African Americans and Latinos use services that require a doctor’s order at lower rates than do whites. Racial bias and patient preferences contribute to disparities, but their effects appear small. Communication during the medical interaction plays a central role in decision making about subsequent interventions and health behaviors. Research has shown that doctors have poorer communication with minority patients than with others, but problems in doctor-patient communication have received little attention as a potential cause, a remediable one, of health disparities. We evaluate the evidence that poor communication is a cause of disparities and propose some remedies drawn from the communication sciences.

**KEY WORDS:** communication; racial disparities; race; health care utilization.  
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African Americans and Latinos use health services at lower rates than do white Americans. Although lower use does not always mean underuse, in some conditions, for example lung cancer and coronary heart disease, lower rates of use are associated with lower survival rates.

Disparities in health services use and outcomes have been attributed to differences in access to care. Abundant evidence shows that compared with whites, African Americans and Latinos have lower incomes, less education, lower rates of private health insurance coverage, a higher probability of being underinsured, and greater dependence on public health care programs, all of which impede the ability to seek and obtain timely services. However, what is most intriguing is that African Americans and Latinos use services that require a doctor’s order (e.g., invasive procedures, hospitalization, operations) at lower rates than do whites, even when their access to care, diagnosis, and illness severity are the same. This means that some disparities in use emerge after the patient gets to the doctor, not from difficulties in getting to the doctor in the first place. In other words, some disparities are emerging from the context of the doctor-patient interaction.

There are three possibilities that might explain this phenomenon: racial bias on the part of the doctor, patient preferences, and poor communication. In this paper, after briefly touching on what is known about how racial bias and patient preferences affect health disparities, we will examine in depth the role poor doctor-patient communication might be playing. Poor communication has received very little attention as a cause for disparities in use and health outcomes, but its role in producing disparities is supported by theoretical as well as empirical work in communication sciences.

**THE BIAS HYPOTHESIS**

Because of conscious or unconscious racial bias, perhaps doctors do not offer or prescribe the same services for African Americans and Latinos that they do for whites. For this to be true, the evidence must show that the patient’s race and ethnicity are at times such strong influences on the doctor’s clinical reasoning and recommendations that they override the effects of diagnosis and illness severity. We believe that most doctors strive to keep their clinical work free of bias. Yet social psychology research documents that bias can occur without intention or recognition, and that certain situational factors, e.g., working under time pressure, can boost the effects of racial or gender stereotypes. In a widely quoted 1996–97 study, doctors who did not know the research question viewed videotapes of simulated patients using scripted symptom descriptions whose clinical characteristics were held constant but whose race and gender were varied. Doctors were somewhat less likely to refer African-American women for cardiac catheterization than white men. African-American men, and white women. Although the effects were small, these findings establish that skin color and gender can influence doctors’ diagnostic and test-ordering proclivities. Moreover, other things besides skin color, e.g., the physician’s perceptions about the patient’s social class and education, may lead to bias on the part of the physician. Nonetheless, the effects of bias have been small in empirical studies to date. Racial and ethnic disparities in the use of services requiring a doctor’s referral are large, and unlikely to be solely attributable to racial bias.
THE PREFERENCES HYPOTHESIS

Perhaps African Americans and Latinos choose to forego certain services and their potential benefits because of personal preferences and values rooted in their race and ethnicity. Few studies have directly assessed preferences, but their findings do not indicate African Americans systematically prefer fewer services compared with whites. African Americans are more likely than whites to seek mental health services for depression,¹¹ and want more aggressive end-of-life care than do whites.¹² On the other hand, African Americans may be more averse than whites to surgical risks, although we are aware of only 1 study that has explored this.¹³

The assumptions underlying the preferences hypothesis are dubious. Even if doctors make the same recommendations to all patients who have the same condition and illness burden (which is challenged by evidence reviewed above), the assumption that patients’ values and preferences impel them to follow or not to follow doctors’ recommendations directly implies that patients are informed decision makers. However, an abysmal 9% of clinical decisions met reasonable criteria for informed decision making in a 1993 study of 1,057 audiotaped medical interactions.¹⁴ The ethical model of informed decision making requires intense dialog between doctor and patient.¹⁵ Such dialog may be more problematic for African-American and Latino patients, because with minority patients, doctors have poorer interpersonal skills,¹⁶ provide less information,¹⁷ and use a less-participatory decision-making style.¹⁸–²⁰ It is unlikely that patients’ preferences are the driving force for racial and ethnic disparities in health care use and outcome.

