R-E-S-P-E-C-T: Patient reports of disrespect in the health care setting and its impact on care

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Practice recommendations

- Perceptions of disrespect or of receiving unfair treatment within the patient-provider relationship are prevalent, particularly among racial/ethnic minorities.

- Negative perceptions in the patient-doctor relationship can effect whether a patient follows advice or delays needed care.

- Therefore, physicians should strive to be respectful and culturally sensitive to the needs of their patients, regardless of ethnic or racial background.

Abstract

Objective   The health care encounter is a setting in which racial/ethnic disparities can arise. Patients who experience disrespect in this encounter may be less likely to use health care services that improve outcomes. The objective of this study was to examine factors in the health care encounter and to model how negative perceptions of the encounter influence health care utilization.

Design, subjects, and setting   Data were derived from the Commonwealth Fund 2001 Health Care Quality Survey, a nationwide random-digit-dial survey of 6722 adults, conducted between April 30 and November 5, 2001. Bivariate and multivariate analyses were performed on weighted data.

Main outcome measures   Measures of negative perceptions of the patient-provider relationship included feelings of being treated with disrespect or being looked down upon, a belief that unfair treatment was received due to race or language spoken, and a belief that better treatment would have been received had the respondent had been of a different race. Measures of utilization included receipt of a physical exam within the prior year, receipt of optimal cancer screening and recommended elements of chronic disease care, delay of needed care, and not following the doctor's advice.

Main results   Minorities were significantly more likely to report being treated with disrespect or being looked down upon in the patient-provider relationship. Specifically, 14.1% of blacks (P=.06), 19.4% of Hispanics (P<.001), and 20.2% if Asians (P<.001) perceived being treated with disrespect or being looked down upon, compared with only 9.4% of whites. Persons who thought that they would have received better treatment if they were of a different race were significantly less likely to receive optimal chronic disease screening and more likely to not follow the doctor's advice or put off care (P<.01.)

Conclusions   Perceptions of disrespect or of receiving unfair treatment within the patient-provider relationship are prevalent, particularly among racial/ethnic minorities. Such negative perceptions influence health care utilization and may contribute to existing health disparities.

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Racial and ethnic disparities in health care have been catalogued across numerous diseases and care settings.[1] By clarifying the causes of these disparities, we can develop solutions. In a seminal study, Shulman found in patient simulations that identical presentations for heart disease received different recommendations for care based on the patient's race and gender, thus pinpointing the patient-provider relationship as a potential source of disparities.[2] Other research suggests interactions with non-physician health care personnel might also be a source of negative experiences with care.[3]

Research is beginning to identify how the health care encounter might relate to disparities in use of services and quality of care. For example, race concordance between the physician and patient, at least for blacks, is associated with higher patient satisfaction and greater participatory decision-making. This in turn can impact compliance and possibly outcomes.[4–6] While black patients who have black physicians are more likely to report receipt of counseling about preventive care and cancer screening,[7] race concordance does not appear to be independently associated with different patterns of utilization.[8]

Perceived discrimination has also been associated with lower levels of satisfaction with the health care system.[9] In one survey, two thirds of respondents reported feeling discriminated against in their interactions with health care providers due to their race or socioeconomic status.[10] How perceived discrimination influences quality and outcomes of care has not been fully explored.

We hypothesized that minority patients and those who do not speak English perceive negative experiences with the health care encounter more often than whites or English-speakers. We further hypothesized that patients who report such negative experiences are less likely to seek care initially or return for follow-up care. We tested these hypotheses using data from the Commonwealth Fund 2001 Health Care Quality Survey.

■ METHODS

Sample

Respondents were from a nationally representative sample of 6722 adults, aged 18 years and older, living in the continental United States, and who speak English, Spanish, Mandarin, Cantonese, Vietnamese, or Korean.

The sampling frame was based on random-digit dialing; telephone exchanges with higher-than-average numbers of minority households were oversampled. In addition to the oversampling based on telephone exchanges, we interviewed members of 394 households identified from a nationwide demographic tracking survey as having an Asian/Asian American or African American family member. Interviews were conducted in English, Spanish, Mandarin, Cantonese, Vietnamese, or Korean, depending on the respondent preference. The response rate for the entire sample was 53.1%.

