The Relevance of Cultural Distance Between Patients and Physicians to Racial Disparities in Health Care

Ever since studies began to reveal pervasive racial inequities in the quantity and quality of health care over 2 decades ago, people have speculated about the role of the patient-physician relationship in explaining these disparities. It made sense. If racial inequalities were observed even after accounting for differences in income and insurance,[1] even within an "equal access" system like the Veterans Health Administration,[2–4] even in studies of care within a single hospital,[5] what was left to explain them other than dysfunctional interactions between minority patients and predominantly nonminority health professionals? Along the way, other studies provided supportive evidence. Minority patients appeared less likely than whites to have good relationships with their physicians, as characterized by effective communication, partnership, and trust.[6–8] Moreover, patients reported better relationships when seeing physicians of their own race or ethnicity,[9,10] lending further credibility to the notion that barriers between patients and physicians might explain racial disparities in health care.

While acknowledging that the nature of race-related barriers in the patient-physician relationship was not entirely clear, we in the health care community made a leap of faith and focused on cultural differences as the principal culprit. Our primary response to the call to eliminate racial disparities was to adopt the existing principles of cross-cultural health care,[11,12] and to apply them broadly, under the more modern label of "cultural competence." Over time, the cultural competence movement evolved into an all-encompassing approach to helping health care providers, and the institutions within which they work, become more responsive to diverse patient populations. Even now, though, the primary focus is on accommodating cultural diversity.[13]

This emphasis on culture, despite lack of substantial evidence that cultural discordance is an important source of unequal care, arises at least in part from the tendency to conflate the concept of culture with race and ethnicity. Although the effect of race on patient-physician relationships may be attributable to cultural differences, there are other plausible culprits as well. Because of racial segregation, both geographic and social, many people in the U.S. have limited experience interacting with members of other racial groups. This can give rise to "interracial anxiety," or discomfort, when interacting across racial lines.[14] This discomfort may negatively affect relationships, independent of cultural differences. Unfamiliarity with other racial groups, especially in a context of historical or personally experienced racial discrimination, may also impede the building of trust,[8] an essential component of any good relationship. Patients from minority groups may disproportionately lack the literacy skills needed to engage as full partners with physicians in promoting their health.[15] Finally, both patients and physicians may harbor racial biases, stereotypes, or fears that limit their ability to interact in a mutually respectful and collaborative way.[16,17] In short, although cultural differences may be a source of deficient interactions between physicians and minority patients, there are other potential sources as well. It is therefore essential that we empirically explore, rather than assume, the relevance of culture in explaining racial differences in the quality of health care.

Culture is a broad and complex concept. In simple terms, it can be thought of as a source of identity that situates individuals on the vast landscape of beliefs and perspectives that influence the way we interpret events, interact with others, and live our lives. We derive this situating identity from our "memberships" within different groups. Within our own ranks, we speak of physician culture and nursing culture, primary care culture and specialist culture. As a group, we are all influenced by Western biomedical culture. Other sources of cultural identity include age, generation, gender, and where we live. For many people, race and ethnicity are dominant sources of identity because of their strong influence on our experiences and social interactions. This is particularly true for minority groups who, because of shared heritage, nationality, language, or experiences such as segregation and discrimination, derive much of their identity from their race and ethnicity.

It stands to reason, then, that the separate cultural influences on a minority patient and a race-discordant physician might situate the 2 parties in very different locations on the cultural map. In addition, because social class strongly influences cultural identity, socioeconomic differences might exacerbate the "cultural distance" between doctors and minority patients. Helping both parties navigate this cultural distance—so that they can share "common ground" in their interactions, communicate more effectively, and see things from each other's point of view—may make for more productive patient-physician relationships. But will it help reduce racial disparities in health care? Just how relevant is cultural distance in the patient-physician relationship? Empirical research on these questions has been scant.[18–20]

The study by Garoutte et al.[21] in this issue of *JGIM* represents an important effort to empirically examine the significance of cultural differences in the patient-physician relationship. Using simple scales, the authors asked patients and family practice providers in a clinic serving the Cherokee Nation to locate themselves on 2 different cultural axes: 1 assessing American-Indian identity, the other assessing white American identity. They also asked both parties to rate the patient's global health status. Reflecting the fact that most health professionals in the U.S. are either members of—or become acculturated through their training to the norms of—the majority (white) race, the providers in this study all identified strongly with white American culture; most identified weakly with American-Indian culture. Patients were more widely distributed across both axes. This gave the authors the opportunity to examine the impact of cultural distance between patients and providers, in this case on health status assessments. They found that patient-provider differences on the white American axis were associated with discordant health status assessments: providers tended to rate patients' health

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status higher than patients did themselves, and this was most true among patients identifying weakly with white American culture. Interestingly, patient-provider differences on the American-Indian axis were not associated with discordant health status assessments, suggesting that the 2 cultural axes were orthogonal to each other rather than reciprocally aligned, and that shared white identity was more influential than shared lack of American-Indian identity.

These findings offer some important insights about the potential significance of cultural distance in the patient-physician relationship. If physicians overestimate patients' health status, perhaps because of culturally determined differences in styles of communicating symptoms or their severity, they may undertreat those patients. Additionally, physicians may not fully appreciate all of the dimensions—mental, emotional, and spiritual, in addition to physical—that patients with different cultural backgrounds consider important to their overall health. This may reduce the patient's perception of the physician's relevance to promoting health and, in turn, the patient's interest in seeking care from the physician. Finally, if patient and physician are not on the same page with regard to the patient's health status, they may have difficulty establishing common ground, forming an effective partnership, and working toward a mutually agreed-upon goal. Thus, to the extent that cultural distance between patient and physician contributes to discordant understanding of the patient's health, it could significantly reduce the quality of the patient-physician relationship and the care emanating from it.

Measuring patient-physician cultural distance might someday have clinical applicability. Currently, cultural competence education is generally tailored to improve health professionals' ability to care for all patients, but particularly for those from racial and ethnic minority groups. This raises the concern that physicians may use race and ethnicity as proxies for culture, bluntly applying cross-cultural skills according to the presence or absence of racial or ethnic discordance. The ability to gauge cultural distance might help physicians more deftly apply cross-cultural skills according to the degree and nature of cultural differences (just as they may approach counseling on diet and exercise differently for patients with mild vs severe obesity or dyslipidemia). In trying to meet patients where they are culturally, physicians would need to recognize that people do not occupy fixed positions on the cultural landscape. Culture is multifaceted and dynamic; individuals may employ different perspectives for different issues, or even for the same issue at different points in time.

Much more research on the concept of cultural distance is needed. The measures and analysis employed by Garroutte et al.[21] were basic and allowed for only gross determinations of cultural discordance, rather than gradations of cultural distance. The observed differences in health status assessments may also have been related to culturally driven differences in survey response tendencies, rather than true differences in perceived health.[22,23] Despite these limitations, this study represents a significant advance and should serve as a model for future research. In the important struggle to eliminate racial disparities in health care, we must apply our efforts where they are needed most. These efforts should be guided by evidence, rather than conviction, about the nature and significance of race-related barriers in the patient-physician relationship.—**Somnath Saha, MD, MPH,** Section of General Internal Medicine, Department of Medicine, Portland VA Medical Center, Oregon Health & Science University, Portland, OR, USA.

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