

EVOLUTION OF & THE IMPACTS OF SOCIOLOGY ON THE PATIENT EXPERIENCE

By

BRIANA YAMAMOTO

---

A Thesis Submitted to The W.A. Franke Honors College

In Partial Fulfillment of the Bachelor's degree

With Honors in

Biology

THE UNIVERSITY OF ARIZONA

M A Y 2 0 2 4

Approved by:

Dr. Angel C. Pimentel

Department of Molecular & Cellular Biology

## **Abstract**

Throughout the years, the patient experience has constantly evolved with a more recent emphasis on patient-centered care. Now, as patients have become more proactive in their health, healthcare providers are expected to be more transparent, providing care that is respectful to individuals preferences, needs, and values. Consequently, patient satisfaction surveys like HCAHPS have grown to great value for measuring success and satisfaction with care and for encouraging the implementation of patient-centered care; such implementations creates higher quality care, greater healthcare outcomes, and improved patient experience and satisfaction, ultimately strengthening the healthcare system. However, despite these advancements, racial and ethnic disparities in health continue to exist; based on one's social identity, "fundamental" factors like socioeconomic status, racial inequalities, and discrimination can dramatically impact the level of care received. Critical race theory offers a framework to address this structural racism in healthcare, while strategies like contextualizing risk factors, diversifying the healthcare workforce, and cultural competence training aim to mitigate disparities by fostering trust and awareness and by providing the tools necessary to respond to such sociocultural issues.

## **Acknowledgments**

I would like to express my deepest gratitude to my mentor, Dr. Pimentel, for providing immense support, patience, and guidance throughout the entire process. With his advice and encouragement, I was able to find the direction of my paper and create a piece of work that I am incredibly proud of. Thank you also to my family and friends who have supported me through the many late nights of research and writing, providing feedback and assistance when needed. Without their encouragement, this entire process would have been much more difficult and lonely. And lastly, I would like to thank my dogs, Bella and Butchington, for loving me unconditionally and distracting me when I would become incredibly overwhelmed.

## **Breakdown of the Patient Experience and Patient-Centered Care:**

### *Patient-Centered Care and the Evolution of the Patient Experience*

The value and definition of the patient experience have changed drastically throughout the years. More recently, the spotlight has moved off of the physician and onto the patient's preferences, values, and goals; consequently, the determination of healthcare quality has shifted from merely looking at the quality of care to a more patient-centered approach. With these changes, the patient experience is markedly more critical to not only establishing such patient-centered care but also to determining how successful implementation has been.

The idea of patient-centeredness first originated in the 1940s, proposed by American psychologist Carl Rogers (Yao & Kabir, 2023). In terms of psychology, Rogers believed the client knows best, that they are experts in their own life and cannot be “mind-read”; the client themselves should thus take the lead on the direction of their therapy while the therapist takes the backseat, providing an environment that facilitates honest self-exploration (Yao & Kabir, 2023). Although originally dismissed as quite radical at the time, the concept has become more widely accepted and promoted in the field of healthcare as it has aligned with many positive outcomes including higher quality healthcare, greater efficiency, and improved patient experience and satisfaction (Cliff, 2012). So, what led to this shift? Why now emphasize the patient-centered model? Simply put, it is a new generation and revolutionary advancements in technology.

The current older generation, ironically named the “silent generation,” is more reluctant to take an active role in their care; they tend to speak out less and are significantly more passive (E. Kahana & B. Kahana, 2014). Conversely, the incoming senior citizens, the baby boomers, are much “more savvy, assertive, health-conscious, and engaged in their care” (E. Kahana & B. Kahana, 2014, p. 380). Consequently, they are much more likely to take control of their health

and hold much higher expectations concerning their healthcare experience than the older generations before them (Cliff, 2012). As mentioned briefly, baby boomers are also more technologically savvy, generating greater expectations regarding their healthcare.

In this time and age of great technological advancements, including the internet and new medical technologies, there has been unprecedented access to health information and an increased expectation for timely and convenient access to healthcare (Cliff, 2012). With this has come an increased demand for greater transparency (Cliff, 2012). Not only is this transparency now expected, but necessary to ensure that the patient and their families have adequate information for the decision-making process. Furthermore, greater transparency on outcomes and avenues for support encourage greater engagement from the patient, a key component of the patient-centered model (Cliff, 2012). Thus, with a growing population of independent and resolute individuals in this new world, it is no wonder that this model of care is evolving. Together with this change, we have inevitably seen an evolution in the patient experience.

Patient advocate Tiffany Christensen (2017) highlights this evolution in a commentary in which she describes disparities in grievances between the elderly and young adults. While the elderly tended to complain about a lack of hygienic care, such as not receiving a basin to wash their face, younger adults tended to complain about a lack of respect and/or infrequent communication. From this simple real-world example, it becomes clear how healthcare expectations have shifted from merely expecting proper treatment to expecting proper care, respect, *and* communication; these observations also reflect the trend described earlier by the incoming older generations, the baby boomers, becoming more proactive with their healthcare.

In the 1970s, with a movement already established to ensure the right *to* healthcare, a movement to establish rights *in* healthcare joined the spotlight. Beginning with the establishment

of the right to informed consent through a series of court opinions, patient autonomy became key to the establishment of patient rights (Annas, 1998). In 1973, the American Hospital Association became the first to establish a patient bill of rights outlining various rights including the right to respectful care, informed consent, refusal of treatment or experimentation, privacy and confidentiality, emergency care, and continuity of care (Olejarczyk & Young, 2022; Annas, 1998). Although many states, hospitals, and corporations followed suit, adopting their own patient bill of rights, a national patient bill of rights in the US has yet to be established.

Nevertheless, as a result of these shifts in expectations, patient experience, and satisfaction surveys grew to great value and importance, consequently ensuring that physician-patient interactions are continuously guided by ethical principles and patient rights. This is evident particularly with the distribution of one of the first Patient Satisfaction Questionnaires (PSQ) in the early 1980s (Ware, et al., 1983). This was one of the first attempts to conceptualize patient satisfaction, looking at both objective and subjective aspects of care to investigate the patient experience; the key aspects were found to include:

- *Interpersonal manner*: physician-patient interactions (eg. friendliness, disrespect)
- *Technical quality*: physician competency and accuracy (eg. thoroughness, mistakes made)
- *Accessibility/convenience*: factors relating to arranging appointments (eg. wait times, ease of scheduling)
- *Finances*: factors relating to payments (eg. reasonable costs, insurance coverage)
- *Efficacy/outcomes*: results maintain or improve patient health
- *Continuity*: consistency in physician and location

- *Physical environment*: features of the environment (eg. cleanliness, pleasantness, clear directions)
- *Availability*: proper resources readily available (eg. facilities, physicians) (Ware, et al., 1983)

Following the PSQ, more efforts were made to refine the survey, particularly with the establishment of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) by the Agency for Healthcare Research and Quality (AHRQ) in 1995 (Wynne, 2019). While PSQ was a positive step in the right direction, it still reinforced a narrow conception of the patient experience. With these refinements, the focus shifted away from simply care quality and safety to incorporating additional elements focusing on the patient's subjective satisfaction and experience. This shift was also witnessed in 1992 with the founding of The Institute of Patient and Family-Centered Care; its four guiding principles are defined as: "dignity and respect, information sharing, participation, and collaboration" (Christensen, 2017, p. 1). While these factors could be generalized into the categories described above, the breakdown and elaboration ensure a more direct emphasis on the patient with values that establish the basic needs of the vulnerable.