The final sample was weighted to correct for the disproportionate sample design and to ensure the sample was representative of all adults aged 18 years and older based on the March 2001 Current Population Survey (CPS). The final weighted sample is therefore reflective of the 193 million adults in the United States who have telephones. A more detailed description of the sampling and weighting methods can be found elsewhere.[11] Data were collected between April 30 and November 5, 2001.

We focus on the subset of questions addressing respondent's experience with the health care encounter and their use of certain health care services. We used STATA Version 6.0[12] to conduct statistical analyses using the weighted sample.

Dependent variables

Negative perceptions of the patient-provider relationship. We identified factors that define the patient-provider relationship, and formulated questions based on these factors that would elicit meaningful responses. Specific questions included:

• "Did the doctor treat you with a great deal of respect and dignity, a fair amount, not too much, or none at all?" (4-point scale)

• Please tell me if you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with the statement, "I often feel as if my doctor looks down on me and the way I live my life." (4-point scale)

• "Thinking about all of the experiences you have had with health care visits in the last two years, have you ever felt that the doctor or medical staff you saw judged you unfairly or treated you with disrespect because of how well you speak English?" (yes/no)

• "Thinking about all of the experiences you have had with health care visits in the last two years, have you ever felt that the doctor or medical staff you saw judged you unfairly or treated you with disrespect because of your race or ethnic background?" (yes/no)

• "Do you think there was ever a time when you would have gotten better medical care if you had belonged to a different race or ethnic group?" (yes/no)

Those who said they did not have a doctor were unable to answer these questions and were excluded from our analysis. We combined the first 2 questions into a single dichotomous variable, characterized as "being treated with disrespect," because both questions described negative perceptions of the health care encounter and because doing so preserved sample size for our analyses.

Utilization and optimal care

We examined self-reported use of specific services, including whether respondents had a physical exam within the past year. For cancer screening and chronic disease care, we created variables designed to represent optimal care. For example, optimal cancer screening was defined as being up to date on *all* tests for which the individual was eligible, based on age and gender. These included:

• fecal occult blood testing for colon cancer screening within the prior year (both female and male respondents aged >50 years)

• cervical cancer screening within the prior 3 years (all women over the age of the 18)

> **Perceived discrimination has been associated with lower levels of satisfaction with the health care system**

• mammography within the prior year (women over the age of 50).

We excluded men younger than 50 years since colon cancer screening is not routinely recommended.

We considered respondents to have optimal chronic disease testing if they reported receiving all appropriate testing relevant for their particular condition. For persons with diabetes, this included having a hemoglobin A1c level checked within the past 6 months, a blood pressure check and foot and eye exams within the year, and cholesterol testing within 5 years. For those with heart disease or hypertension, it included having had blood pressure checked within the prior year and cholesterol testing within the prior 5 years. This approach is consistent with that of McBean et al, who have shown that a combination of appropriate tests is more predictive of glycemic control for diabetes.[13]

Because we were interested in different aspects of patient-initiated care seeking, we also evaluated delay in seeking care and adherence to physician recommendations as further measures of outcome. Specific questions were:

• "During the last 12 months, was there any time when you had a medical problem but put off, postponed, or did not seek medical care when you needed to?"

• "Has there been a time in the last two years when you didn't follow the doctor's advice or treatment plan, get a recommended test, or see a referred doctor?" (asked of respondents who had visited a doctor or clinic or had been admitted to the hospital in the last 2 years.)

■ ANALYSIS

To test our first hypothesis—that persons of racial/ethnic minorities perceive negative experiences with the health care encounter more often than whites or English speakers—we examined

