# Perceptions of How Race & Ethnic Background Affect Medical Care

## Highlights from Focus Groups

Conducted by Frederick Schneiders Research
For The Henry J. Kaiser Family Foundation

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Prepared by
**Frederick Schneiders Research**

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## HIGHLIGHTS FROM FOCUS GROUPS

In order to better understand the experiences of minorities with the health care system, as well as their perceptions about the potential for discrimination in the delivery of health services, the Henry J. Kaiser Family Foundation commissioned a qualitative study of both consumers and providers of health care. Twelve separate focus groups were conducted by Frederick Schneiders Research (FSR) in February and March of 1999.

Seven of the focus groups were conducted with minority consumers, including African Americans, Hispanics, Asians, and Native Americans -- all of whom had some health care experience in the past two years, either personally or through someone in their immediate family. Some of the questions used to explore the extent to which minority populations experience or perceive any discrimination by health care providers included:

- Do these participants have difficulty accessing health care?
- How do they define quality health care?
- Do they trust the US health care system to do the best thing for them and their families?
- Have they experienced discrimination by health care providers and others in the health care profession? What types of discrimination have they experienced?
- Do they believe they get the same kind of preventive care and diagnostic tests and procedures as whites?

Five focus groups were conducted with health care professionals—two with doctors, two with hospital administrators, and one with nurses. Most of these professionals were white. The main questions addressed in this part of the study were:

- What types of challenges do health care providers face serving multicultural populations?
- How are they addressing these challenges?
- Do they feel discrimination by health care providers is a problem?

### Findings from Minority Consumer Groups

These Hispanic, African American, Native American, and Asian consumers believe several forms of discrimination exist in the health care system. Many say they have been discriminated against by health providers and that it is a problem. Treatment disparities due to health insurance coverage, age, gender, and where a person lives, were foremost in these consumers' minds. In fact, examples of racial or ethnic

discrimination were not volunteered by any of the participants until the moderator specifically asked about it.

Recognizing health care as a business, minority consumers believe that those with health insurance (or the money to pay) receive better quality of care. Furthermore, many feel that HMOs and other types of managed care plans create financial incentives to underserve patients -- which in their view is another form of discrimination.

Consumers in these focus groups do not trust the U.S. health care system to do what is best for them and their families. African Americans are especially distrustful because of historical evidence of racial discrimination. The Tuskeegee medical experiment on African American males was often referenced. Some of the perceptions that erode their trust include:

- the lack of time and attention given to patients by health care professionals;
- the perception that health care professionals lack concern and empathy for patients;
- the perception that the behavior of health care professionals (specifically doctors) is primarily driven by the desire for profits;
- the perception that managed care plans are not designed to be in the best interests of patients; and
- the perception that many health care professionals hold negative stereotypes of minority patients.

Some of the consequences of this lack of trust in the health care system are:

- participants don't trust health care professionals to accurately diagnose their problems;
- they believe they have to do their own research to validate their doctors' treatment recommendations; and
- they believe they need to be more proactive and aggressive in order to get quality care.

Although concerns about racial or ethnic discrimination were not initially volunteered by any of the participants, the U.S. health system is not viewed as entirely color-blind either. As moderators probed further into the issue of discrimination, examples of racial stereotyping were described in each of the consumer and provider groups. Several of the stereotypes associate an inability to pay for services -- which in their view was the primary basis for health care discrimination -- with certain minority groups. These socioeconomic stereotypes may in effect create racial and ethnic disparities in medical treatment. Many of these participants feel victimized by stereotyping. From their perspective, common racial/ethnic stereotypes are:

- African Americans, Native Americans, and some Hispanics (especially young males) are not able to pay for services;
- African Americans over-utilize the emergency room;
- young African American mothers are all unmarried;
- Native Americans are more likely to be drunk than ill; and
- Asians are compliant, deferential, and non-assertive.

Several consumers wondered whether racial or ethnic discrimination is the reason why they have had to wait longer to see a doctor or dentist, did not receive medical treatment promptly, were not referred for diagnostic tests, or did not receive quality care in general. Many of these consumers believe that health care professionals do not emphasize preventive care as often with minority consumers as they do with others. However, at the same time, they agree that minority consumers are somewhat less likely than others to seek preventive care. Some African American consumers (and to a lesser extent Hispanic consumers) say they have experienced racial or ethnic discrimination even from health care professionals of their own race or ethnic background.

