The Patient-Physician Clinical Encounter

Thea James, MD

Abstract

The success or failure of clinical outcomes depends upon specific steps and variables that present during the clinical care process. As healthcare providers, we can control some of these steps and variables, but not others. The most important step in the clinical care process is the patient-physician clinical encounter or "what occurs in the examination room." We ***can*** control this most important and sensitive step. For emergency physicians, the clinical encounter represents an even greater challenge; we have only one window of opportunity to make a solid connection and produce a successful encounter. The provider may not know when a failed clinical encounter has occurred, but the patient **always** knows. The clinical encounter affects trust, patient comprehension, and follow-up, all vital for a positive clinical outcome. Successful encounters are thus valuable/important opportunities for the clinician.

Health providers are responsible for establishing an environment for successful clinical encounters. In the examination room, patients are on the physician's turf as an equal partner and a guest and must be treated as both. The goal of the clinical encounter is to establish trust, to educate, and to increase the likelihood for patient follow-up and compliance. This chapter presents background information to support the significance of successful clinical encounters. The chapter will identify commonly-adopted norms and pitfalls physicians can experience and stress necessary cautions and levels of awareness that can aid in avoiding unintentional actions that perpetuate cycles of partial effectiveness and that lead to suboptimal outcomes. The chapter offers five elements for a successful strategy to achieve a positive patient-physician encounter in the examination room:

Summary Points

1) Be Aware of a Bi-Directional Culture
2) Establish a Partnership: Respect
3) Provide Education: TEACH the Diagnosis
4) Make the Deal (offer a partnered treatment plan)
5) Seal the Deal ("When you leave and someone asks you what the doctor said, what will you tell them?")

Introduction

One of the greatest challenges in the clinical practice of Emergency Medicine is to engage and connect successfully with each patient. The clinical encounter between physician and patient is a vital "first impression." It is the best opportunity the physician has to establish a positive relationship with the patient that will result in good follow-up, egalitarian access and care, and ultimately positive health outcomes. Certain barriers can unfortunately impede that successful clinical encounter. In today's diverse society, culture is a natural initial barrier. A multicultural physician and patient population present a dual and sometimes formidable barrier when providing appropriate and equal healthcare access. Important cultural considerations include race, ethnicity, language, religion, sexual orientation, gender, and social constructs.

Discussion

Culture and the Clinical Encounter

The definition of culture applies to patients and also physicians. The different cultures present in these two groups affect both parties when they begin a clinical encounter and become the lens through which each party views and interprets the other. Penetrating the barrier created by this "elephant in the examination room" requires a keen awareness of all the active elements actually present in the examination room during the patient-physician clinical encounter. These elements include bidirectional culture, social constructs, stereotypes, biases, competence, power and a level of patience. The most important element for physicians, however, is bidirectional culture, which means to understand that both patients AND physicians have a culture that always accompanies them to any joint clinical encounter.

Perceptions, ideas and beliefs held by members of the public accompany these individuals as they navigate through the world and their daily activities. It is logical then that these opinions would also accompany them into the examination room. Medical literature is rife with research that reveals how this situation can occur [1,4,5,8,14,16,17,20,22].

