Minority Perceptions of Healthcare

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Patient empowerment, or the degree to which patients are made a full partner in decisions regarding their own health care, has been, and remains, a major topic of discussion among healthcare providers (Candib, 1994). It has also been shown to be a major factor in determining patient responses to their healthcare (Du Pre, 2000). Yet, the ways that patients respond to efforts to offer them partnership in the decision-making process may be determined by perceptions based more on prior experience and cultural expectations than on intentional attempts at empowerment by the healthcare provider. This study was designed to investigate the role these two elements, prior experience and cultural expectations, may play in determining a patient's response to physician communication patterns as they relate to empowerment.

Prior experience, including the development of one's locus of control or sense of mastery over the environment and self-directed changes in health and in other areas of one's life, is examined here as a determinant, to some extent, of one's understanding, investment, motivation, and compliance with health care and health treatment. Arising from one's individual experience, cultural expectations are seen as an important issue in current health care education and practice, as widespread attempts to include a multi-cultural understanding of medical, health prevention, and rehabilitation clientele are indicated by the increasing inclusion of multicultural issues in research and literature. A greater understanding of the patient's prior individual experience and one's cultural expectations will enhance diagnostic accuracy and treatment planning. Additionally, this will allow the clinician to incorporate the patient's health perceptions and personal health style into the treatment process.

This study examines the experience of the American healthcare system between two distinct minority groups: African Americans and Asian students living in the United States. The study was conducted through survey methodology, using two instruments that measured health locus of control and perceptions of health experiences, respectively. The first is a form of the Multidimensional Health Locus of Control instrument, a widely used and validated instrument (Goldsteen, Conte, & Goldsteen, 1994). Locus of control is thought to be rooted in both culture and in individual experience. The second

instrument used in the survey was a 10-item measure of physician-centered communication, the Health Experiences Questionnaire, which was developed by the authors. This scale offers an overall assessment of the patient's perception of physician-centered communication and may be taken as a measure of the degree to which the patient perceives that he or she has been empowered in the decision-making process of health care.

Physician-Centered Communication

Physician-centered communication is a term used by several communication scholars to indicate an overall concept of interaction between the patient and healthcare provider which seems to be focused more on the needs and desires of the provider than on those of the patient. Overall, this concept has been shown to affect a patient's satisfaction with his or her own empowerment (Balint & Shelton, 1996), and to compose most of the patient's memory of the medical encounter (Rubin, 1993). Physician-centered communication appears to be a multi-dimensional construct composed of several sub-constructs, including physician domination of talk time, physician listening behavior, interruption, condescending behavior by the physician, questioning practices, and topical avoidance.

Du Pre asserts that physicians tend to "do most of the talking, choose conversational topics, and begin and end communication episodes" (De Pre, 2000), and his work points to medical tradition, medical education, and cultural expectations as reasons for this domination. Current thinking and optimal healthcare practice embrace the notion that the patient must be involved to the fullest extent possible in healthcare decision making and in health maintenance (Schraeder & Britt, 2001). The traditional expectation that patients receive health care in a passive manner, and that health care professionals dispense it in an authoritarian and dogmatic manner, does not hold true today. In this climate of patient-oriented health treatment, clinicians must practice in a manner that enhances the patient's ability to fully partner in his or her health regimes.

Listening behavior has been shown to relate directly to the provision of emotional support (Brady & Cella, 1995). Lehman, Ellard, and Wortman (l986) assert that most people in distress, such as medical patients, want to listen and be heard more than they want others to talk or offer advice.

Similarly, interruptions by the physician appear to be interpreted as controlling behavior by their patients. There are a number of studies that support the idea that physicians talk more than their patients (Roter 1989; Roter, Hall, & Katz 1988; Arnston & Philipsborn, 1982). In one doctor-patient interactions study by Beckman and Frankel (1984), patients talked for less than thirty seconds before being interrupted by the physician. Related findings show that physicians expect to ask questions and give directives, not give answers to questions posed by their patients. West (1993) showed that physicians were less

apt to answer questions than their patients. A number of others have shown that physicians tend to ask closed questions, giving the patient little opportunity to raise new issues (Roter, 1989; Coulthard & Ashby, 1975; and Arnston & Philipsborn, 1982).