In 2001, the AHRQ collaborated with the Centers for Medicare and Medicaid Services (CMS) to research, develop, and implement the new and improved Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (Siegrist, 2013). This survey built off of CAHPS progress and asked more questions regarding the "customer service" aspects of care such as responsiveness to the call button, quietness near the room, room cleanliness, etc. (Merlino & Raman, 2015). This collaboration occurred at the same time that the Institute of Medicine publicly defined Patient and Family Engagement as "providing care that is respectful

of, and responsive to, individual patient preferences, needs, and values; and ensuring that patient values guide all clinical decisions” (Christensen, 2017, p. 1). This moved beyond establishing needs to establishing the importance of patients having control over their medical destiny; at this point, we were beginning to see definitions and statements made to clarify aspects of the patient-centered model.

By 2006, the HCAHPS survey had been approved and implemented in various hospitals by CMS (Siegrist, 2013). In fact, the government began providing financial incentives for hospital participation in 2007, which were further reinforced through the Affordable Care Act of 2010 by providing pay-for-performance incentives based on their comparative performance and improvement (Siegrist, 2013). This occurred around the same time, in 2007, that the Beryl Institute publicly defined the patient experience as “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care” (Christensen, 2017, p. 6). The patient is the only one who must walk through every step of their healthcare journey and, sometimes, must act as their own patient advocate; the Beryl Institute’s definition of the patient experience acknowledges this and takes into account every step of the patient’s journey (Gualandi, et al., 2019). By this point, the spotlight has finally moved off of the physician and onto the patient’s preferences, values, and goals.

Ultimately, patient experience and satisfaction surveys attempt to look at the patient experience from both an objective and subjective perspective. In doing so, measures can be taken for both the care provided and the patient providing the information. Thus far, with the implementation of the surveys, hospital scores have continued to increase as they encourage change and shed light on areas of weakness (Siegrist, 2013). This is explicitly highlighted by the Cleveland Clinic, which strategically tried and succeeded at improving the patient experience,



increasing its patient satisfaction rankings from an average of 55% in 2008 to 92% in 2012 (Merlino & Raman, 2015).

According to Merlino and Raman (2015), Cleveland Clinic's rude awakening came when the CMS made their satisfaction surveys for different hospitals publicly available. They state that while the Clinic was ranked among the top 5 US hospitals for overall quality of care by the *US News & World Report*, they ranked incredibly low in their satisfaction surveys. For example, they ranked 4% for staff responsiveness and room cleanliness and 14% and 16% for doctor and nurse communication skills respectively. After conducting their own surveys within the Clinic, providing an ample budget, and encouraging staff participation by publicizing the problem internally, they implemented changes in an effort that became known as "managing the 360":

- Every staff member became a caregiver and played an active role in solving the problem (doctors, nurses, janitors, etc.)
- Established new services such as a centralized scheduling service, electronic display of active problems for staff, mandated hourly nursing rounds, etc.
- Re-set realistic patient expectations and encouraged communication through print and interactive online videos for incoming patients.
- Increased employee engagement with weekly huddles, celebration programs, and other incentives and training.

Ultimately, in the words of Chief Experience Officer James Merlino, the Cleveland Clinic recognized that "the patient experience was everyone and everything people encountered from the time they decided to go to the clinic until they were discharged" (Merlino & Raman, 2015, Understanding Patients' Needs section).

### *Patient Experience vs Patient Satisfaction*

But what is the difference between the patient experience and patient satisfaction? How do we take into account patient satisfaction surveys while ensuring that the patient still receives proper, safe, and efficient care? As mentioned previously, patient satisfaction surveys utilize both an objective and subjective perspective for analyzing the patient experience. The experience itself is from a more objective lens while the resulting satisfaction rating is from a more subjective one. Thus, one notable difference between experience and satisfaction manifests in a situation where two people receive the exact same care but report different satisfaction ratings.

Based on a patient's expectations and current attitudes or circumstances, discrepancies can emerge in satisfaction, with ratings varying drastically between patients. In multiple studies analyzing consumer satisfaction, an inherent link has been established between a patient's expectation for the care journey and outcome as well as overall satisfaction with their medical care (Locker & Dunt, 1978). In a different study on the health and social care of the elderly, participants rationalized that while the service didn't provide everything they needed, all of their expectations were met; thus, the satisfaction remained positive because everything was carried out as expected (Locker & Dunt, 1978).

In this regard, the survey analyzes whether the expectations of a patient were fulfilled in that particular health encounter, a clearly subjective measure ("What is patient experience," 2016). On the other hand, patient experience analyzes whether what is generally expected to happen in a healthcare setting truly did happen and how often ("What is patient experience," 2016). It is a much more objective and straightforward analysis that indicates when care deviates from what is expected by the hospital itself; a quality that the patient is not always able to judge accurately due to a lack of knowledge and expertise (Locker & Dunt, 1978).

However, one important note is that memory is fluid and may be different from what the patient experiences in real time, creating discrepancies between patient reports and what happened (Gualandi, et al., 2019). As the recall period increases, the likelihood of recall error increases, including the omission of events, creation of false events, and/or placement of events at the wrong time sequentially (Kjellsson, et al., 2014). The emotional state of a patient is also strongly tied to the responses and interpretation of certain scenarios, which can alter the patient's experience and memory of it (Robert, 2013). While difficult to come to conclusions from one report due to the fluidity of memory, the compilation of many reports can create trends that are likely overall indicative of the care being provided.

By taking into account this distinction between experience and satisfaction, a solution can be crafted when dissatisfaction is discovered: should the approach to care be changed, should the expectations, preferences, and standards of a patient be changed, or should both be changed to increase overall satisfaction (Ware, et al., 1983). Aligning dissatisfaction ratings can indicate where the hospital is failing to meet a certain general standard or where there are discrepancies between patient and hospital expectations. Indications of the former may indicate a need to improve certain areas of the hospital whereas the latter may suggest that the hospital is not clearly outlining and managing the expectations of their patients.

Management of these expectations is important to ensure proper satisfaction *and* safety. For example, bed alarms are critical to patient safety but can feel like a nuisance and result in decreased patient satisfaction levels (Christensen, 2017). While it is important to maintain patient autonomy and acknowledge their preferences, there must be a balance to keep the patient safe despite their own beliefs in their capabilities at a particular time in their care. One means of accomplishing this is communication; clearly outlining what and why is being done can manage

expectations and consequently establish effective, safe, respectful, and responsive care (“What is patient experience,” 2016).

Oftentimes a conflict of preference arises, inevitably created by a variance in patient expectations and consequently satisfaction ratings. When evident, this may merely indicate the need for flexibility when providing a particular service to accommodate the ranging expectations and needs of patients; this places great importance on the patient’s interests and creates a more patient-centered model of care (Locker & Dunt, 1978).

### *Important Factors to the Patient Experience*

From the moment a patient first receives care to the moment they are healed, each step of the patient’s journey affects their experience. Various factors influence and play a crucial role in determining the outcome of the patient experience, which proves to be continuous throughout a patient’s journey in the hospital and vital to their care. Some of these include the countless people they encounter and the environment in which they receive care as well as their expectations for satisfaction.

When a physician communicates with their patient and vice-versa, varying communication patterns inevitably emerge that can dramatically influence the patient experience. Before delving into these patterns, it’s important to preface with their origins. Habermas’ Communicative Action Theory intends to encourage mutual understanding and consensus through clear communication (Habermas, 1987). He distinguishes between the system, a technical, goal-oriented approach grounded in efficiency and success, and the lifeworld, a social approach grounded in communicative action that incorporates everyday experiences to obtain understanding and consensus (Leanza et al., 2014; Barry et al., 2001).

