Vulnerable Patients and the Primary Care Visit
The process of provider–patient communication

SUMMARY

M. Robin DiMatteo, PhD, and a research team at the University of California, Riverside, examined links between patient vulnerability—including minority status, low income, gender, and older age—and provider–patient communication during primary care visits.

The project, which ran from 2006 to 2009, was funded under the Robert Wood Johnson Foundation Investigator Awards in Health Policy Research program. This national program supports researchers whose crosscutting, innovative ideas promise to improve U.S. health and health care policy. (See Program Results Report for more information on the program; it contains links to Program Results Reports on other funded projects.)

Key Findings

The researchers published their findings in three articles and a book chapter (see the Bibliography for details):

- Nonminority male primary care physicians communicate with male and female African American patients differently, and those differences tend to disadvantage African American women.
- The use of humor varied significantly with patients’ socioeconomic status.
- Mutual trust was stronger between physicians and high-income patients than between physicians and low-income patients.
- Vulnerable older patients receive less information about their health, and less counseling on health-related behavior, during primary care visits.
- Patients who are minority and poor, and have low levels of health literacy and education, are not heard in medical visits. Without a sense of empowerment in medical interactions, these patients are unable to advocate for themselves.

Funding

The Robert Wood Johnson Foundation (RWJF) funded this project with a grant of $267,500 that ran from April 2006 to September 2009 under Robert Wood Johnson
Foundation Investigator Awards in Health Policy Research. For more information on the program, read the Program Results Report.

The project also used funding from the National Institute on Aging and the University of California, Riverside.

CONTEXT

Disparities in health status, treatment, and outcomes related to patients’ race, ethnicity, and socioeconomic status persist in the United States. For example, a 2003 report\(^1\) from the Institute of Medicine documented that ethnic minority patients at all income levels were less likely than Whites to receive needed care across a wide range of services.

Some of these disparities may reflect the way health providers and vulnerable patients communicate, both verbally and nonverbally, during medical visits. These patients receive less information, ask fewer questions, and participate less during these visits. However, while many analysts are trying to tackle inequalities through health policy, they have devoted less attention to communication between physicians and patients.

RWJF’s Interest in This Area

RWJF has supported the RWJF Investigator Awards in Health Policy Research program since 1992. The program encourages researchers to think creatively about the most important problems affecting U.S. health and health care, and supports research unlikely to be funded elsewhere.

Through June 2013, RWJF has made awards totaling more than $46 million for 175 projects pursued by 224 investigators. Their research has focused on public health, sociology, economics, political science, ethics, journalism, medicine, and law. Grants have ranged up to $335,000 over two to four years.

For more information, read the Program Results Report.\(^2\)

THE PROJECT

M. Robin DiMatteo, PhD, and a research team at the University of California, Riverside, examined links between patient vulnerability—including minority status, low income,
gender, and older age—and provider–patient communication during primary care visits. The researchers sought to determine whether:

- The way providers communicate with patients during such visits disadvantages patients from minority, low-income, and other vulnerable populations.

- Training physicians and patients in communication and participation skills can reduce communication disparities for vulnerable patients.

The team analyzed a dataset from the Institute for Healthcare Communication, in New Haven, Conn. The information included audiotapes of 2,197 primary care visits at a university medical center, a health maintenance organization, and a Veterans Administration clinic in southern California in the late 1990s.

After each visit, physicians and patients completed a detailed questionnaire on their communication, therapeutic relationship, and partnership in care. Patients also answered questions on their physical and mental health, and physicians answered questions on their attitudes, stress levels, and burnout.

The research team also analyzed other studies of communication between providers and vulnerable patients.

**FINDINGS**

DiMatteo and her research team published their findings in several journal articles and a book chapter:

**Gender Disparities in Physician–Patient Communications with African American Patients**

For this study, the team used information on 137 African American patients (70 males and 67 females) and 79 physicians of varying race and ethnicity (53 males and 26 females) from the Institute for Healthcare Communication dataset. Patients’ median family income ranged from $10,000 to $19,999 (in 1996 dollars), and their median education level was high school.

The team reported these findings in an article in the *Journal of Black Psychology*:

- **Nonminority, male primary care physicians communicate with male and female African American patients differently than their counterparts, and those differences tend to disadvantage African American women.** For example:

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These physicians discussed disease prevention and health promotion—exercise, stress reduction, and weight loss—significantly more often with male patients than with female patients. The male patients also took a more active role in their care.

The communication differences occurred only with nonminority male physicians. Female and minority physicians did not show disparities in communicating with their male and female patients, and their male and female patients collaborated equally in their care.

**Limitation**

The medical interactions were audiotaped only. Videotapes would have provided information on nonverbal as well as verbal communication.

**Humor in Physician–Patient Communication and Patients’ Socioeconomic Status**

For this study, the research team examined differences in the use of joking, sarcasm, and displays of dominance and submission between physicians and high-income versus low-income patients.

- The study included 121 physicians, and one high-income and one low-income patient for each (242 patients), from the Institute for Healthcare Communication dataset. Household income among higher-income patients averaged $50,000 to $59,999 (in 1996 dollars), and among low-income patients averaged $19,999 or less.