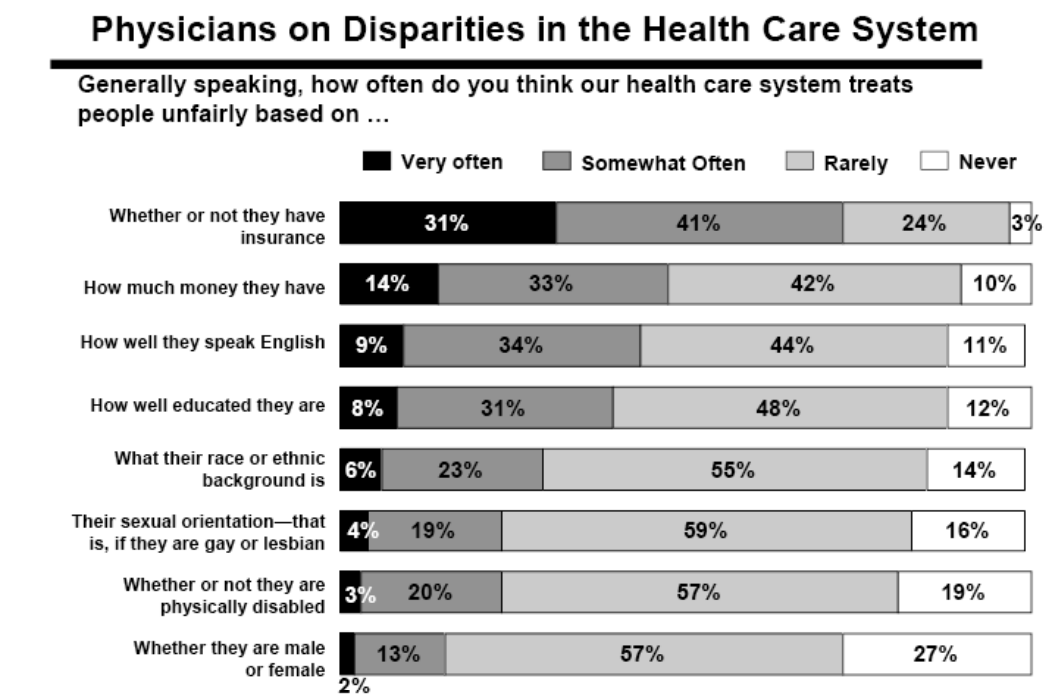
One example of research that reveals public opinion about the healthcare system in the United States is The Commonwealth Fund Study of 2001.[1] This was a Health Quality Survey whose purpose was to query patients about healthcare, health beliefs, access to healthcare, and language barriers to that healthcare. Survey respondents represented four ethnic groups: White, Latino, African American, and Asian. In the study results, minorities were more likely to answer "yes" to "the likelihood of being treated with disrespect", said they "would receive better care if they were a different race," that "staying healthy is luck", and indicated they "have greater difficulty communicating with physicians."

Another study, the Kaiser Family Foundation National Survey of Physicians 2002 [2] showed that physicians' opinions are not necessarily different from those of the public. Asian, Latino, White and African American physicians were surveyed. In their perspectives on healthcare, namely causes, unfair treatment, equitable access, insurance and language barriers, the physicians' opinions mirrored those of the public. "Physicians of different races and ethnicities tended to perceive disparities in the healthcare system very differently." African American physicians and, to a lesser extent, Latino physicians were more likely than White or Asian physicians to believe that people were "somewhat often" treated unfairly based on various characteristics, with differences regarding race and ethnicity being most notable. "White physicians were less likely than minority physicians to blame doctors' assumptions about minorities ability to pay, and more likely to instead believe this happens because minorities live in areas with few healthcare providers. This study showed that, even when querying physicians, not unlike the general public, study responses varied based upon race and ethnicity. This reflects individual physicians' culture, personal experiences, and professional experiences as they walk through the world. These experiences shape their perspectives (on questions asked in the survey) and become the lens through which they view the world.

The responses by physicians that attributed disparities in the healthcare system to patient demographics reflects the use of race as a proxy for class.[11] This quick classification can lead to abbreviated history-taking and a less than thorough

investigation, leading to potential poor decision-making. Examples of the misappropriation of race for class, and culture for formulating ideas and decisions about health are the following. In the United States, Black people are disproportionately poor, however two-thirds of Black people are not poor.[12] Of poor people in the United States, two-thirds of them are White. In other words, in the United States, not all Black people are poor and most poor people are White. Similarly, assumptions about behavior, health and culture of patients based upon race are a misappropriation. In another example, misappropriation of race can misdirect physicians in the way health, disease and treatment is interpreted. People of the same race do not necessarily have the same culture. South-Paul described diverse infant mortality rates and perinatal outcomes among African American mothers living in the United States and recent immigrant Black mothers in the United States from Africa. When the two groups are compared, the African American mothers have poorer outcomes than the immigrant mothers raised in Africa.[12] These outcomes are more suggestive of social factors than they are of race to explain health.