Based upon Habermas' theory, Mishler applies a similar approach to medicine redefining the system as the voice of medicine (Mishler, 1984). Here, the voice of medicine is solely technical and decontextualized from the patient's experiences with control in the hands of the doctor; in contrast, the voice of lifeworld contextualizes health issues to everyday life and the personal experiences of the patient, incorporating more listening, open-ended questions, and layman terms (Barry et al., 2001). A main concern arising today is the "colonization" of the lifeworld by the voice of medicine, which ultimately threatens the ability to achieve true communication and patient satisfaction (Barry et al., 2001; Collins, 2019).

Ultimately, varying uses of each of these voices, including complete dismissal of one or the other, can significantly impact the patient experience. In one study of general practice cases, four patterns of communication emerged:

- Strictly medicine: both patient and doctor strictly use the voice of medicine,
- Mutual lifeworld: both engaged with the lifeworld,
- Lifeworld blocked: glimpses of the lifeworld emerged but were immediately dismissed through structural questioning by the doctor, and
- Lifeworld ignored: the patient largely discussed lifeworld but was ignored and responded to with solely the voice of medicine (Barry et al., 2001, pp. 493-496).

In a different but similar study, four patterns of communication were also identified but differentiated based on meaning and under the presumption that the lifeworld was heard and included: lifeworld rationalization, strategic use of lifeworld to achieve biomedical goals, mutual lifeworld, a true interest in the lifeworld (very natural and casual), integration of medicine and lifeworld, an interest in and linkage of both the lifeworld and medical world and referral to another professional, which had no ultimate meaning (Leanza et al., 2014).

While each communication pattern was successful to some degree, the most success came when engaging the lifeworld; as emphasized by the findings of Leanza et al. (2014), the lifeworld can be utilized strategically to accomplish biomedical goals and/or it can be linked to the medical world. When an emphasis was placed on the voice of medicine from both ends, both walked out satisfied, but oftentimes patients would leave with prescriptions they didn't want or major misunderstandings because they would simply take the doctor's word as law (Barry et al., 2001). When lifeworld was ignored or blocked, often seen with chronic patients, they walked out feeling "dehumanized, objectified, stereotyped, disempowered, and devalued"; they felt dismissed and remained confused and worried (Barry et al., 2001, p. 491). However, with the incorporation of the lifeworld by both parties, there was more engagement, respect, and validation resulting in more things being voiced; as equal partners, this model migrates towards a more patient-centered model (Barry et al., 2001).

As a student at the University of Arizona, I participated in a Patient Experience internship that granted me the opportunity to talk with multiple patients throughout the year regarding their experience at Banner hospitals during their stay; I heard both their praises and grievances. One of the major complaints I received regarding patient experience was the lack of humanity felt during their stay. As I entered the room of one patient and discussed her experience, she described how she felt as less than a person, merely something to be treated rather than someone to be cared for. In this case, the patient felt exclusively treated in the voice of medicine with little personalization to bring in the voice of the lifeworld. While understanding the heavy workload that much of the medical staff undergoes, she emphasized the importance of taking a couple of moments to check up on the patient and their well-being; "to make them feel human". While the

lifeworld can introduce important connections for the diagnosis, incorporating the lifeworld also functions to humanize the patient.

Although incorporating the lifeworld is important, a balance is crucial; the voice of medicine must be used to some extent as a communication tool, but not to the point where it endangers the humanity of the interaction. Throughout medical school, the voice of medicine has a large emphasis; more importance is placed on the technical and physiological details over the personal and emotional ones (Collins, 2019). As a result, humanistic attitudes necessary for such sensitization, such as empathy, decrease as students progress through medical school (Ruiz-Moral, 2017). Furthermore, within the medical school curriculum, there tend to be some common themes that reinforce the idea that moral weakness can be the cause of some illnesses but not others; consequently, certain illnesses, particularly psychological ones, tend to go under-recognized by physicians (Robbins et al., 1994).

Dr. Rana Awdish, while discussing her medical training in an autobiography, states “We were trained to value efficiency over cultivating a relationship through trust and disclosure. We weren’t trained to value the patient’s story” (Awdish, 2017, p. 51). Unsurprisingly, students testing a new training program to increase awareness of contextual and emotional cues and respond empathetically felt notably uncomfortable when participating (Robbins et al., 1994). The growing conversation surrounding sensitivity training and the integration of these new training programs are critical to ensuring the incorporation of the lifeworld and consequently stronger patient-centered care (Christensen, 2017).

Thus, the sensitization of physicians to the importance of the lifeworld, to knowing which voice is appropriate, and when acknowledgment of the lifeworld is important to the patient is a positive step towards better, well-rounded care (Barry et al., 2001). In fact, one study found that

physicians who are more sensitive to their patients' nonverbal forms of communication are more likely to identify psychiatric disorders, even in patients with more severe medical illnesses and higher levels of medical morbidity (Robbins et al., 1994).

With a better understanding of when to use which voice and the importance of a more humanistic approach, the communication between physician and patient also improves, allowing for an easier exchange of information. According to McGhee, the greatest weakness in hospital care arises when there is a “barrier to easy exchange of information” (Locker & Dunt, 1978, p. 285). When an information gap exists and the patient is missing information or lacking communication, there is a notable increase in confusion, anxiety, and fear (Gualandi, 2019). In one study, some patients reported feeling abandoned because they were not informed about various findings regarding their care (Gualandi, 2019).

While surveying patients myself during my internship, I found similar findings reinforcing the idea that the frustrations experienced by many are a result of a lack of communication or lack of understanding. For example, one patient explained that she came in for a broken arm, but was being kept for further tests and observation regarding something completely different than the broken arm. She was incredibly upset, confused, and frustrated because nothing was being communicated to her; she felt almost completely left in the dark and disregarded in terms of her care. In explaining these emotions, she described feeling “like a test subject” rather than a patient, an example of someone whose lifeworld concerns were blocked and responded to very minimally in the voice of medicine. Thus, proper communication and ensuring understanding are key to the patient experience by relieving certain stressors. Furthermore, this ensures that the patient has the information necessary to make decisions regarding their care, an important feature of the patient-centered model of care.



In many instances, patients described experiences similar to those of the patient described above, highlighting another common theme among many patients, feelings of neglect and disregard. During multiple shifts, I've heard from multiple patients that their experience was tainted by feelings of neglect and disregard, making them feel less human. One patient I encountered one day was super positive, conversational, engaged, and joyful. The next day it was like a 180 shift, she was quiet and down. She explained that the large shift was due to the terrible attitude and poor treatment by her nurse the night prior.

While just one example of many, it's clear how healthcare providers, including their attitudes, care, and effort, have a large impact on the patient experience. In a study by Cartwright, he discovered that 87% of patients most appreciated something about their doctor's manner or personality while 67% most appreciated something about the care they received, for example, listening or not rushing through the visit (Locker & Dunt, 1978). Korsch et al. found that patient satisfaction improved when the doctor was friendly and the patient's expectations regarding treatment and information were met regardless of the doctor or diagnosis (Korsch et al., 1968). When an expectation is not met, it usually concerns the manner rather than the nature of the interaction (Koos, 1955). For example, when investigating pediatric care, Mechanic (1964) found that patients who switched doctors did so not because of a lack of medical qualifications, but rather due to a lack of interest, care, and motivation, reinforcing the importance of engaging the lifeworld and of the instrumental role that patient's expectations play in determining patient satisfaction.

The importance of the manner of the relationship was emphasized in a different study investigating the patient-professional relationship. The study reported that patients "remember, even after some time, some aspects of the relationship with professionals that are not directly

related to clinical care, but which are perceived as being of value for the patients” (Gualandi, 2019, p. 9). One example from the study was a patient who remembered the nurse who went out of their way to say goodbye to them before they left (Gualandi, 2019). While difficult to remember smaller details and circumstances regarding their care/treatment, many patients remember those impactful interactions with healthcare providers that sometimes go unrecognized by the providers themselves.