Healthcare providers often show a lack of respect for patients and their feelings. Often this may involve inappropriate comments or actions (Farber, Novak, & O'Brien, 1997; Todd, 1984). Physicians also have been shown to avoid topics that make them uncomfortable or which are high in emotional content (Suchmam, Markakis, Bechman, & Frankel, 1997). In sum, these behaviors simply involve treating the patient as less than a full partner in the healthcare process, and perpetuate an authoritarian stance that further impedes free flow of communication. Taken as a whole, these behaviors give patients less opportunity to explore areas of concern, thus leading to a possible perception that they are less than a full partner in their own healthcare.

Locus of Control, Culture, and Sense of Self

An important aspect of a client's personality is his or her belief surrounding control over (or ability to manipulate) the environment; this is generally referred to as "locus of control." An individual's locus of control, with regard to health, is commonly described as being "internal" (the individual senses an ability to control destiny), "external-chance" (the individual feels destiny is out of his or her direct control), or "external-powerful-others" (the individual believes his or her fate is controlled by others, such as medical personnel, family, or others (Wallston, 1991). Locus of control in health matters refers to the client's perception of where the responsibility for his or her health lies (Wallston, 1991). Health maintenance behaviors, highly correlated to one's locus of control, are viewed as the set of behaviors that protect and promote an individual's health and prevent illness.

An internal locus of control has been identified as a predictor of depression in individuals experiencing long-term or life-threatening conditions (Wong, Heiby, Kameoka, & Dubanoski, 1999). This latter premise could raise questions as to the source of the depression: Does the internal locus of control itself promote depression, or does the healthcare provider's response to clients who happen to have an internal locus of control promote depressive symptoms? As noted in the preceding section, physician-centered behavior has an effect upon the client's overall perception of full partnership in health care. The authors believe that determining the client's locus of control, then, is important in medical planning, promotion of desirable health behaviors, ongoing assessment and treatment, and can help drive procedural, functional, relational, and professional aspects of the health provider-client relationship.

Little research exists to delineate client-physician relationships in terms of locus of control as a factor in medical planning or in relating a client's locus

of control to the treatment approach. Several studies have identified determinants of health promotion and health practices in Western society; these include locus of control, attitudes toward aging and health, and financial status (Duffy, 1993). However, it is the authors' experience that locus of control is a viable factor in one's ongoing health maintenance efforts, in both realms of physical/medical and psychological well-being. Locus of control has been determined to be important in assessing a client's sense of mastery over the environment, approach to problem-solving, and as a factor in overall life satisfaction (Ashby, Kottman, & Rice, 1998; Janssen & Carton, 1999; Leone & Burns, 2000). The significance of the "powerful-others" locus cannot be overlooked; Pointer-Smith and colleagues concluded that health care is the only area in which older people are likely to show deference to powerful others in an area of personal control (Pointer-Smith, Woodward, & Wallston, 1988).

Despite several studies examining cultural background and locus of control (Armer, 1993; Wallston, Wallston, & Devellis, 1978; Walker, Sechrist, & Pender, 1987), few results point to more than descriptive conclusions surrounding health locus of control, and findings previously attributed to culture might in reality pertain more closely to minority status in a particular population. Interestingly, although health promotion is of great interest in recent studies of diverse, non-mainstream populations that may experience real or perceived isolation or other life stressors (Huck & Armer, 1996), the present study is perhaps the first to examine locus of control as a predictor of the perception of physician-centered behaviors. The different backgrounds of the authors (in communication science and the behavioral sciences), and the experience of both in healthcare communications and client treatment issues, prompt both to perceive the necessity of including an assessment of locus of control in the examination of client-physician interactions.

Method

Locus of Control was measured by use of the Health Locus of Control scale. This scale yields three separate scores by totaling items in each of the three areas of internal locus of control, external-significant-other, and external-random locus of control. The test does not yield an overall score (see Appendix A).