Chart 1

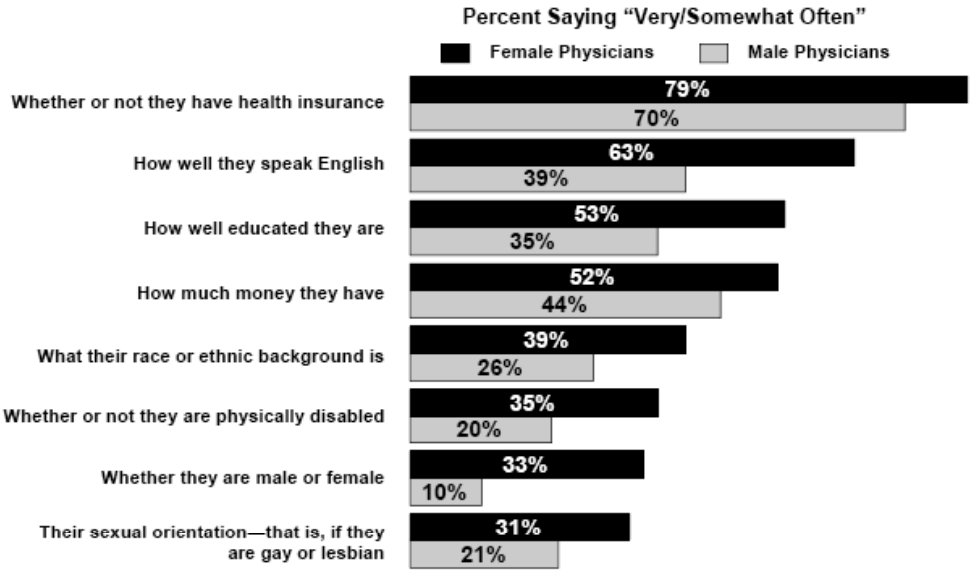


Note: "No answer" not shown
Source: Kaiser Family Foundation, *National Survey of Physicians*, March 2002 (conducted March-October 2001)

Chart 3

Female and Male Physician Perspectives on Disparities in the Health Care System

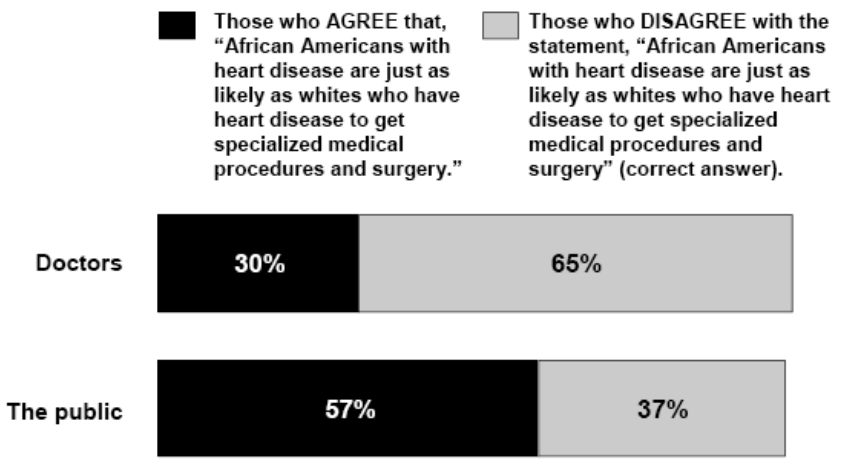
Generally speaking, how often do you think our health care system treats people unfairly based on …



Source: Kaiser Family Foundation, *National Survey of Physicians*, March 2002 (conducted March-October 2001)

