settings, characterised by time pressure, psychological stress, fatigue, or multitasking (Aberegg and Terry, 2004).

1.3. Language barriers

Several studies indicate that language barriers diminish physicians' ability to provide high-quality care (Vargas Bustamante and Chen, 2011) and complicate the medical encounter as patients may not possess the vocabulary to accurately describe their history, symptoms, and concerns, which renders diagnostic and treatment decision-making more uncertain (Jensen et al., 2011). The results of a survey study conducted in three gynaecology and internal medicine emergency departments in Germany demonstrated that physicians' satisfaction with the course of treatment was significantly lower for patients of Turkish origin. One stated main reason were problems with communication. When communication problems were addressed the relevance of Turkish origin disappeared (Babitsch et al., 2008).

2. Theoretical explanations for the influence of ethnic background on medical decision-making

In social psychology, there is a substantial body of literature focusing on how physicians manage the massive amount of complex information and stimuli which they are exposed to, including how prejudice, stereotyping and clinical uncertainty can affect assessments of patients and treatment decisions (Balsa and McGuire, 2001; Balsa et al., 2005; van Ryn, 2002). Van Ryn (2002) suggests that ethnicity related disparities in health care may stem from providers' beliefs about these patient groups as a result of negative stereotyping. Like all other members of society, medical professionals also share internalized social stereotypes of groups and these stereotyping beliefs or attitudes are triggered unconsciously (Moskowitz et al., 2012). Sabin et al. (2009) measured implicit and explicit attitudes regarding race among medical doctors and compared the results with a large and diverse sample. The study reported that the majority of medical doctors held implicit preferences for white over black patients. This finding is in line with general patterns that can be observed in large, heterogeneous public samples. By contrast, Balsa and McGuire (2001) suggest that discrimination may be the result of the application of conditional probability assumptions due to clinical uncertainty. The so-called statistical discrimination model assumes that in cases of uncertainty about patients' underlying conditions physicians may use patients' ethnicity as one determining factor in order to formulate a diagnosis. In cases of clinical uncertainty, plausible presumptions about epidemiological patterns of diseases can lead to justified differences in the diagnoses of, for example, hypertension or diabetes (Balsa and McGuire, 2001). In addition, empirical research indicates that physicians' certainty about their own diagnosis affects subsequent diagnostic and therapeutic actions, like test ordering and writing prescriptions, and that these vary according to patients' non-medical characteristics (Lutfey et al., 2009). The theory of statistical discrimination constitutes another possible cause of discrimination in the medical encounter: "Discrimination stemming from prejudice is of a very different character than discrimination stemming from the application of rules of conditional probability as a response to clinical uncertainty. While in the former case, doctors are not acting in the best interests of their patients, in the latter, they are doing the best they can, given the information available" (Balsa et al., 2005).

2.1. Objectives of the study

The objective of this study was to examine how patients' immigration background and associated social (language barriers/necessary translation, economic status of the patient, and residence permit status) and contextual factors (high time pressure of the physician, uncovered treatment costs) influence judgments of physicians on prioritisation or posteriorisation of patients with severe (e.g. chest pain) or less severe (e.g. back pain) medical symptoms. We presupposed that the physicians know the indicated methods and that all patients will be treated.

It is well known that physicians are reluctant to admit that rationing by posteriorisation of patients takes place although it is also known that rationing is a regular feature of medical care (Ginsburg et al., 2000; Hurst et al. 2006, 2007; Strech et al., 2009; Strech et al. 2008). Therefore, we expected a negatively-skewed distribution of the physicians' judgments, meaning that the judgments are generally expected to cluster toward prioritisation of the patients.

We hypothesized that professional judgments of physicians related to the prioritisation or posteriorisation of patients are mainly guided by patients' medical condition, i.e. that the most immediate treatment should and would be provided for patients