Social Science & Medicine 116 (2014) 161–168

Contents lists available at ScienceDirect

Social Science & Medicine

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

Investigating the influence of African American and African Caribbean race on primary care doctors' decision making about depression

A. Adams [a,*], L. Vail [a], C.D. Buckingham [b], J. Kidd [a], S. Weich [a], D. Roter [c]

[a] Warwick Medical School, University of Warwick, Coventry, CV4 7AL, UK
[b] Computer Science, Aston University, Aston Triangle, Birmingham, B4 7ET, UK
[c] School of Public Health, Johns Hopkins University, 624 N. Broadway, Suite 750, Baltimore 21205, USA

ARTICLE INFO

Article history:
Received 30 April 2013
Received in revised form
24 June 2014
Accepted 3 July 2014
Available online 3 July 2014

Keywords:
Primary care
Clinical decision making
Racial disparities
African-Americans
African-Caribbeans
Depression
Video vignettes
Cognitive processes

ABSTRACT

This paper explores differences in how primary care doctors process the clinical presentation of depression by African American and African-Caribbean patients compared with white patients in the US and the UK. The aim is to gain a better understanding of possible pathways by which racial disparities arise in depression care. One hundred and eight doctors described their thought processes after viewing video recorded simulated patients presenting with identical symptoms strongly suggestive of depression. These descriptions were analysed using the CliniClass system, which captures information about micro-components of clinical decision making and permits a systematic, structured and detailed analysis of how doctors arrive at diagnostic, intervention and management decisions. Video recordings of actors portraying black (both African American and African-Caribbean) and white (both White American and White British) male and female patients (aged 55 years and 75 years) were presented to doctors randomly selected from the Massachusetts Medical Society list and from Surrey/South West London and West Midlands National Health Service lists, stratified by country (US v.UK), gender, and years of clinical experience (less v. very experienced). Findings demonstrated little evidence of bias affecting doctors' decision making processes, with the exception of less attention being paid to the potential outcomes associated with different treatment options for African American compared with White American patients in the US. Instead, findings suggest greater clinical uncertainty in diagnosing depression amongst black compared with white patients, particularly in the UK. This was evident in more potential diagnoses. There was also a tendency for doctors in both countries to focus more on black patients' physical rather than psychological symptoms and to identify endocrine problems, most often diabetes, as a presenting complaint for them. This suggests that doctors in both countries have a less well developed mental model of depression for black compared with white patients.

© 2014 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY license (http://creativecommons.org/licenses/by/3.0/).

1. Introduction

Previous research has demonstrated variation in the ability of different ethnic groups to access appropriate care for depression (Das et al., 2006), and subsequently in the quality of care they experience (Simpson et al., 2007; Gonzalez et al., 2010). The extent to which observed disparities are the result of conscious or unconscious racial bias amongst clinicians, or lack of understanding about how people from different segments of the population present with depression, is open to question. This paper seeks to contribute to this area by exploring doctors' responses to standardised patient presentations of depression (i.e. using identical, scripted verbal and body language) portrayed by actors of different race. It compares the responses of doctors in two developed countries, the US and the UK, to people of African descent (African Americans and African-Caribbeans) versus white people (White Americans and White British).

These countries have been chosen because both have a history of racial discrimination against people of African descent. Discrimination has been overt in the US, while in the UK it has manifested itself in cumulative social exclusion processes, involving cultural, institutional and socio-economic exclusion (McLean et al., 2003). However against this similar 'backdrop', it appears that racial disparities in health care may play out

* Corresponding author.
E-mail addresses: A.E.Adams@warwick.ac.uk (A. Adams), Laura.Vail@warwick.ac.uk (L. Vail), c.d.buckingham@aston.ac.uk (C.D. Buckingham), J.M.Kidd@warwick.ac.uk (J. Kidd), S.Weich@warwick.ac.uk (S. Weich), droter@jhsph.edu (D. Roter).

http://dx.doi.org/10.1016/j.socscimed.2014.07.004
0277-9536/© 2014 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY license (http://creativecommons.org/licenses/by/3.0/).

differently in the two countries. In the US, African Americans delay help seeking and have less access to mental health services (Dinwiddie et al., 2013); whereas in the UK Smaje and LeGrand (1997) and Cooper et al. (1999) found higher rates of GP use by Asians and African-Caribbeans compared to whites, but lower rates of referral among these groups to outpatient services. Our purpose is to clarify what happens within clinical encounters, and the role played by racial bias versus clinical uncertainty within the diagnostic process for depression itself. Findings will permit identification of mechanisms driving differential diagnoses and disparities that are common to black and white people in both countries, and also between-country variation due to cultural and health care system differences. New insights gained will help target efforts to reduce disparities in depression care in both countries.

2. Background

There is evidence to suggest that African-Caribbean and other ethnic minority communities in the UK are over represented in secondary mental health in-patient and forensic services and have more negative care experiences compared with their white counterparts (Fernando, 2010). Social exclusion processes are clearly influential in this. There is an independent relationship between lower socio-economic status and poorer mental health (Gary, 1988), and African-Caribbeans in the UK are disproportionately located in lower socio-economic status groups (Modood, 1997). In terms of cultural social exclusion, African Caribbeans' distinctive speech, language and gestures can lead to misunderstanding and fear amongst predominantly white clinicians (General Medical Council, 2014), so that they attract labels such as ‘big, black, bad, mad and dangerous’ (McLean et al., 2003; Keating, 2007). Consequently they experience more control and restraint procedures within secondary mental health services, which act as agents of social control (McLean et al., 2003).