TABLE 1

Demographics/characteristics and health care utilization of study participants

Overall sample	Whites (%) n=3488 (69)	Blacks (%) n=1037 (11)	Hispanics (%) n=1153 (10.3)	Asians (%) n=669 (4.2)
Gender				
Male	45.1	41.9	45.9	49.7
Age (years)				
18–64	79.9*	86.1*	91.1*	91.2*
65+	18.9*	12.5*	8.6*	6.9*
Education				
High school grad or less	44.0	56.0	68.3	25.8
Some college/technical school or more	56.0	44.0*	31.7*	74.2*
Income as percentage of poverty level				
<100%	7.7	15.7*	23.0*	10.7
100%–200%	17.2	25.4*	23.2*	16.5
>200%	57.4	40.0*	31.4*	53.9
Unknown	17.7	18.9	22.4*	18.8
Insurance status				
None	10.6*	20.6*	32.8*	13.6
Medicaid	2.4*	8.6*	5.8*	3.3
All other	87.0*	70.8*	61.4*	83.1
Presence of chronic illness†	35.9*	44.4*	30.2*	24.5*
English as primary language at home	99.9*	99.6*	59.4*	91.7*
No primary physician	19.1*	28.6*	41.1*	32.1*
Physical exam within prior year	47.1*	56.8*	48.5	41.0
Put off care in prior year	19.5	19.4	19.2	16.3
Sub-sample	n=3205	n=947	n=969	n=561
Not followed doctor's advice	24.9	21.9	21.7	22.1
Sub-sample	n=974	n=367	n=258	n=111
Optimal chronic illness screening	76.9*	73.7	54.8*	61.5*
Sub-sample	n=2612	n=811	n=770	n=401
Optimal cancer screening	50.2*	61.9*	60.1*	53.3

*Statistically significant difference detected between whites and blacks, Hispanics or Asians with chi-squared test for *P*<.05.

†Hypertension, heart disease, diabetes, asthma.

associations between demographic characteristics, utilization variables, and negative perceptions of the health care encounter using chi-squared tests and multivariate logistic regression. In these analyses, we dichotomized education into high school graduate or less, and some technical school/college and more. We dichotomized the primary language spoken at home into non-English and English, and we used federal poverty level groupings (<100%, 100%–200% and >200%) to categorize household income. Almost 19% percent of respondents did not report incomes, so we created a dummy variable to account for those with unreported incomes.

We classified insurance status as none or any (either public or private); race/ethnicity as white, black, Hispanic, Asian, and other (Native American, mixed race, or other). We examined the effect of these variables alone and in concert. For example, we calculated predicted percentages to evaluate the combined effects of race and gender, as well as race and education, in relationship to our outcome variables.

Finally, we used multivariate logistic regression to test the relationship between negative perceptions of the patient-provider relationship and our utilization variables. In these analyses, perceptions were the covariate of interest; we controlled for patient characteristics that could also influence utilization, including education, income, insurance status, presence of a primary physician and existence of a comorbid condition (in this case, hypertension, diabetes, heart disease, asthma, and cancer.) This last variable was, by necessity, excluded from the analysis involving optimal chronic disease testing.

■ RESULTS

Table 1 describes demographic characteristics and utilization measures for our sample. Consistent with prior literature, blacks and Hispanics had lower incomes and higher rates of non-insurance than both whites and Asians. Hispanics responded most frequently that English was not their primary language.

Blacks and Hispanics were more likely than whites to have received optimal cancer screening

Hispanics and Asians were less likely than whites to have received optimal chronic disease care, while blacks and Hispanics were more likely than whites to have received optimal cancer screening. There were no differences between racial/ethnic groups in not following the doctor's advice or in putting off care.

Negative perceptions of the patient-provider relationship

Race. Over 14% of blacks, 19% of Hispanics, and 20% of Asians reported they had been treated with disrespect by their doctor. Members of these groups were also more likely than whites to report that they were treated unfairly because of their race or their language, and that they would have received better care had they belonged to a different race (**Table 2**).

Language. Persons for whom English was not the primary language were also more likely to say they had been treated with disrespect, and to report they would have received better care had they been of a different race. For each racial/ethnic group, bivariate relationships persisted after controlling for other respondent characteristics, including education and income (**Table 2**).

Sex. Men were significantly more likely than women to perceive being treated with disrespect by the doctor (15.9% vs 11.6%), and the percentage varied by race/ethnicity. Using our model to predict the combined effects of race and gender, we found that Asian and Hispanic men (24% and 23%, respectively) were more likely than black men (17%) or white men (11%) to perceive being treated with disrespect.