The consumer focus groups had several ideas about how to achieve equity in the health system. They suggested diversifying the health workforce, improving physician awareness about diseases that disproportionately affect specific minority populations, and increasing the acceptance of alternative health care practices such as herbal therapy and spiritual healing.

**Findings from Groups of Hospital Administrators, Doctors, and Nurses**

The doctors and nurses in these focus groups pride themselves on being open-minded and equally fair. They describe real efforts to incorporate patient beliefs and preferences into the care they give. All the health care providers, including the hospital administrators, feel that the challenges in serving multicultural patient populations—particularly language differences—are greater than issues of patient discrimination.

Language differences are a major barrier to better health care. Most doctors treating non-English speaking patients appear to be making efforts to have a bilingual staff. Nurses and hospital administrators seem to be more at a disadvantage in treating non-English speaking patients because many do not have interpreters readily available to them. They rely on patients' family members, ancillary hospital staff, or outside sources (such as AT&T operators, consulates, and embassies) and recognize that relying on non-professional interpreters means information can get lost in the translation.

Other common challenges voiced by these doctors, nurses and hospital administrators include:

- Incorporating alternative medicine and therapies into their own medical care plans --
  Physicians and nurses report widespread experience with the use of alternative medicine and therapies by African Americans, Hispanics, Asians, and Native Americans. They also say certain groups are more likely to have access to and use potentially unsafe pharmaceuticals (e.g., drugs only available in Mexico), leading to serious adverse drug interactions when used without their knowledge.

- Conforming cultural norms and practices to standard hospital policies --
  Hospital administrators in these groups for example, find it hard to allow patient requests for non-traditional treatment because of concerns about potential lawsuits.

- Achieving patient compliance with medical treatment among groups believed to be less adherent --
  For example, doctors in Philadelphia and Phoenix say it is more difficult to get Hispanics, Native Americans, and African Americans to comply with their dietary restrictions.

- Ensuring that illegal immigrants, who fear being deported, get proper medical treatment.

While physicians and nurses did not see themselves as discriminatory, the hospital administrators did describe experiences with doctors and nurses who provided lower quality of care to patients because of personal beliefs and stereotypes about their race or ethnicity, economic status, or lifestyle. Examples of racial/ethnic stereotypying expressed by doctors, nurses, and even hospital administrators in these focus groups included:

- Asians won't discuss symptoms or complain;
- Obtaining medical history information from immigrants is impossible;
- Native Americans don't show emotion;
- Asians won't complete prescription drug regimens; and
- Hispanics and African Americans won't lose weight or eat healthy diets.

However, awareness of the need to be more sensitive to minority patients' cultural norms appears fairly high among the nurses and hospital administrators in these focus groups. Both groups place a high value on cultural competency training. In Los Angeles, hospital administrators say their hospitals can afford the "luxury" of cultural competency training, have a diverse workforce to draw upon, and seem to have made progress in adapting to minority patients' needs. In fact, all of the nurses in the Los Angeles focus group had completed some type of cultural competency training. In contrast, Washington, DC area hospital administrators are experiencing staff and budget cutbacks and cultural competency programs are a low priority.

While these nurses and hospital administrators praise the benefits of cultural competency training, doctors in both groups did not see a need for mandatory cultural competency courses when asked about it initially during the focus group discussions. However after being made aware of the results from a February 1999 study in the *New England Journal of Medicine* documenting racial differences in physician decision-making, almost all agreed that some cultural competency training in medical school is probably needed.

**Concluding Observations**

The focus group findings suggest that while health care professionals do not see themselves as discriminatory, several forms of discrimination may exist in our health system. The most common form of discrimination described by minority consumers was not racial nor ethnic, rather it was discrimination based on the ability to pay for health services. These minority consumers believe that those with health insurance (or the money to pay) receive a better quality of care.

Our health system is not entirely color-blind, however. Examples of racial and ethnic stereotyping and how it effects the quality of care were described in every focus group. While racial stereotypes exist in health care, as in other places in society -- other factors such as insurance coverage, where a patient lives, age, and gender, tightly interact with and can obscure racial discrimination, creating disparities in medical treatment.


**The Henry J. Kaiser Family Foundation**
2400 Sand Hill Road
Menlo Park, CA 94025

650-854-9400 Facsimile: 650-854-4800

**Washington Office:**
1450 G Street N.W., Suite 250
Washington, DC 20005

202-347-5270 Facsimile 202-347-5274

**http://www.kff.org**

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