With proper communication and understanding, the patient-professional relationship is much more likely to thrive. As a result, this positive relationship can then compensate for other areas in which the organization struggles or is inefficient; it serves as a key buffer to disruptions or delays in the patient journey and creates opportunities for reassurance (Gualandi, 2019). Many patients when alone, waiting, or in-between transfers experience great amounts of confusion and anxiety; communication and managing the patient flow can relieve some of these stressors that drastically impact the patient experience (Gualandi, 2019).

However, other influences relating to the way the patient is treated can dramatically impact the way a patient views the care they were provided and impact this relationship. In one study, it was found that “awareness, attitudes, and skills are key factors for improving hospital discharge” (Hesselink et al., 2014, p. 8). Thus, within the patient experience, this includes timely care, good communication with health care providers, and ensuring the patient feels human, listened to, empathized with, understood, and treated with proper care and respect; frequently, this correlates with better outcomes after discharge and overall experience.

## **Sociology of the Patient Experience:**

Understanding the intersection of sociology and medicine is integral to understanding the impacts of social factors on health, the persistence of healthcare disparities, and ultimately how to provide more patient-centered care. One's social identity can dramatically influence their patient experience, affecting things such as communication, trust, quality and access to care, health literacy, etc. all of which are crucial to the patient experience; depending on one's identity, disparities can manifest.

### *Social Identity and the Patient Experience*

Shaped by various factors including socioeconomic status, race, ethnicity, gender, and cultural background, one's social identity can significantly alter the patient experience. While navigating the realm of medical care, this identity can impact the interaction between the patient and their healthcare providers, services, and systems, manifesting in implicit biases that create disparities in health, access to healthcare, and quality of care.

While many advancements have been made in the field of healthcare and many initiatives taken to improve public health, health disparities continue to exist (Link & Phelan, 1995; Williams et al., 2010; Phelan et al., 2010). One major contributor to this disparity in health is socioeconomic status. Link and Phelan (1995) introduced the theory of "fundamental causes" to suggest the fundamental quality of certain social conditions due to how they shape access to opportunities and resources that dramatically impact health; it attempts to explain the persistent association between socioeconomic status and health disparities despite changes in the disease itself, the risk factors, and interventions expected to explain it (Phelan et al., 2010). A low socioeconomic status is persistently and strongly associated "with lower life expectancy, higher

overall mortality rates, and higher rates of infant and perinatal mortality” (Link & Phelan, 1995, p. 81). Conversely, individuals with higher socioeconomic status are better positioned to know of changes in disease and risk factors *and* have the social and economic resources to act accordingly to avoid significant affliction by the disease; thus, targeting the disease or particular risk factors while failing to address the underlying social determinants of health may create a never-ending cycle of health disparities (Link & Phelan, 1995).

Health outcomes are also largely influenced by the complex intersection of race and socioeconomic status (Williams et al., 2010). While health disparities are associated with and rooted in socioeconomic differences, these disparities are perpetuated by the unequal distribution of resources, structural inequalities, and discrimination (Phelan et al., 2010). Consequently, according to Williams et al. (2010), socioeconomic status is crucial to determining racial health disparities as race and status are intertwined, impacting health together; varying degrees of intersection due to things such as location and gender can create distinct challenges that lead to varying disparities.

As one example, in a New York Times article, Lee (2019) states a racial wealth gap is ever-present as a “legacy of American slavery and the violent economic dispossession that followed” (para. 5). Today, black people have a median family wealth of just \$17,600 compared to \$171,000 for white people, are less likely to own a home, and continue to face discriminatory lending practices and disparities in access to affordable housing (eg. redlining) (Lee, 2019). In a study of mortgage lending practices, Turner and Skidmore (1999) observed that African Americans and Hispanics persistently faced discrimination, receiving less information and time with lenders, but higher rates.

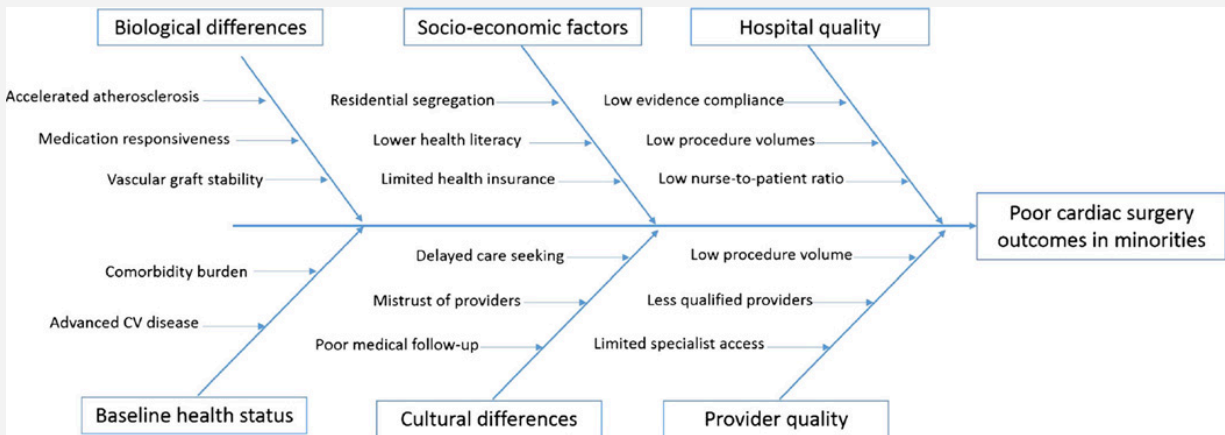
Additionally, one's race might influence the degree to which one experiences segregation and socioeconomic disadvantage. For example, residential segregation is a structural inequality, creating areas concentrated with racial and ethnic minority groups; these areas experience fewer resources (including access to quality education), weaker infrastructure, and greater exposure to stressors and other risk factors that influence health inequalities (Williams et al. 2010). Evidently, remnants of racism and discrimination continue to remain in various aspects of life despite the progress that has been made and continue to perpetuate healthcare disparities.

Furthermore, research continuously indicates a lower quality of and access to health care services by racial and ethnic minorities; in African-American patients, these disparities are associated with greater mortality from heart disease, cancer, cerebrovascular disease, and HIV/AIDS (Institute of Medicine, 2003). For example, although black patients have higher rates of fatal coronary heart disease, the rates of intervention, treatment optimization, and clinical outcomes are worse when compared to those of white patients (Johnson, 2019). Beyond just African Americans, American Indians experience higher death rates from diabetes, liver disease and cirrhosis, and unintentional injuries; Hispanic Americans are nearly twice as likely to die from diabetes when compared to non-Hispanic whites; some Asian-American groups face rates above the national average of stomach, liver, and cervical cancers (Institute of Medicine, 2003).

While the causes of these disparities are not fully understood, these disparities may stem from multiple factors such as biological differences, “socioeconomic differences, differences in health-related risk factors, environmental degradation, and direct and indirect consequences of discrimination” (Institute of Medicine, 2003, p. 29; Williams et al. 2010). In a study investigating the root cause of higher mortality rates in black and other minority patients post-cardiac surgery, Khera et al. (2015) also suggest that the cause of this relationship is likely multifaceted (Figure

1). However, while impacted by multiple factors, research indicates that these disparities in outcomes might be more significantly impacted by minority patients being more likely to receive care at hospitals that provide lower-quality services (Khera et al., 2015).

