The Clinical Examination and Socially At-Risk Populations

The Examination Matters for Health Disparities

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KEYWORDS

• Social determinants of health • Health care disparities • Patient-centered care
• Shared decision making • Cultural competency

KEY POINTS

- Disparities exist in health status, health outcomes, and health care delivery.
- The medical interview provides an opportunity for eliciting and addressing the social determinants of health.
- To build a relationship, clinicians should strive to individualize the patient, respond to emotion, and be aware of personal bias/values.
- In gathering data, clinicians may seek information about domains for social risk, and screening tools exist to facilitate this.
- Education, counseling, and decision making should take into account the individual patient's context, health literacy, and degree of activation.

Disclosure Statement: None.

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Med Clin N Am 102 (2018) 521–532
https://doi.org/10.1016/j.mcna.2017.12.013
medical.theclinics.com

INTRODUCTION

The population of the United States is increasingly diverse. Recent estimates show the US population is 26.4% nonwhite, 13.2% foreign-born, and 3.4% lesbian, gay, bisexual, transgender (LGBT).[1] Economic inequality is also increasing, with the top 1% of the population holding an estimated 42% of the nation's wealth.[2] Sociocultural differences between patients and clinicians can create communication challenges and increase the potential for disparities.[3–5]

There are disparities in health status and health outcomes for many subpopulations.[6] These differences span individual assessments of health status to maternal mortality to morbidity from a myriad of chronic diseases.[3] Increasingly, it is recognized that disparities are driven not by differences in biology or individual patient characteristics, but rather by social determinants, or the conditions of the environments in which people live, including access to healthy food, education, employment, transportation, and housing options.[3,4]

Just as disparities exist in health, there are also disparities in the care people receive when they interface with the health care system. The National Academy of Medicine's (formerly the Institute of Medicine) landmark report *Unequal Treatment* found that members of racial and ethnic minority groups did not always receive needed services at the same rates as whites, and that disparities existed across a range of diseases and persisted even after accounting for confounders such as insurance status and disease severity.[7] Health disparities are also influenced by the social environment, including the quality of interpersonal care, in health care settings.[7,8]

The health care workforce remains less diverse than the US population as a whole. Only about one-third of all physicians are women, and only 8.9% of physicians identify as black or African American, American Indian or Alaska Native, or Hispanic or Latino.[9] Concordance on various dimensions between patients and clinicians, including both visible demographic characteristics and underlying attitudes and values, positively affects the relationship.[8] Racial concordance between patients and providers has been linked to longer clinic visits, more positive patient affect, and greater ratings of patient satisfaction, adherence, and participatory decision making.[10,11] However, such concordance is not always achievable owing to the systemic disparities in the workforce as well as local factors. Even in the best cases, there is rarely full concordance of all aspects of identity between patient and clinician.

The medical interview serves 4 functions: relationship building, data gathering, patient education and counseling, and facilitation and patient activation.[12] We describe how clinicians can uncover and address the social determinants of health within this conceptual framework during a patient–clinician encounter. It is also important for clinicians to consider their relationships with the broader communities in which they work and their relationships with other clinicians.

RELATIONSHIP BUILDING

Dimensions of Relationship-Centered Care

Many studies have reported reduced levels of trust among racial and ethnic minorities in physicians, researchers, and the health care system.[8,13,14] Relationship-centered care considers the experiences, values, and perspectives of the patient and clinician, and how these intersect in the clinical encounter.[7,15] To build a successful patient–clinician relationship, mutual respect, communication, knowing, affiliation/liking, trust, and partnership building must all be present.[8] Respect for the individual underlies and enhances each of these dimensions, and communication is