

Examining African Americans' Mistrust of the Health Care System: Expanding the Research Question

Commentary on "Race and Trust in the Health Care System"

WILLIAM D. KING, MD, JD^a

What makes health care a different transaction from any other sale of a product? Why should we care about the interaction between the "supplier" and "consumer" and whether the consumer is treated fairly? The delivery of health care is bound within legal and economic restraints that should protect the interests of the consumer and of the provider. Yet health care is a unique economic good on several levels: information is asymmetrical, and third parties such as payers and utilization review committees influence decision-making and access.^{1,2} The uniqueness of health care should make us view the transaction between the patient and the provider carefully, because the patient does not come into the relationship at arms length, with equal power to that of the provider. Therefore, the patient is placed in a vulnerable position in which he or she must trust that the provider will do what is in the patient's best interest.^{3,4}

We can hypothesize that a person's past experiences influences that person's level of trust. Negative experiences result in a lower level of trust. A patient who has experienced racism or discrimination from individuals and institutions would be less willing to be vulnerable and place trust in a system of unknowns such as medical care. Recent analyses of the relationships of minority patients with their physicians have demonstrated that provider racism and patient awareness of invidious past events such as the experimentation on slaves and the Tuskegee syphilis experiment have contributed to minority patients having less access to and knowledge of specific medical treatments than their white counterparts,⁵⁻¹⁰ lower levels of trust, and greater unwillingness to participate in clinical trials.^{3,11-13} This places minority patients at a disadvantage not only in receiving preventive care but also in access to newer technology and treatment stemming from clinical trials. However, as Boulware et al. point out,¹⁴ prior analyses have not fully addressed minority patients' attitudes toward components of the health care system.

In Boulware et al.'s study, 118 respondents—42% non-Hispanic black and 58% non-Hispanic white—were asked to rate their level of trust in physicians, health insurance plans, and hospitals.¹⁴ Overall, respondents trusted physicians and hospitals more than health insurance plans. When results were stratified by

^aCARE Clinic, Department of Infectious Disease, School of Medicine, University of California—Los Angeles, Los Angeles, CA

Address correspondence to: William D. King, MD, JD, UCLA CARE Clinic, 10833 Le Conte Ave., BH-412 CHS, Los Angeles, CA 90095; tel. 310-794-7569; fax 310-206-3311; e-mail <wdking@mednet.ucla.edu>.

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race, African American respondents were found to be less likely to trust their physicians and hospitals and more likely to trust their health plan than white respondents. Although there was no statistically significant difference between the groups in trust in hospitals, a greater percentage of African American respondents than of white respondents reported mistrust of hospitals, and African Americans were more likely to report concerns about privacy and harmful experimentation. Placing Boulware et al.'s work in the context of prior analyses on race and trust in health care suggests that studying all aspects of entry into and interaction with the health care system is necessary.

Past solutions such as cultural competence curricula, sensitivity training, the presence of interpreters, and increasing the number of minority physicians may not fully address the problem, however, if racism and discrimination in the health care system goes beyond the patient-physician relationship. Yet these solutions may be adaptable in order to change hospital and system policy. Additional solutions such as the recruitment of minority health care administrators and executives and the presence of a community advisory board that represents the demography of the catchment area served could also foreseeably change the perception of African American patients. Regaining the trust of the African American patient at all points of entry to the health care system is imperative if we are to reduce health disparities.

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