Figure 1



*Note.* Diagram displaying the multifaceted relationship between race and cardiac surgery outcomes. Adapted from “Racial disparities in outcomes after cardiac surgery: The role of hospital quality,” by R. Khera, M. Vaughan-Sarrazin, G. Rosenthal, and S. Girotra, 2015, *Current Cardiology Reports*, 17(5), p. 29. Copyright by PubMed Central.

In fact, Johnson (2019) discovered that, irrespective of race, coronary heart disease patients tend to use hospitals closer to where they live and of higher quality; however, white patients are more likely to use high-quality hospitals while black patients are more likely to use hospitals based on location. Additionally, minorities generally have less nearby access to specialty care and are less likely to seek regular sources of care, turning to emergency care instead (Institute of Medicine, 2003). All of this together highlights the potential impacts of racial segregation on these race-based differences in hospital quality and capabilities, again reinforcing the deeper impact of social and economic factors on racial health disparities.

However, racial differences in the quality and intensity of medical care persist even after accounting for SES, insurance status, education, and other factors that could influence access to health care with minorities receiving fewer procedures and poorer quality care (Williams 1999; Institute of Medicine, 2003). In an intricate analysis by the Institute of Medicine (2003), they concluded that while there is no direct evidence, there is a sufficient collection of evidence to base the inference that racism, bias, or prejudice by healthcare providers may influence care and perpetuate racial and ethnic healthcare disparities.

In the early 1800s, Dr. Thomas Hamilton, a well-respected physician carried out excruciatingly painful experiments to prove that differences exist between blacks and whites; many of his “findings,” such as beliefs that black people have large sex organs, small skulls, less intelligence, thicker skin, higher pain tolerance, etc., were published as fact in medical journals (Villarosa, 2019). Although these experiments are now interpreted as immoral and unacceptable with many of these beliefs dismissed as absurd and far-stretched, some of these perceptions exist today and continue to play into structural racism and inequality, including racial and ethnic disparities in health.

In the early 2000s, van Ryn and Burke surveyed physicians on their perceptions of patients. Physicians rated African Americans as less intelligent and educated, less likely to participate in rehabilitation, more likely to abuse alcohol or other drugs, more likely to fail to comply with medical advice, and more likely to lack support. While physician perceptions of patients are clearly influenced by race, the effect of these perceptions on patient care outcomes is not explicitly clear. Nevertheless, physicians with these beliefs may be influenced to put in less effort or fail to recommend proper treatment and rehabilitation whether conscious or not (Institute of Medicine, 2003).

More recently, Hoffman et al. (2016) found that individuals without medical training, medical students, and residents hold at least one false belief about biological differences between whites and blacks. Some held the perception that blacks feel less pain, which led to insufficient treatment for black patients, while the same perception for whites did not. This reinforced some of the findings by Weisse et al. (2001) that healthcare providers prescribe different amounts of medications for pain management to patients based on race; more specifically, they found that male physicians prescribe twice the amount of hydrocodone to white patients than blacks while female physicians prescribed the opposite. Regardless, the persistence of false beliefs about biological differences is clearly present today and influences diagnostic treatment decisions in one way or another; without acknowledgment, the existence of these beliefs promotes disparities in health and continues to ignore the internalized bias and racism that contribute to it.

The existence of explicit and implicit biases may play a role in the existence of healthcare disparities. However, due to a lack of direct evidence, more research is needed to better understand its prevalence and influence on healthcare disparities. Questions also lie regarding the “accuracy” of the stereotypes held by medical professionals and how this can be reconciled with these stereotypes being a cause of disparities (Institute of Medicine, 2003). However, even if the stereotypes may be true, they can still create problems by leading to and almost justifying doctors’ decision to treat minorities differently.

### *Effects on Care & the Interpersonal Relationship*

Stereotypes, whether explicit or implicit, can significantly affect healthcare providers’ perceptions, attitudes, and clinical decision-making. Oftentimes, individuals are not even aware of their attitudes, creating implicit biases that operate subconsciously (Institute of Medicine,



2003). Nevertheless, these stereotypes shape interpersonal relationships between physicians and their patients, impacting trust, communication, health literacy, care-seeking, treatment adherence, and more.

As discussed above, the continued existence of biases and prejudice in physician beliefs, the history of segregated and inferior care, and the history of mistreatment create great distrust among racial and ethnic minorities of health professionals (Institute of Medicine, 2003; Jacobs et al., 2006). For example, Jacobs et al. (2006) surveyed African American patients and found that some determinants of distrust in physicians include interpersonal incompetence (i.e. a lack of empathy and care), technical incompetence (i.e. right diagnosis, treatment, and follow-up care), focus on profit, racism, and foreign physicians. One interesting takeaway was the common expectation and fear amongst African American patients that they would be experimented on due to their knowledge of the Tuskegee Syphilis Study.

The Institute of Medicine (2003) summarizes multiple studies further exemplifying distrust and discriminatory experiences in healthcare. In one study, it was found that African American patients were four times more likely to perceive racial discrimination as common in doctors' offices and notably more inclined to mistrust healthcare systems. A nationwide survey found that 30% of Hispanics and 35% of African Americans believe racism is a “major problem” in healthcare whereas only 16% of whites believed this true. Additionally, 64% of African Americans and 56% of Hispanics believed they receive a lower quality of healthcare compared to whites of which only 23% and 27% believed this to be true. In fact, the Seattle and King County (WA) Department of Public Health concluded that almost one-third of African Americans and more than one-fifth of Hispanic patients report experiencing healthcare

discrimination at some point in their lifetime. Of these, almost 95% reported delays in seeking needed healthcare.

Evidently, interpersonal trust is a key determinant of care. According to Jacobs et al. (2006), it greatly predicts treatment adherence, satisfaction of care and physician, loyalty, patient honesty, and willingness to give control to the physician (Jacobs et al., 2006). When minorities perceive higher levels of discrimination and respond with greater distrust, this can contribute to racial and ethnic disparities in health. Essentially, patient experiences, whether personal or not, and their expectations of racism from healthcare providers can generate feelings of distrust, drastically impacting the patient experience and satisfaction with care. Mitigating these fears and actively working to create a relationship built on trust could possibly increase satisfaction and healthcare outcomes.

Another barrier to patient-provider communication is language and health literacy. Language concordance is crucial to effective communication and establishing an empathetic connection between patient and provider (Institute of Medicine, 2003). When the barrier exists and is not addressed, minorities may struggle to understand medical terminology, treatment options, etc., and they become more at risk for misunderstandings, non-adherence, and poorer overall health outcomes. Consequently, due to a lack of truly informed decision-making, this language mismatch is a major contributor to racial and ethnic disparities in care.

Dubard and Gizlice (2008) found that, compared to English-speaking Hispanics, Spanish-speaking Hispanics experience significantly poorer health status, face higher rates of uninsurance, lower access to preventive services and personal doctors, and report poorer perceived health status even with adjustments for demographic and socioeconomic factors. In a similar study, Morales et al. (1999) investigated Latino patient satisfaction with communication

and concluded that Spanish-speaking Latino respondents were markedly more dissatisfied with communication than English-speaking Latino and white respondents. Assuming communication satisfaction is an indicator of communication quality, Spanish-speaking Latinos are therefore at a higher risk for poorer quality of care and treatment outcomes.

This begs the question of race concordance and how it can influence patient satisfaction and experience. In a study regarding physician selection, 42% of Hispanic patients reported choosing race-concordant physicians to avoid linguistic barriers (Saha et al., 2000). Generally, cultural competence and sensitivity allow for greater connection and understanding between patient and provider, facilitating more effective communication and rapport building; this establishes a stronger foundation for trust and ultimately a stronger patient-provider relationship and more patient-centered care (Stubbe, 2020). Race concordance increases the odds of shared “cultural beliefs, values, and experiences,” creating more effective communication and increased comfortability (Institute of Medicine, 2003).