In order to measure physician-centered communication, a questionnaire was developed that was comprised of 10 Likert-type items, which addressed each of the component constructs of physician-centered communication identified above. These components included such constructs as communication dominance, the initiator of communication, interruptions, and condescending or discounting behaviors. The items were scored from 1 to 5 (from low to high agreement), and polarity was reversed on several items in order to achieve consistent scoring and to avoid response bias. The items were simply totaled to

give an overall score for perception of physician-centered communication (see Appendix B).

A questionnaire was prepared consisting of the two tests described above. The questionnaire was submitted to separate samples of African-American individuals who were contacted through a neighborhood community center in a large southeastern city, and to students at a large southeastern University who identified themselves as being from Asian cultures. The questionnaire was submitted to one hundred persons in each sample. Persons in the African American sample were contacted face-to-face while those in the Asian sample were contacted through electronic mail, although the instruments were identical in content and format. Each respondent was asked to fill out the questionnaire in response to the last visit to an American physician or other primary healthcare clinician. Of the questionnaires submitted, 88 usable questionnaires were obtained from the African American sample, while 82 usable questionnaires were obtained from the Asian sample. The resulting data were analyzed using the Statistical Package for the Social Sciences (SPSS).

Results

First the data were submitted to descriptive statistics arranged by culture. A simple observation of the means of the totaled score from the physician-centered communication scale revealed that further analysis by culture was unnecessary. There was no meaningful or significant difference between the Asian and African American samples based on their total score for physician-centered communication. The mean for the African American sample was 28.23 while the mean for the Asian sample was 28.07. Thus, it was concluded that there was no significant difference between cultures with regard to the respondents' perception of physician-centered communication.

It was noted, however, that there was a significant bias in each sample in terms of the proportion of the internal versus external locus of control scores. In the African-American sample, 64.6 percent of subjects had their highest locus of control score in one of the two external categories, while only 35.4 percent had their highest score in the internal category. In the Asian sample, the proportion was quite different. In the sample, 87.7 percent revealed the highest score in the internal category, while only 12.7 percent were in one of the two external categories. This proportional predominance is even more noteworthy when one observes the lack of significance in perception of physician-centered scores based on culture. We thus concluded that differences on physician-centered scores must be explained by another variable.

When the data was re-coded by locus of control, a very different result was obtained. The data was rearranged so that subjects could be classified according to whether one's highest score in locus of control was in the internal category or in one of the two external categories. There were not a large enough

number of subjects in the external random category to make a separate categorization meaningful; thus, the two categories were collapsed into one.

A simple one-way analysis of variance was performed using the category system mentioned above and the total score from the physician-centered communication scale.

This analysis showed that there was a significant difference between internal and external locus of control individuals with regard to their perception of physician-centered communication, $F(1,161) = 8.92$, $p = .003$. The mean was 26.89 for internal locus of control individuals and was 30.28 for external locus of control. These findings clearly indicated that external locus of control individuals, in comparison to internal locus of control counterparts, have a significantly more negative perception of physician-centered behaviors.

Further, an analysis of the descriptive statistics from each category shows that internal and external locus of control individuals were responding to different items on the test. Internal locus of control subjects were above the neutral point of 3.00 only on item number one (mean=3.62). That item dealt with a perception that the physician talked more than the patent. External locus of control subjects were above the neutral point of 3.00 on items 1, 4, 8, 9, and 10. The means for these five items were 3.69, 3.25, 3.28, 3.42, and 3.20 respectively. These items showed that external locus of control subjects not only perceive that their physicians talked more than they did, but also perceive that they are interrupted more often, that the doctor avoided some subjects, that they did not get a chance to mention all of the things they wanted to talk about, and that in general they were not made a full partner in their health care.

To more fully explore the relationship between health locus of control and perception of physician-centered communication, a multiple regression analysis was performed using the total physician-centered score as a dependent variable and the three component scores for health locus of control as predictor variables. This regression analysis was significant, $p = .000$. The regression model showed that in internal locus of control scorers explained the least amount of variance in the dependent variable. High external chance locus of control scores explained the greatest amount of variance, which was followed very closely by external significant other locus of control scores (Table 1). These results clearly showed that subjects scoring higher in the external categories of locus of control had a significantly more negative perception of physician-centered behaviors, and were more likely to feel that they were less than a full partner in their own health care.