Chart 5

Specific Racial Disparities in Heart Disease Treatment



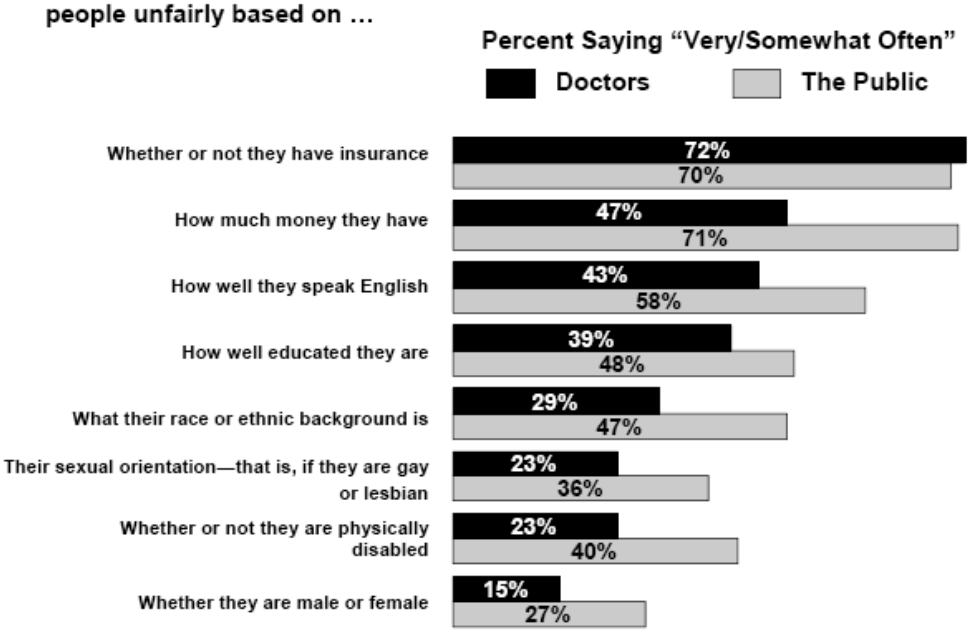
Note: "No answer" not shown

Source: Kaiser Family Foundation, *National Survey of Physicians*, March 2002 (conducted March-October 2001); Kaiser Family Foundation, *Survey of Race, Ethnicity and Medical Care: Public Perceptions and Experiences*, October 1999 (Conducted July-Sept. 1999)

Chart 4

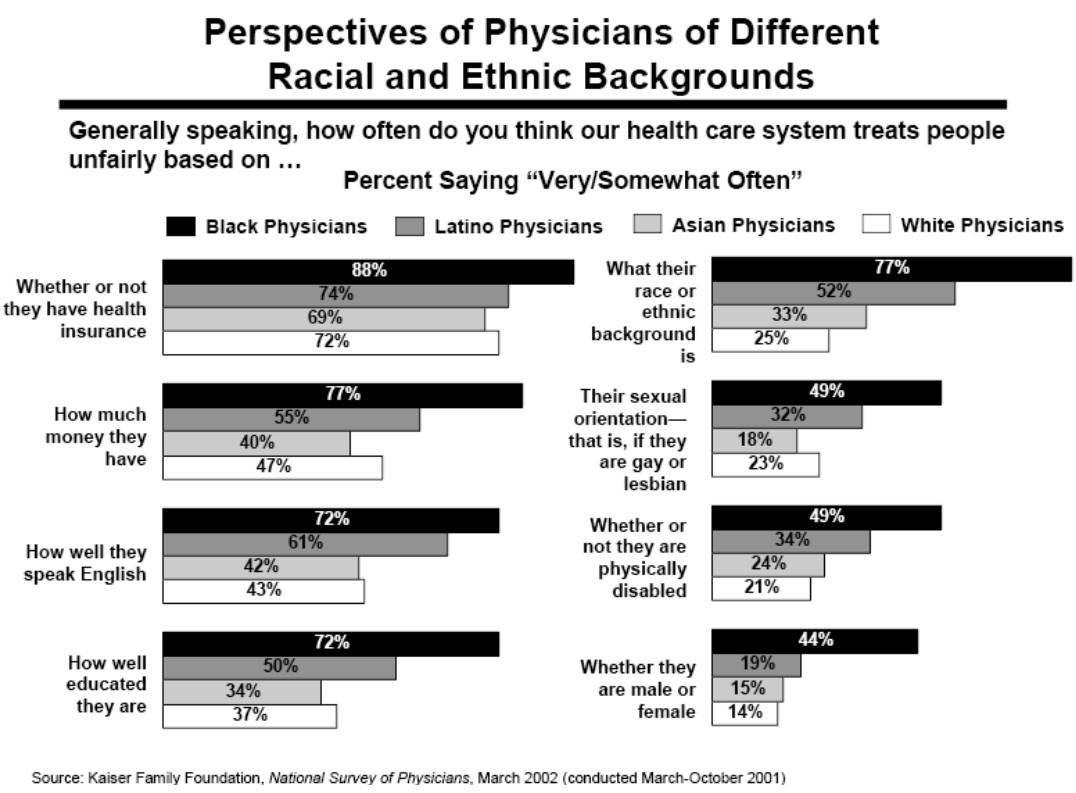
Disparities in Health Care System

Generally speaking, how often do you think our health care system treats people unfairly based on …



Source: Kaiser Family Foundation, *National Survey of Physicians*, March 2002 (conducted March-October 2001); Kaiser Family Foundation, *Survey of Race, Ethnicity and Medical Care: Public Perceptions and Experiences*, October 1999 (Conducted July-Sept. 1999)

Chart 2



Source: Kaiser Family Foundation, *National Survey of Physicians*, March 2002 (conducted March-October 2001)

When respondent answers to questions in the Kaiser survey were examined according to gender, overall, female physicians were more likely to answer "very often or "somewhat often" to items in the survey about whether disparities in the healthcare system actually happen.[2] When answering the question about "whether the healthcare system treats people unfairly based upon English fluency, educational status, and monetary resources, male physicians were more likely to answer "never" or "rarely." On the other hand, female physicians were more likely to respond that disparities in healthcare can happen "somewhat often" based upon English fluency, gender, level of education, and whether a person is disabled. The Commonwealth Fund Study 2001 and the Kaiser Family Foundation National Survey of Physicians Study Part 1 are important examples of how patients and physicians BOTH have their own cultures, (beliefs, perceptions, and values), and that culture determines how members of each group interpret the world they live in and experience and observe it.[1,2] They are active elements in the patient-physician clinical encounter and serve as the foundation for the examination room dynamic.