In multiple studies, race concordance has been associated with “greater participatory decision-making, greater patient-centered care, lower levels of physician verbal dominance, and greater patient satisfaction” (Institute of Medicine, 2003, p. 134). Laveist and Nuru-Jeter (2002) found that patients were more likely to select a race-concordant physician when given the choice. In similar studies by Saha et al. (1999) and Cooper-Patrick et al. (1999), they found that race-concordant relationships were notably more participatory than nonconcordant relationships; African American patient-physician concordance, in particular, was associated with a higher likelihood of patients rating their physicians as excellent, respectful, explicative, attentive, and accessible.

Interestingly, in a study investigating the outcomes of concordant and discordant interpersonal relationships presented by the Institute of Medicine (2003), the greatest amount of patient-centered care was seen during visits between African American physicians with white patients; in contrast, visits between white physicians and African American patients were some of the shortest and least patient-centered with the highest presence of physician verbal dominance. One possible explanation for this is the likelihood that African American physicians are bicultural and thus able to operate successfully in both cultures.

However, while there is evidence indicating strong associations between concordance and better quality care, there is little evidence directly connecting the two. Some evidence indicates the persistence of racial disparities despite concordance suggesting non-concordance is an insufficient explanation of existing health disparities (Institute of Medicine, 2003). Additionally, in a study on physician trustworthiness, many African American patients indicated that race concordance was not a major determinant of trust, but that proper communication across language and cultural barriers was (Jacobs et al., 2006).

Further, the perception of similarity in personal beliefs, values, and communication and patient-centered approach, rather than simply race concordance, are associated with greater trust, satisfaction, and adherence ratings (Street et al., 2008). Nevertheless, race concordance typically creates a groundwork for similar beliefs and culture due to ethnic similarity. While not always the case, concordance makes it less likely that a physician will be viewed as disrespectful or non-accommodating. Consequent trends of greater patient satisfaction and trust are associated with greater patient compliance, participation in decision-making, and use of preventive care services (Institute of Medicine, 2003).

## *Critical Race Theory*

Critical race theory has recently been delicately integrated into the field of public health to more directly address the disparities that exist in healthcare, including access to care and health outcomes; it encourages healthcare providers to not only recognize but acknowledge the effects of both historical and systemic racism on healthcare practices and work towards achieving health equity. But what exactly is critical race theory?

Critical race theory came to be in the 1980s when legal scholars of color came together to create a framework that addressed the presence and continued influence of structural racism and the powers that perpetuate it (Ford & Airhihenbuwa, 2018). It encourages an analysis through a critical lens that challenges society's overconfidence in certain objectivities and the persistence of racism in modern society (Ford & Airhihenbuwa, 2010). While critical race theory is applied in many contexts such as law and sociology, it has been introduced into the realm of medicine and public health with a similar intent.

In essence, its application to medicine highlights the persistence of structural racism in public healthcare and how this prevents the achievement of health equity; it ultimately provides the context and clarity to understand the disproportionate impact of social determinants of health on minorities (Ford & Airhihenbuwa, 2018). Critical race theory in this public health context provides a means of more aptly identifying racial biases and an expanded vocabulary that can serve as the foundation for proper conversation regarding work toward true health equity (Ford & Airhihenbuwa, 2010, 2018). Whether in research or in practice, critical race theory provides a foundation in public health to clarify how racism exists in the modern day, make adjustments accordingly, understand the implications, and act, either by working to undo power differentials and/or benefit the community directly (Ford & Airhihenbuwa, 2010, 2018).

As mentioned briefly, critical race theory challenges objectivities, particularly those in research, that were likely influenced by racialized policies during that time; thus, it encourages a more critical analysis of and attentiveness toward certain “scientific truths” and practices (Ford & Airhihenbuwa, 2010). In one example to demonstrate the incorporation of critical race theory concepts, a research team acknowledged the impacts of chronic exposure to daily racism and shifted the research perspective to the minority; this involved acknowledging factors that may influence one’s interaction or decision-making including, but not limited to power differentials, implicit biases, and stereotypes (Ford & Airhihenbuwa, 2010). Following the conclusion of their research, they took action by sharing their findings with the affected community.

Ultimately, the increased incorporation of the critical race theory encourages healthcare providers to become more culturally competent regarding the contexts of their patients’ lives and consequently provide more patient-centered care.

### *Structural Interventions*

Understanding the complex intersection between different social conditions is crucial to developing inclusive interventions to address social inequalities and target the underlying causes of disease and health inequalities (Phelan et al., 2010). Health disparities can be attributed to many factors beyond just income and education and must be addressed first by increasing awareness among the general public and healthcare providers themselves (Williams et al., 2010; Institute of Medicine, 2003). Moreover, improving healthcare access in underserved communities by focusing improvement efforts at hospitals that disproportionately serve racial and ethnic minorities could largely contribute to combating racial disparities (Khera et al., 2015).

However, providing education and access alone may sometimes not be enough. Depending on lifestyle and conditions, certain minorities may need to continue engaging in risk behaviors to survive. Instead of blaming individuals and communities for poor health outcomes based on outdated beliefs about racial differences in physiology, it's important to recognize race as a risk for bias and disadvantage, especially considering the historical discrimination faced by black communities and other minorities (Lee, 2019). Without understanding the cause of risk exposure, education about necessary behavior changes is useless as they fail to provide minorities with the resources and support to change such behavior (Link & Phelan, 1995).

Thus, in order to increase the potential for sustainable success of an intervention, it is important to contextualize the risk factors of disease and confirm that those risks do not overpower. While it may seem impractical to target the root causes of inequality that are so embedded within our society, efforts to create more social and economic equity, such as homeless housing, head-start programs, and proper resource access, would create the foundation for reducing health disparities (Link & Phelan, 1995).

Currently, the percentage of US doctors who are Black/African American or Hispanic/Latino is less than the percentage of the US population that identifies as such; in contrast, the percentage of Asian American/Pacific Islander and White doctors is considerably greater (Boyle, 2023). In a CNN Health article, Jacqueline Howard (2023) discusses the potential of these shortages in racial and ethnic minority health professionals to become detrimental to healthcare. She highlights the story of Seun Adebago, a third-year medical student born in Nigeria and raised in Boston, who pursued medicine with the intent of bridging the worlds of Western medicine with Nigerian culture. With greater cultural competence, she can effectively

connect with patients from diverse backgrounds and “empower them to advocate for themselves” (para. 5).

Diversifying the healthcare workforce by increasing the proportion of underrepresented racial and ethnic minorities in healthcare would be an instrumental step toward eliminating disparities. Doing so would create greater opportunities for racial concordance between physician and patient, which can significantly influence patient satisfaction and experience; multiple studies highlight the associations between concordance and greater participatory decision-making, patient-centered care, and higher patient satisfaction, which is a key determinant of health-related outcomes (Laveist & Nuru-Jeter, 2002). Not only this but racial and ethnic physicians are much more likely to serve in underrepresented communities, increasing the geographic accessibility of care for minorities (Institute of Medicine, 2003).

However, while race concordance lays the groundwork for shared beliefs and culture, the general perception of similarity in personal beliefs, values, and communication style is associated with greater trust and satisfaction leading to better patient compliance and participation in health care decisions. Thus, promoting greater cultural competence, anti-racist practices, sensitivity and empathy within the healthcare workforce is another important step toward reducing disparities in health.