Table 1. Predicting Perception of Physician-Centered Communication

Model		B	Adjusted R^2
1	Internal locus of control	.043	.109
	External chance locus of control	.313	
	External significant other locus of control	.234	

Discussion

Taken as a whole, these data clearly indicate that perception of physician-centered communication is more a matter of individual experience than of cultural learning. The explanation, we believe, for the fact that the Asian sample was proportionately more internally located in locus of control, while the African American sample was proportionately more external, is that African Americans in this sample have spent their entire lives as members of a minority group, while members of the Asian sample not only represent a number of different cultures, but have in common the fact that they are not lifelong members of a minority group. (The Asian students, via their participation in an international student organization, from which this sample was derived, were known to be temporary U.S. residents and to have been in the U.S. for a limited time span.) Thus, the subjects in our Asian sample would likely have formed initial perceptions and expectations not as members of a minority but as part of a majority culture. This experience is in fact what sets these subjects apart as a minority rather than their common native culture.

We know that such experiences as long-term, stable, emotional and psychological support have an effect upon one's actual health status, as do a sense of belonging and integration into one's cultural and reference groups. Similarly, one's cultural values and beliefs have an effect upon health status as well as perceptions of health care (Marks & Choi, 2001; Ortega, Stewart, Dowshen, & Katz, 2000).

The ways that individuals perceive their ability to influence and to direct their own health precautions, maintenance, and health recovery, then, are directly related to the individual's experience within his or her cultural background, from which the locus of control evolves. Our findings that locus of control is significantly related to one's perception as a fuller or lesser health partner are strongly supported by these premises.

Assessing the patient's locus of control and healthcare expectations, which according to these data are affected by one's experience as a cultural minority, promotes a client-oriented approach to medical treatment by providing a better understanding of the patient's motivation and perceptions of his or her needs, and the importance that the patient attaches to active participation in the healthcare process. The coping style of adults is also related to an individual's

motivations, beliefs, and attitudes when seeking help such as medical care services, and these variables can be part of the overall assessment and treatment planning. Therefore, one of a physician's (or any health professional's) primary tasks is the careful and thorough evaluation of the patient's beliefs about health status, the presenting of health problems, and the patient's overall sense of capability and competency in health maintenance or recovery. Further, the health clinician must assess the patient's motivation to carry through on recommended diagnostics and treatments, as well as the patient's potential investment of time and effort. This may be particularly important when the patient has long-term experience as a member of a cultural minority.

Direct questions pertaining to the patient's understanding and expectations are imperative, for example. Questions such as "What are your questions or concerns about what we talked about?" can help the clinician assess patient understanding and passive or active stance. Other comprehension-assessing questions will help the physician ascertain the degree to which the patient feels a full partner, enhancing the potential for full disclosure of anxieties, misunderstandings, or other obstacles to treatment compliance.

A third, and more process-oriented series of questions and observations can help determine the patient's expectations, not only of the diagnosis and treatment, but also of the process itself. What role does the patient expect to play? What degree of assertiveness or passivity can the clinician expect? What dependencies or anxieties might impede medical progress? Because early life experience and developmental variation will have influenced all of the above factors, the clinician's best practice is to simply ask these questions of the patient, rather than to assume anything based upon cultural background, socioeconomic appearance, and the like. Following this assessment, of course, the course of treatment can be individually adjusted and refined to meet the patient's needs and to promote optimal treatment effect.

Locus of control is integrally related to the coping style of each individual patient, and might be seen as a basis for the patient's motivation to "take charge" or to await change in a more passive manner. If a patient does not feel that the physician, for example, is engaging in a client-centered approach, he or she may not feel empowered to even ask questions pertinent to the ongoing care and health maintenance, or may anticipate interruption or change of topic. Such behaviors on the part of the physician can, of course, reinforce the patient's expectations and can result in decreasing attempts to partner fully in the healthcare experience.