This situation is mirrored in the US amongst African Americans (National Institute of Mental Health, 2001), despite African Americans having less access to mental health care services in the first place (Dinwiddie et al., 2013). Studies have shown that African Americans suffering from depression receive poorer quality of care compared with White Americans (Young et al., 2001; Stockdale et al., 2008; Alegria et al., 2008), and a systematic review by Simpson et al. (2007) concluded that African Americans and Hispanics are less likely to receive appropriate treatment than White Americans. Only two out of the nine US studies reviewed (Rollman et al., 2002; Sleath et al., 2001) showed no differences in treatment between the groups. In a related vein, Gonzalez et al. (2010) found that clinicians were less likely to use guideline-concordant therapies for African American or Mexican American patients compared with White Americans or other ethnic groups. In the current study, the focus is on the early phase of a patient's care journey when the diagnostic process unfolds as they first encounter the health care system. Research shows that African-Caribbeans are equally or more likely to suffer from depression, often mixed with anxiety, than White British people (Nazroo, 1997; Shaw et al., 1999; Weich and McManus, 2002), although findings about the prevalence of depression amongst African Americans compared with White Americans are inconclusive (Riolo et al., 2005; Williams et al., 2007). What is clear however is that diagnostic rates vary widely. Cultural differences in the conceptualisation of depression and in people's help-seeking behaviours aside, previous research suggests that in the UK African-Caribbeans are less likely than White patients to receive a diagnosis of depression from their general practitioner (Lloyd, 1993; Odell et al., 1997), and this is also the case in the US for African-Americans and white patients (Borowsky et al., 2000; Miranda and Cooper, 2004; Simpson et al., 2007; Trinh et al., 2011; Lukachko and Olfson, 2012).

There is evidence to suggest that disparity mechanisms associated with the diagnostic process itself are at the heart of the matter. The systematic review carried out by Das et al. (2006) identified a number of factors affecting doctors' ability to recognise and treat major depression amongst African Americans, including clinical presentation complicated by: somatisation, stigma regarding a diagnosis of depression, competing clinical demands of co-morbid general medical problems, and problems with the doctor–patient relationship. A recent US study of primary care consultations with patients who had screened positive for depressive symptoms, found that doctors were less likely to discuss depression, respond to emotional disclosures or recognise significant emotional distress of their African American relative to their White patients (Ghods et al., 2008). Cooper et al. (2010) have argued that racial differences in communication contribute to racial disparities in depression detection and treatment. Previous research therefore highlights the importance of identifying where and how communication and clinical decision making can go wrong in primary care.

One cause of ethnic and racial disparities within different healthcare systems may be doctor bias (Cooper et al., 2012; Schulman et al., 1999; Van Ryn and Burke, 2000; Weisse et al., 2001; Kales et al., 2005; McKinlay et al., 2006). However, findings from these studies suggest it is plausible to consider that doctors lack a clear mental model of depression for black (defined for the purposes of this paper as African Americans and African-Caribbeans collectively) compared with white patients (defined here as White Americans and White British collectively), which can lead to differential treatment rather than discriminatory behaviour *per se*. For instance, Baker (2001) highlighted doctors' tendency to misdiagnose affective disorders amongst African Americans. Similarly, Ghods et al. (2008) suggested that clinicians are more likely to attribute distress in African Americans to critical life events rather than depression, than they are for White American patients. Health care system differences between the US and the UK have also been shown to impact on primary care doctors' diagnostic and management behaviour. US doctors in our own sample had longer patient consultations compared with UK doctors (Konrad et al., 2010), and US doctors expressed greater certainty in their diagnosis of depression and were significantly more likely to prescribe antidepressants at a first visit compared with their UK colleagues (Link et al., 2011).

In order to explain the racial differences identified above and any disparity mechanisms, it is important to understand how doctors make diagnostic and treatment decisions. The aim of this paper is to examine the micro-processes of clinical decision making using a coding system we have previously developed and applied called CliniClass (Buckingham and Adams, 2000a, 2000b; Adams et al., 2008). It enables the disentanglement of disparity effects due to doctor bias and health care system differences, from effects due to doctors' uncertainty about depression presentation. Understanding the root causes of racial disparities emanating from doctor-patient interaction in depression care will show where to target interventions designed to minimise them, thereby helping reduce inequalities in care in the US and the UK.

Our expectations were that racial disparity will be evident in less elaborate and more cursory clinical decision making (CDM) processes for black compared with white patients. These will be characterised by: considering fewer patient cues; generating fewer inferences based on activating fewer types of diagnostic knowledge structures; considering fewer potential outcomes associated with inferences; instigating fewer interventions; and citing more health care system constraints associated with intervention decisions. Where different mental models of disease are in operation for black

Download English Version:

https://daneshyari.com/en/article/7334840

Download Persian Version:

https://daneshyari.com/article/7334840

Daneshyari.com