Implementing cross-cultural education and training for current and future medical professionals is one mechanism to accomplish such a goal (Institute of Medicine, 2003; Betancourt et al., 2003). Such educational interventions would allow healthcare professionals to become more aware, knowledgeable, and prepared to handle sociocultural issues that arise during clinical encounters; they could then provide greater quality care to minority populations with varying cultural perspectives and backgrounds. Beyond cultural competence, sensitivity



training to increase medical students' comfortability and ability to operate in the lifeworld would also be incredibly beneficial; teaching future physicians how to detect contextual and emotional cues and respond empathetically would remind them of humanistic attitudes oftentimes lost during the course of medical school (Ruiz-Moral et al., 2017; Adwish, 2017).

With these educational tools and trainings, physicians could become more apt to practice “cultural competemility”, the merging of competence and humility (Stubbe, 2020). Cultural humility entails the acknowledgment of one's own implicit biases with the intention to honor and appreciate a person's beliefs, customs, and values; cultural competence entails the cultural knowledge, skill, awareness, desire, and encounters themselves. The combination of the two allows for a more purposeful use of cross-cultural knowledge to provide care that is more “respectful of, and responsive to, individual patient preferences, needs, and values, and [ensure] that patient values guide all clinical decisions,” the definition for patient-centered care and desired outcome of modern healthcare (Christensen, 2017, p. 1).

Ultimately, patient-centered care can increase equity in healthcare and cultural competence can improve the quality of patient-centered care (Stubbe, 2020). Thus, aside from technical competence, ensuring cultural competence, lifeworld sensitivity, and interpersonal skills are vital to providing more patient-centered care and decreasing disparities in healthcare.

## **Conclusion**

The concept of patient experience has evolved significantly over the years, transitioning from a focus on the physician to a more patient-centered approach that emphasizes the patient's preferences, values, and goals. This shift has been driven by changes in demographics, technology, and societal expectations, particularly with the emergence of the baby boomer

generation, who are more assertive and engaged in their healthcare. Alongside technological advancements, there has been an increased demand for transparency and patient engagement, leading to the development of patient satisfaction surveys and initiatives to improve patient-centered care. Factors influencing the patient experience include communication patterns between patients and healthcare providers, the incorporation of patient expectations, and a humanistic approach by healthcare providers. Balancing the voices of medicine and lifeworld, managing patient expectations, and ensuring effective communication are crucial for enhancing the patient experience and satisfaction, ultimately leading to better outcomes and quality of care.

Understanding the intricate relationship between sociology and medicine is crucial for comprehending the impact of social factors on health outcomes and healthcare disparities, and for advancing patient-centered care. Social identity, influenced by factors such as socioeconomic status, race, ethnicity, and gender, significantly shapes the patient experience, affecting communication, trust, and access to quality care. Persistent healthcare disparities, particularly rooted in socioeconomic differences and racial inequalities, highlight the need for targeted interventions. Structural interventions, informed by critical race theory, aim to address systemic racism and social determinants of health. Diversifying the healthcare workforce, promoting cultural competence and sensitivity, and implementing cross-cultural education and training are vital steps toward reducing disparities and achieving health equity. These efforts not only improve patient-provider relationships but also enhance patient satisfaction, trust, and adherence to care, ultimately leading to better health outcomes.

## References

- Annas, G. J. (1998). Scholarly commons at Boston University School of Law. *New England Journal of Medicine*, 338(10), 695-699. <https://doi.org/10.1056/NEJM199803053381020>
- Awdish, R. (2017). A hollowness. In *In shock: My journey from death to recovery and the redemptive power of hope*. St. Martin's Press.
- Barry, C. A., Stevenson, F. A., Britten, N., Barber, N., & Bradley, C. P. (2001). Giving voice to the lifeworld. More humane, more effective medical care? A qualitative study of doctor-patient communication in general practice. *Social Science & Medicine*, 53(4), 487-505. [https://doi.org/10.1016/S0277-9536\(00\)00351-8](https://doi.org/10.1016/S0277-9536(00)00351-8)
- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong 2nd, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118(4), 293–302. <https://doi.org/10.1093/phr/118.4.293>
- Boyle, P. (2023, January 12). *What's your specialty? New data shows the choices of America's doctors by gender, race, and age*. AAMC. <https://www.aamc.org/news/what-s-your-specialty-new-data-show-choices-america-s-doc-tors-gender-race-and-age>
- Collins, V. (2019). Conflicts of patient-caregiver communication and some workable solutions. *Harvard Public Health Review*, 23, 1-3. <https://doi.org/10.54111/0001/W5>
- Christensen, T. (2017). Rebalancing the patient experience: 20 years of a pendulum swing.” *Patient Experience Journal*, 4(3), 6-8. <https://doi.org/10.35680/2372-0247.1257>
- Cliff, B. (2012). The evolution of patient-centered care. *Journal of Healthcare Management*, 57(2), 86-88.

- Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race, gender, and partnership in the patient-physician relationship. *JAMA*, 282(6), 583–589. <https://doi.org/10.1001/jama.282.6.583>
- DuBard, C. A., & Gizlice, Z. (2008). Language spoken and differences in health status, access to care, and receipt of preventive services among US Hispanics. *American Journal of Public Health*, 98(11), 2021–2028. <https://doi.org/10.2105/AJPH.2007.119008>
- Ford, C. L. & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health*, 100(Suppl 1), S30. <https://doi.org/10.2105/AJPH.2009.171058>
- Ford, C. L. & Airhihenbuwa, C. O. (2018). Commentary: Just what is critical race theory and what's it doing in a progressive field like public health? *Ethnicity & Disease*, 28(Suppl 1), 223-230. <https://doi.org/10.18865/ed.28.S1.223>
- Gualandi, R., Masella C., Viglione D., & Tartaglini, D. (2019). Exploring the hospital patient journey: What does the patient experience? *PLOS ONE*, 14(12), 1-15. <https://doi.org/10.1371/journal.pone.0224899>
- Habermas, J. (1987). *The theory of communicative action, vol. 2* (T. McCarthy, Trans.). Beacon Press. (Original work published 1981)
- Hesselink, G., Zegers, M., Vernooij-Dassen, M., Barach, P., Kalkman, C., Flink, M., Ön, G., Olsson, M., Bergenbrant, S., Orrego, C., Suñol, R., Toccafondi, G., Venneri, F., Dudzik-Urbaniak, E., Kutryba, B., Schoonhoven, L., & Wollersheim, H. (2014). Improving patient discharge and reducing hospital readmissions by using Intervention Mapping. *BMC Health Services Research*, 14(389), 1-11. <https://doi.org/10.1186/1472-6963-14-389>

- Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the United States of America*, 113(16), 4296-4301. <https://doi.org/10.1073/pnas.1516047113>
- Howard, J. (2023, February 21). *Only 5.7% of US doctors are Black, and experts warn the shortage harms public health*. CNN Health. <https://www.cnn.com/2023/02/21/health/black-doctors-shortage-us/index.html>
- Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care* (B. D. Smedley, A. Y. Stith, & A. R. Nelson, Ed.). National Academies Press (US). <https://doi.org/10.17226/12875>
- Jacobs, E. A., Rolle, I., Ferrans, C. E., Whitaker, E. E., & Warnecke, R. B. (2006). Understanding African Americans' views of the trustworthiness of physicians. *Journal of General Internal Medicine*, 21(6), 642-647. <https://doi.org/10.1111/j.1525-1497.2006.00485.x>
- Johnson, A. (2019). Understanding why black patients have worse coronary heart disease outcomes: Does the answer lie in knowing where patients seek care? *Journal of the American Heart Association: Cardiovascular and Cerebrovascular Disease*, 8(23). <https://doi.org/10.1161/JAHA.119.014706>
- Kahana, E., & Kahana, B. (2014). Baby boomers' expectations of health and medicine. *American Medical Association Journal of Ethics*, 16(5), 380-384. <https://doi.org/10.1001/virtualmentor.2014.16.5.msoc2-1405>
- Khera, R., Vaughan-Sarrazin, M., Rosenthal, G., & Girotra, S. (2015). Racial Disparities in

