

Ethnic Concordance May Not Promote Patient-centered Care

By Ming-Cheng Miriam Lo and Roxana Bahar, UC Davis

In recent years, ethnic concordance—matching the ethnicity of healthcare workers to that of their patients—has been promoted as an important measure for achieving “patient-centered care” for minority patients in the U.S.

A new study by Center for Poverty Research Faculty Affiliate Ming-Cheng Miriam Lo and Graduate Student Researcher Roxana Bahar finds that among low-income immigrants, ethnic concordance may actually introduce unexpected problems in clinical communications.

Key Findings

- Low-income immigrants want patient-centered care but have little voice in deciding treatment options.
- Ethnic concordance may facilitate direct communications between patients and co-ethnic health workers, but does not automatically promote patient-centered care.
- Ethnic concordance can introduce additional problems, especially when medical staff is perceived to engage in “social distancing”, or when patients link their doctors’ professional ethics and competence to their race.

Patient-centered care encourages greater partnership between patients and healthcare workers. Proponents of ethnically concordant care—matching the ethnicity of healthcare workers to that of their patients—argue that the shared cultural beliefs and social experiences encourage mutual trust and respect, which assures patient-centered care.

Empirical studies have not found this to be universally true. Some studies have found ethnically concordant care to be more satisfying and communicative, and that it also makes patients more likely to use healthcare services. Other studies have found the opposite, or report mixed findings. A number of important questions remain unanswered. For example, when ethnic concordance appears to improve communication, what aspects of the

relationship do patients find most helpful or empowering? When patients say they dislike ethnic concordance, how exactly are they experiencing these relationships?

This new study analyzes how ethnic concordance shapes the experiences of low-income immigrant patients. It finds that ethnic concordance can introduce unexpected problems into clinical communications. The study also indicates that in order to unblock patients’ voices, the ability to listen to and to treat patients with respect and compassion, along with the language skills for direct communication, can be more effective than simply relying on the shared cultural values assumed to exist among people of the same ethnicity.

About the Center

Over the past 50 years, the U.S. has experienced a rising standard of living without reducing the fraction of the population that live in poverty. In response to this, the Center for Poverty Research at UC Davis is one of three federally designated National Poverty Centers whose mission is to facilitate non-partisan academic research on poverty in the U.S., to disseminate this research, and to train the next generation of poverty scholars. Our research agenda spans four themed areas of focus:

- Labor Markets and Poverty
- Children and the Intergenerational Transmission of Poverty
- The Non-traditional Safety Net, focusing on health and education
- The Relationship Between Poverty and Immigration

The Center was founded in the fall of 2011 with core funding from the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services.

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UC Davis Center for Poverty Research:
One Shields Avenue: Davis, CA 95616
(530) 752-0401

Interviews about Patient Care

This study is part of a larger project on immigrant health in Northern California. The researchers analyzed 60 in-depth interviews conducted with low-income Vietnamese and Mexican immigrant patients with limited English proficiency (LEP) between 2006 and 2007. Interviewees were between the ages of 20 and 70, and had visited one of three major local primary care facilities at least two times, either for themselves or for their children. The study focused on low-income, LEP immigrants because they are particularly vulnerable to physician domination and are often targeted by ethnic concordance policies.

Patient-Centered Care Unavailable

Most patients in this study complained that co-ethnic healthcare providers left them little opportunity to articulate questions or concerns. Several young mothers, who had experienced pregnancy complications, stillbirths or miscarriages described how their emotional needs were overlooked even though their physical health was cared for. For example, Norma,¹ an elderly diabetic patient, was deeply frustrated that doctors at the community clinic kept prescribing insulin without remembering the eyesight concerns she expressed in previous visits.

In general, patients were dissatisfied when being objectified as a diseased body to be processed quickly through the system. In many cases, when a patient's own treatment choices differed from that of their doctors', they were overpowered.

Boundary Work and Co-ethnic Staff

Patients talked at length about "mean" co-ethnic staff, ranging from uncaring nurses to case workers appearing to deliberately make care unavailable. While the study's goal is not to report "what truly happened," these accounts illustrate what patients perceived to be important.

Patients felt that co-ethnic staff (but not co-ethnic doctors) were more likely than their white counterparts to emphasize their social distance. This kind of "boundary work" allows those in non-elite positions, such as nurses or interpreters, to achieve a sense of dignity by constructing similarities between themselves and elite groups (such as doctors) and by emphasizing their differences from dominated groups (such as low-income co-ethnic patients).²

Hoang, a 56-year old Vietnamese patient with chronic kidney disease had several negative encounters with an interpreter. He said about the Vietnamese interpreter, "you know English so you don't see anybody else as good." He became so annoyed that he eventually refused the interpreter's service and asked the doctor to write down the instructions so

that he could ask his child to interpret afterward.

Less Intervention and Co-ethnic Providers

Patients were often frustrated with what they perceived as under-medication or under-medicalization. They also seemed to favor quick and unequivocal diagnoses and heavy-handed medical interventions. The patients' one-sided accounts cannot tell us whether these complaints indicate bad doctoring or different but justifiable treatment plans. These stories do indicate that patients felt their providers had denied them the best that modern medicine can offer. Many felt trapped in a substandard healthcare setting.

The Vietnamese immigrant patients (but not the Mexican immigrant patients) reported that this problem was worsened by ethnic concordance. Many stated that Vietnamese American doctors were less competent, less compassionate, and less well-educated than white doctors, which, the patients believed, explained why co-ethnic doctors would not provide their desired treatments. This "racializing" by linking professional competence and ethics to race may predispose them to distrust co-ethnic doctors.

The Path to Truly Patient-centered Care

Although these empirical findings suggest that ethnic concordance tends to negatively influence patient experience, it by no means implies it is inherently destructive. While not reported by the patients in this study, it is theoretically possible that ethnically concordant clinical relationships can push back the dominating power of the medical system.

To truly listen, co-ethnic healthcare workers, like any healthcare workers, must actively engage in open-ended communication, and treat patients with compassion and respect. It is noteworthy that not a single patient in this study considered better "matching" with providers or staff (e.g., same race, same national origin, same gender, etc.) to be more important than patient-centered communication. Instead, they emphatically expressed the desire to be respected and listened to, preferably through direct communication.

¹ The names of the subjects in this brief are pseudonyms.

² Lamont, M. (2000). *The dignity of working men: Morality and the boundaries of race, class and immigration*. Cambridge: Harvard University Press.

Meet the Researchers

Ming-Cheng Miraim Lo is a Professor of Sociology at UC Davis. Her research interests include civil society and social movements, sociology of culture and health and illness experiences.

Roxana Bahar is a Ph.D. candidate in Sociology at UC Davis, where she completed her M.A. in 2007. In 2012, she won the Consortium for Women and Research Graduate Research Award.