Education. Education was similarly associated with perceptions of disrespect. Almost 18% of persons without a college education believed they had been treated with disrespect, versus only 10% of

TABLE 2

Relationship of demographic variables to measures of negative perceptions

	Looked down on or treated with disrespect (%)	Treated unfairly because of race (%)	Treated unfairly because of language (%)	Would have received better care if different race (%)
Overall sample	n=6663	n=6008	n=6008	n=6722
Gender				
Male	11.6	4.0	2.5	7.0
Female	15.8*	4.3	2.7	7.2
Primary language				
English	13.0	3.7	2.0	6.0
Non-English	15.9*	9.8	10.1	19.5‡
Income as percentage of poverty level				
<100%	19.6†	8.4§	4.6	12.5
100%–200%	17.3‡	7.3‡	3.9	9.5
>200%	10.1	9.9	1.7	5.1
Insurance status				
Insured	11.4	2.9	1.9	5.3
Not insured	23.0*	11.4*	6.4‡	16.4*
Race				
White	9.4	1.2	0.5	1.4
Black	14.1§	7.9*	3.5*	15.2*
Hispanic	19.4*	7.9*	7.2*	13.3*
Asian	20.2*	6.1*	4.5*	12.2*
Education				
High school grad or less	17.9	5.0	3.7	7.8
Some college/ technical school or more	10.3*	3.6	1.9	6.6‡

Adjusted percentages using multivariate regression analysis.

This table reports predicted percentages derived from our multivariate regression analysis. The dependent variables of interest: "looked down on/treated with disrespect," "treated unfairly because of race," "treated unfairly because of language," and "would have received better care if different race." Independent variables: gender, language, income, insurance, race, and education.

* $P \leq .001$ † $P \leq .01$ ‡ $P \leq .05$ § $P \leq .10$

TABLE 3

Relationship of negative perceptions to health care outcomes

	Exam within prior year (%)	Optimal chronic disease screening (%)	Optimal cancer screening (%)	Did not follow doctor's advice (%)	Delayed care (%)
Treated with disrespect or looked down on	n=6663	n=1790	n=4794	n=6008	n=6663
Yes	41.3§	58.9†	52.9	32.3†	31.1*
No	48.6	76.0	54.1	23.6	18.6
Treated unfairly because of…	n=6008	n=1729	4500	n=6008	n=6008
Race					
Yes	52.5	50.7‡	64.9§	46.5*	40.8†
No	51.4	75.3	55.3	23.9	20.2
Language					
Yes	48.2	62.0	59.4	32.1	37.5‡
No	51.6	74.7	55.5	24.5	20.6
Would have received better treatment if different race	n=6722	n=1794	n=4827	n=6008	n=6722
Yes	46.2	53.6‡	56.6	33.8‡	33.7*
No	47.4	74.3	54.2	24.1	19.2

This table reports predicted percentages derived from our multivariate regression analysis. Dependent variables: "exam within prior year," "optimal chronic disease screening," "optimal cancer screening," "did not follow the doctor's advice," and "delayed care." Principal independent variables: "treated with disrespect or looked down upon," "treated unfairly because of race," "treated unfairly because of language," and "would have received better treatment if different race." In each model, we examined the relationship of the dependent variable to each of our principal independent variables controlling for income, insurance, education, presence of a primary physician, and chronic disease (excluded from the heart disease/diabetes screening regression.)

* $P \leq .001$ † $P \leq .01$ ‡ $P \leq .05$ § $P \leq .10$

those with a college education. Minorities with lower education were more likely to have this perception. Twenty-nine percent of Asians, 22% of Hispanics, and 19% of blacks without a college education reported being treated with disrespect or being looked down upon, versus 13% of whites.

Impact on care

Respondents who reported being treated with disrespect were significantly less likely to have had a physical exam within the prior year; those with diabetes, hypertension, or heart disease were less likely to have received optimal care. These respondents were also more likely to report not following the doctor's advice and putting off needed care (**Table 3**). This relationship was not seen for optimal cancer screening.

Persons who believed they had been treated unfairly due to their race and who thought they would have received better care had they been

> Those who reported being treated unfairly were less likely to get a routine physical or receive preventive care

of a different race were more likely to ignore the doctor's advice and put off care when medically needed. Those who believed they would have received better care had they been of a different race were also less likely to receive optimal chronic disease care. In analyses not shown, we examined the independent effects of income and education, as well as interactions between these variables and insurance, and found the results basically unchanged.