THE COMMUNICATION HYPOTHESIS

Not surprisingly, communication behaviors during the medical interaction influence patient satisfaction,¹⁶,¹⁸,²¹–²³ adherence to the doctor’s recommendations,¹⁶,²⁴ and the likelihood of malpractice claims.²⁵ What is surprising, at least to some doctors, is the evidence tying good communication during the medical interaction to better disease outcomes. In a study of urban, indigent people with high blood pressure, those who gave more information to their doctor about their history and symptoms had lower blood pressures 4 weeks after the visit.²⁴ An Ontario study showed that the probability that a main symptom would resolve in 2 weeks was related to the extent the doctor allowed the patient to express symptoms, expectations, thoughts, and feelings.²⁶ More powerful evidence comes from a set of studies in which patients were randomized to a previsit coaching session on how to ask questions and negotiate with their doctor.²⁷–²⁹ Compared with non-coached, disease-matched controls, intervention patients with peptic ulcers had better functional status gains, diabetics had greater functional status and lower hemoglobin A1c levels, and women undergoing chemotherapy for breast cancer reported fewer medication-related symptoms, 6 to 12 weeks after the visit.

What is it that goes on during a medical interaction that can explain these phenomena? In a conceptual framework drawing from the disciplines of anthropology, communication sciences, medicine, social psychology, and sociology (Fig. 1), the anthropological concept of the “explanatory model of sickness,” first brought into medical practice by Arthur Kleinman,³⁰ plays a key role. The explanatory model of sickness is a conceptual construction that explains clinical phenomena. Both the patient and the doctor have one, and although they appear to include the same domains (cause, symptom onset, control and meaning, pathophysiology, prognosis and course, treatment), their content varies substantially. To quote Kleinman, “modern [Western] physicians diagnose and treat diseases (abnormalities in the structure and function of bodily organs and systems), whereas patients suffer illnesses (experiences of disvalued changes in states of being and in social function).” Explanatory models are products of national culture, racial and ethnic culture, gender culture, occupational and professional culture, education and knowledge, social class, religious beliefs, and personality traits.

Explanatory models are important because they drive behavior.³⁰ The doctor’s model drives his or her clinical behavior, i.e., the formulation of a differential diagnosis and a diagnostic and therapeutic plan for the patient. The patient’s model drives his or her illness behavior: the monitoring and interpretation of bodily symptoms, decisions to seek formal or informal care, and decisions to follow recommended treatment plans. Because explanatory models drive behavior, the key activity for the doctor and the patient during the medical interaction is to achieve an understanding of one another’s perspectives and develop some degree of congruence between their explanatory models. Congruence may be a necessary although insufficient precondition for trust, satisfaction, respect for preferences, adherence with recommendations, salutary self-management behaviors, and mutuality in the way treatment outcomes are evaluated. “Hypertension” is an example of a label that often evokes different explanatory models in doctor and patient. The patient who believes excessive stress causes elevated blood pressure may feel he or she needs a sedative rather than a blood pressure pill and will find it difficult to share the doctor’s enthusiasm for dietary salt restriction. Other everyday examples of incongruent models include patients’ requests for antibiotics for viral upper respiratory infections and computed tomography scans for tension headaches.

The development of congruence between the patient’s and doctor’s explanatory models for the patient’s sickness depends on the effectiveness of communication during the medical interaction. Because patient and doctor come from different cognitive and value orientations, to develop a shared model they must elicit information from each other,