- To rate the interactions, the team created a scale composed of 21 physician-related humor items, 17 patient-related humor items, and 8 interaction-related humor items. Some items were positive, such as “The doctor used humor to encourage the patient,” and “The patient used humor to cope.” Some items were negative, such as “The doctor made fun of the patient,” and “The patient was sarcastic to the doctor.”

The research team reported these findings in the *Journal of Health Psychology*:

- **The use of humor varied significantly with patients’ socioeconomic status:**
  - High-income patients received and used more positive and less negative humor, and were more dominant during the visits.
  - Physicians used more negative humor—they were sarcastic or made fun of the patient, for example—with their low-income versus high-income patients.

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• Mutual trust was stronger between physicians and high-income patients than between physicians and low-income patients.

Limitations

The study involved only primary care and analyzed only verbal communication.

Physicians’ Communication With Vulnerable Older Patients

For this research, the team analyzed existing studies of interactions between health care providers and older patients who are socially isolated, may be suffering from depression, or are minority or low-income. The team reported these findings in an article in *Clinical Interventions in Aging*:

• Accurate and open communication between physicians and older patients can make an important difference in their health. In fact, the physician–patient relationship itself can prove therapeutic for older patients, particularly those who struggle with depression, complex treatments, and limited resources. However, evidence points to differences between older and younger patients in medical interactions. Older patients:
  — Receive less information about their health and less counseling on health-related behavior during primary care visits.
  — Are less likely to discuss their mental health during primary care visits. Low-income, and socially and emotionally vulnerable older adults with multiple physical challenges tend to be at greatest risk for underreporting depression.
  — Grew up in an era of paternalistic physician–patient relationships, and are reluctant to accept partnerships in care, even when physicians encourage shared decision-making.
  — May need a caregiver to participate in a medical visit, but are often less informative, assertive, and responsive if a third party is present.

Recommendations

• Health care providers should elicit and document older patients’ views regarding their goals and their concept of a good quality of life, and allow them to provide an open-ended narrative of their stories.

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Physicians should expect caregivers to be present during medical visits, and should recognize their impact on patients’ comprehension and involvement. Caregivers can be a positive influence on medical interactions if all are aware of the complexities in communication their presence creates.

Training older patients to be active participants in their care—especially those who are most vulnerable or initially reluctant to assert their views—can promote positive health outcomes.

Physicians’ Communication With Patients From Vulnerable Populations

In a chapter in *Patients as Policy Actors*, the researchers argued that patients who are minority and poor, and have low levels of health literacy and education, are not heard in medical visits. Without a sense of empowerment in medical interactions, these patients are unable to advocate for themselves.

Based on an analysis of their own and other studies, the researchers offered these recommendations:

- To improve communication with patients, all physicians should receive training in culturally sensitive care and empathy. Pairing physicians and patients of the same race or ethnicity can also bolster communication, patient satisfaction, and patient trust, evidence suggests.

- Every medical interaction should include services in translating and interpreting information for patients who need them. “Remote simultaneous medical interpreting systems” can be a useful tool.

- Health organizations and programs should use follow-up surveys, phone calls, and interviews—all culturally appropriate and translated into local languages—to obtain feedback from patients.

- Patients should have access to culturally specific information on health—at appropriate reading levels and in print and multimedia formats—at libraries, health maintenance organizations, and community clinics.

- Training in communication can help all patients participate actively in their care. Approaches include giving patients a personal, wallet-sized list of medications, and offering brochures that suggest questions to ask during medical visits and how to ask them—and provide space for writing down the answers.

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Conclusion

“Evidence shows that communication is essential in delivering good medical care, and in helping patients adhere to their treatments,” noted Project Director DiMatteo. “And communication is not as good as it needs to be with all patients, but especially with vulnerable populations. Many people with low socioeconomic status and low education levels have health literacy challenges. And if they have lower levels of health literacy, they do not understand what they are told to do to care for themselves. Communication needs to be better all-around in medical care: not only by physicians, but by all health care professionals.”

LESSONS LEARNED

1. **Research on physician–patient interactions is challenging and time consuming.** In this project, developing scales for analyzing communication between providers and vulnerable patients—and actually coding their interactions—took years. (Project Director DiMatteo)

2. **When studying provider–patient communication, use video and audiotapes in addition to patient surveys.** Vulnerable patients are likely to evaluate their care positively, but objective analysis often shows deficiencies, and sometimes serious problems, in communication during medical interactions. (Project Director DiMatteo)

AFTERWARD

DiMatteo and the other researchers are continuing to study interactions between providers and vulnerable patients using the Institute for Healthcare Communication dataset and others, including one composed of videos of 250 provider-patient interactions and questionnaires. This research includes:

- Differences in how physicians treat patients with pain, based on patients’ socioeconomic status.
- Development of a scale to measure the use of politeness by physicians when patients are physically and economically vulnerable.
- Differences in how physicians talk to minority patients and patients of low socioeconomic status, versus patients of an ethnic majority who are better educated and have higher incomes.
- The relationship between patients’ health literacy and their adherence to treatment.
- The impact on communication when physicians and patients are the same gender and ethnicity.
BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Articles


Book Chapters