■ DISCUSSION

We hypothesized that patients who have negative perceptions of the patient-provider relationship would be less likely to seek needed care, and that reports of such feelings would be more prevalent among minority patients. As anticipated, large proportions of blacks, Hispanics, and Asians reported that they were treated with disrespect, were treated unfairly, or would have received better care if their race had been different. Male gender and lower educational attainment were also associated with perceived disrespect, particularly among minorities.

Negative experiences lead to suboptimal care

The finding of greater likelihood of perceived disrespect among minority groups, men, and those with lower levels of education is particularly important in light of the strong relationship between such reports and the quality of care that patients receive. Those who reported that they were treated unfairly because of race were less likely to get a routine physical exam, follow a doctor's advice, or receive appropriate secondary preventive care for diabetes, heart disease, and hypertension. In other words, negative experiences within the health care environment may jeopardize care for medically needy patients.

Receipt of suboptimal care, particularly in the context of chronic disease, is likely to be associated with worse health outcomes, and may contribute to disparities.

Cancer screening the exception

While the relationships between negative perceptions and receipt of care for chronic disease and receipt of a routine physical examination were strong, the correlation did not persist for cancer screening. Black and Hispanic respondents were *more* likely than whites to receive optimal cancer screening, a finding that has been reported elsewhere.[14,15]

We hypothesize that this is in part because a wide array of community programs make special outreach efforts allowing patients to "bypass" the traditional office environment.[16] These settings may be more likely to use culturally sensitive approaches or may be so transient that negative perceptions based on race or income may be less likely to form.

However, based on our finding that care requiring follow-up (eg, diabetes management) is less likely to occur with individuals who report negative perceptions of the patient-provider relationship, we would hypothesize that individuals who receive initial cancer screening might be less likely to follow up on abnormal results once screened. It may be that in situations requiring long term relationships, such as chronic disease care, perceptions of discrimination and disrespect may take the greatest toll. This hypothesis is supported by previous literature consistently reporting excess mortality despite higher cancer screening rates among blacks.[17–20]

Limitations

Our study has several limitations. Because we are relying on self-report, we could not assess which specific aspects of the patient-provider relationship may have influenced the reports of disrespect. Responses may have been affected by experiences completely outside of this relationship, or outside of the health care system, that

independently could have impacted health care utilization. We cannot disentangle how general life experience influences perceptions of the health care encounter or care-seeking; for example respondents who perceive racial bias in other environments such as the workplace may also be more likely to perceive it in the healthcare setting. In addition, self-reported utilization measures may not always be accurate, particularly regarding cancer screening.[21,22]

Despite the deliberate oversampling of major racial/ethnic groups, we remain limited in our ability to examine important subgroups within them, whether related to ethnicity (eg, Cuban, Vietnamese) or chronic condition (eg, asthma, diabetes), even though some groups may differ dramatically from others.

We also had insufficient numbers of Native Americans to analyze separately.

We excluded respondents who did not have a regular doctor because they were unable to answer key questions about the health care encounter.

Finally, there is no agreement on the definition of age-appropriate breast and cervical cancer screening.[23,24] We conducted additional analyses varying the age criteria for testing, including starting the required age for screening at age 40 (for breast cancer) as well as setting the age cut off for required screening at 65 (for both breast and cervical cancer screening), and found that the results were essentially unchanged from those presented. Similarly, adding prostate cancer screening to our models for men over age 50 did not alter our results significantly.

Research should focus
on improving perceptions of care

Although it is difficult to quantify or measure negative responses objectively, the strong relationship between patient perceptions of the encounter and utilization suggests an important area for further attention. These findings suggest there may still be a substantial core of individuals who will actively avoid care, perhaps based on previous negative interpersonal experiences in getting care. Interventions aimed at both doctors and potential patients will be required to address this. Research is needed to focus on what approaches can best improve perceptions of care within the patient-provider relationship and how such interventions can reduce racial disparities in health care.

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CORRECTION

In a letter printed in the August 2004 issue, "Isotonic saline or hypertonic saline: which is best for sinusitis?" the last name for of Dr Hanifi Kurtaran was misspelled. We regret the error.