Because of an aging group of patients in western healthcare facilities (Cavanaugh, 1998), and because there is greater utilization of health care then ever before in our U.S. history, it is imperative that the most effective treatments and treatment relationships be formed to enhance patients' regaining of productivity and functional capacity. It is general knowledge that individuals

tend to value their healthcare very highly, and to be socially and politically active in achieving their needs. Our study affirms that concept, and recognizes locus of control, personal beliefs and values, and patient expectations as contributing factors in the development of minority perceptions of healthcare.

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Appendix 1: Health Experience Questionnaire

Please read each of the following statements carefully. Then circle the response that most closely indicates your own feelings about each statement. All of these statements should be taken to refer to your last visit to a doctor or to some other healthcare facility in which you saw a doctor, such as an emergency room or clinic.

(Strongly agree Agree Am not sure Disagree Strongly disagree)

1. In general, the doctor talked more than I did. In general, the doctor listened to my responses to his or her questions.
2. In general, the doctor took me seriously.
3. The doctor interrupted me often.
4. The doctor gave me adequate time to respond to his or her questions.
5. I sometimes felt the doctor was not really listening to me.
6. The doctor asked my opinion about any course of treatment that was discussed.
7. I sometimes felt that the doctor was avoiding some subjects.
8. I did not get a chance to talk about some things that I wanted to mention.
9. In general, I feel like I was a full partner in my health care.

Age (check one) ___18-25 ___26-35 ____36-45 ____46-55 ____55 or older
Gender (check one) _____Male _____Female
Ethnic identification: _____Asian _____African-American _____Caucasian
_____Native American Indian _____Other

Appendix 2: Multidimensional Health Locus of Control

Instructions: Each item below is a belief statement about your medical condition with which you may agree or disagree. Beside each statement is a scale, which ranges from strongly disagree (1) to strongly agree (6). For each item we would like you to circle the number that represents the extent to which you agree or disagree with that statement. The more you agree with a statement, the higher will be the number you circle. The more you disagree with a statement, the lower will be the number you circle. Please make sure you answer every item and that you circle only one number per item. This is a measure of your personal beliefs; obviously, there are no right or wrong answers.

1=STRONGLY DISAGREE (SD) 4=SLIGHTLY AGREE (A)

2=MODERATELY DISAGREE (MD) 5=MODERATELY AGREE (MA)
3=SLIGHTLY DISAGREE (D) 6=STRONGLY AGREE (SA)

		SD	MD	D	A	MA	SA
1.	If I get sick, it is my own behavior which determines how soon I'll get well again.	1	2	3	4	5	6
2.	No matter what I do, if I am going to get sick, I will get sick.	1	2	3	4	5	6
3.	Having regular contact with my physician is the best way for me to avoid illness.	1	2	3	4	5	6
4.	Most things that affect my health happen to me by accident.	1	2	3	4	5	6
5.	Whenever I don't feel well, I should consult a medically trained professional.	1	2	3	4	5	6
6.	I am in control of my health.	1	2	3	4	5	6
7.	My family has a lot to do with my becoming sick or staying healthy.	1	2	3	4	5	6
8.	When I get sick, I am to blame.	1	2	3	4	5	6
9.	Luck plays a big part in determining how soon I will recover from an illness.	1	2	3	4	5	6
10.	Health professionals control my health.	1	2	3	4	5	6
11.	My good health is largely a matter of good fortune.	1	2	3	4	5	6
12.	The main thing which affects my health is what I do myself.	1	2	3	4	5	6
13.	If I take care of myself, I can avoid illness.	1	2	3	4	5	6
14.	Whenever I recover from an illness, it's usually because other people (for example, doctors, nurses, family, friends) have been taking good care of me.	1	2	3	4	5	6
15.	No matter what I do, I'm likely to get sick.	1	2	3	4	5	6
16.	If it's meant to be, I will stay healthy.	1	2	3	4	5	6
17.	If I take the right actions, I can stay healthy.	1	2	3	4	5	6
18.	Regarding my health, I can only do what my doctor tells me to do.	1	2	3	4	5	6