- outcomes after cardiac surgery: The role of hospital quality. *Current Cardiology Reports*, 17(5), 29. <https://doi.org/10.1007/s11886-015-0587-7>
- Kjellsson, G., Clarke, P., & Gerdtham, U. (2014). Forgetting to remember or remembering to forget: A study of the recall period length in health care survey questions. *Journal of Health Economics*, 35, 34-46. <https://doi.org/10.1016/j.jhealeco.2014.01.007>
- Koos, E. L. (1955). Metropolis-what city people think of their medical services. *American Journal of Public Health*, 45(12), 1551-1557.
- Korsch, B. M., Gozzi, E. K., & Francis, V. (1968). Gaps in doctor-patient communication: I. Doctor-patient interaction and patient satisfaction. *Pediatrics*, 42(5), 85-871. <https://doi.org/10.1542/peds.42.5.855>
- Laveist, T. A., & Nuru-Jeter, A. (2002). Is doctor-patient race concordance associated with greater satisfaction with care?. *Journal of Health and Social Behavior*, 43(3), 296–306.
- Leanza, Y., Boivin, I., & Rosenberg, E. (2014). The patient's lifeworld: Building meaningful clinical encounters between patients, physicians, and interpreters. *Communication and Medicine*, 10(1), 13-25. <https://doi.org/10.1558/cam.v10i1.13>
- Lee, T. (2019, August 14). A vast wealth gap, driven by segregation, redlining, evictions and exclusion, separates black and white America. *The New York Times Magazine*. <https://www.nytimes.com/interactive/2019/08/14/magazine/racial-wealth-gap.html>
- Link, B. G., & Phelan J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior, Spec No*, 80-94.
- Locker, D. & Dunt, D. (1978). Theoretical and methodological issues in sociological studies of

- consumer satisfaction with medical care. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology*, 12, 282-292.  
[https://doi.org/10.1016/0271-7123\(78\)90067-6](https://doi.org/10.1016/0271-7123(78)90067-6)
- Mechanic, D. (1964). The influence of mothers on their children's health attitudes and behavior. *Pediatrics*, 38, 444-453.
- Merlino, J. I., & Raman, A. (2015). Health care's service fanatics. *Harvard Business Review*, 14 Sept. 2015.
- Mishler, E. J. (1984). *The Discourse of Medicine: The Dialectics of Medical Interviews*. Ablex Pub. Corp.
- Morales, L. S., Cunningham, W. E., Brown, J. A., Liu, H., & Hays, R. D. (1999). Are Latinos less satisfied with communication by health care providers? *Journal of General Internal Medicine*, 14(7), 409-417. <https://doi.org/10.1046/j.1525-1497.1999.06198.x>
- Olejarczyk, J. P. & Young M. (2022). Patient rights and ethics. *StatPearls*.
- Phelan, J. C., Link, B. G., & Tehranifar, P. (2010). Social conditions as fundamental causes of health inequalities: Theory, evidence, and policy implications. *Journal of Health and Social Behavior*, 51 Suppl, S28-S40. <https://doi.org/10.1177/0022146510383498>
- Robbins, J. M., Kirmayer L. J., Cathébras, P., Yaffe, M. J., & Dworkind, M. Physician characteristics and the recognition of depression and anxiety in primary care. (1994). *Medical Care*, 32(8), 795-812. <https://doi.org/10.1097/00005650-199408000-00004>
- Robert, G. (2013). Participatory action research: Using experience-based co-design to improve the quality of healthcare services. In S. Ziebland, A. Coulter, J. D. Calabrese, & L. Locock (Eds.), *Understanding and using health experiences: Improving patient care* (138-149). Oxford Academic.

<https://doi-org.ezproxy3.library.arizona.edu/10.1093/acprof:oso/9780199665372.001.000>

1

- Ruiz-Moral, R., Pérula de Torres, L., Monge, D., Leonardo, C. G., & Caballero, F. (2017). Teaching medical students to express empathy by exploring patient emotions and experiences in standardized medical encounters. *Patient Education and Counseling*, 100(9), 1694-1700. <https://doi.org/10.1016/j.pec.2017.04.018>
- Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. *Archives of Internal Medicine*, 159(9), 997–1004. <https://doi.org/10.1001/archinte.159.9.997>
- Saha, S., Taggart, S. H., Komaromy, M., & Bindman, A. B. (2000). Do patients choose physicians of their own race?. *Health affairs (Project Hope)*, 19(4), 76–83. <https://doi.org/10.1377/hlthaff.19.4.76>
- Siegrist, R. B. (2013). Patient satisfaction: History, myths, and misperceptions. *AMA Journal of Ethics*, 15(11), 982-987. <https://doi.org/10.1001/virtualmentor.2013.15.11.mhst1-1311>
- Street, R. L., O'Malley, K. J., Cooper, L. A., Haidet, P. (2008). Understanding concordance in patient-physician relationships: Personal and ethnic dimensions of shared identity. *The Annals of Family Medicine*, 6(3), 198-205. <https://doi.org/10.1370/afm.821>
- Stubbe, D. E. (2020). Practicing cultural competence and cultural humility in the care of diverse patients. *Focus: Journal of LifeLong Learning in Psychiatry*, 18(1), 49-51. <https://doi.org/10.1176/appi.focus.20190041>
- Turner, M. A. and Skidmore F. (1999). *Mortgage lending discrimination: A review of existing evidence*. The Urban Institute.
- van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on



- physicians' perceptions of patients. *Social Science & Medicine*, 50(6), 813–828.  
[https://doi.org/10.1016/s0277-9536\(99\)00338-x](https://doi.org/10.1016/s0277-9536(99)00338-x)
- Villarosa, L. (2019, August 14). Myths about physical racial differences were used to justify slavery – and are still believed by doctors today. *The New York Times Magazine*.  
<https://www.nytimes.com/interactive/2019/08/14/magazine/racial-differences-doctors.html>
- Ware, J. E., Snyder M. K., Wright, W. R., & Davies, A. R. (1983). Defining and measuring patient satisfaction with medical care. *Evaluation and Program Planning*, 6(3-4), 247-263. [https://doi.org/10.1016/0149-7189\(83\)90005-8](https://doi.org/10.1016/0149-7189(83)90005-8)
- Weisse, C. S., Sorum, P. C., Sanders, K. N., & Syat, B. L. (2001). Do gender and race affect decisions about pain management? *Journal of General Internal Medicine*, 16(4), 211-217. <https://doi.org/10.1046/j.1525-1497.2001.016004211.x>
- What is patient experience?* (2016, October). Agency for Healthcare Research and Quality. Retrieved April 14, 2024, from  
<https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html>
- Williams, D. R. (1999). Socioeconomic status and health in industrial nations: Social, psychological, and biological pathways. *Annals of the New York Academy of Sciences*, 896(1), 173-188. <https://doi.org/10.1111/j.1749-6632.1999.tb08114.x>
- Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status and health: Complexities, ongoing challenges, and research opportunities. *Annals of the New York Academy of Sciences*, 1186(1), 69-101.  
<https://doi.org/10.1111/j.1749-6632.2009.05339.x>
- Wynne, B. (2019). Who Owns the Patient Experience? *American Marketing Association*.

Yao, L., & Kabir, R. (2023). Person-Centered Therapy (Rogerian Therapy). *StatPearls*.