Other studies explore very specific elements of the clinical encounter. These studies examined specific elements of the patient-physician clinical encounter and investigated additional topics, such as disparities in patient-satisfaction based on race, ethnicity and gender. Examples from these studies examined physician verbal and non-verbal communication, physician information-sharing, patient perceptions of physician respect, and physician participatory style.[5,8,13,14,17,18,22]

Such patient satisfaction studies are more likely to evaluate patient perspectives and opinions of physicians, the most sensitive and defining element of the clinical encounter. A study of participants' ratings of male physicians who varied in race and communication style was conducted using videotape.[13] Participants viewed videotapes showing varied races of physicians and the physician's non-verbal behavior (expressing concern or distance toward a patient), and then completed a questionnaire evaluating that physician. In the results, non-verbal concern was associated with highest satisfaction, trust, self-disclosure, recall of information, likelihood of recommending the physician, and intent to comply with the physician's recommendations. These results suggest that social skills are more important to patients and shape their perceptions of physicians indeed more than does race. Non-verbal communication might be interpreted and measured as a level of respect by minority patients.

A study that investigated how patient and physician race/ethnicity and gender was associated with physician participatory decision-making style. African American patients rated their clinical encounters as less participatory than did White patients. However, race concordance or patient-physician same race/ethnicity significantly increased the reporting of decision-making styles being more participatory.

Patient Observations and Interpretations of the Healthcare System

The Institute of Medicine Report (IOM) of 2002 was the result of a Congressional-mandated study. Congress charged the IOM with conducting a study to "assess the extent of disparities in the types and quality of health services received by U.S. racial and ethnic minorities and non-minorities; explore factors that may contribute

to inequities in care; and recommend policies and practices to eliminate these inequities."[27] The IOM found that minorities were less likely to receive the most sophisticated treatment for multiple diseases; HIV (anti-retroviral therapy), Renal Failure (kidney transplantation), coronary artery disease (coronary bypass surgery and angioplasty), cataract surgery, total joint replacement surgical procedures, and other medical interventions. The IOM report concluded that reasons for healthcare disparities were: 1) the organization and operation of healthcare systems administratively, 2) "patients' attitudes and behaviors," and 3) "healthcare providers' biases, prejudices, and uncertainty when treating minorities." One study was conducted to examine patients' attitudes and behaviors as a potential cause for racial differences in access to appropriate care. Ayanian et al examined how patients' preference affected access to renal transplantation. The authors of this study found that "Black patients were less likely than White patients to want a kidney transplant, to be very certain about this choice, and to expect that their quality of life would improve with transplantation." Blacks were also more likely to report that they had not received all of the information they needed from their nephrologists, and less likely to report that they had been knowledgeable about transplantation prior to beginning dialysis. Black patients also were less likely to report that a kidney transplant had been recommended to them by a physician. The findings in this study suggest failed communication in the examination room and likely lack of trust by Black patients. It is not clear whether Black patients lack trust in physicians or lack trust in the healthcare system. However, the result is a failed clinical encounter and less effective treatment, with potential poorer outcomes. Improved communication through gentle probing might reveal answers as to why patients refuse more sophisticated treatment, and whether they want something different to help them make decisions.[31] In African American culture, lack of trust in the U.S. healthcare system has been shaped by the Tuskegee Study. This study, conducted in Macon, AL for 40 years, deceived nearly 400 African American male sharecroppers who were diagnosed with syphilis. The sharecroppers were told (and they assumed) that they were being treated for "bad blood"; however the infected sharecroppers were in fact not being treated. For decades they lived with untreated syphilis. Physicians and officials of the United States Public Health Service intentionally denied treatment to these patients. This history is well-known in

African American communities and has shaped their attitudes and beliefs towards physicians, the government, and medical research.[30] African American patients enter clinical encounters, with an awareness of history, which has created suspicion and fear of being guinea pigs in this population.[30,32] This barrier can potentially impede trust, and effective treatment.

Further investigation beyond those data reported in the renal transplantation study by Ayanian et al is needed to fully comprehend all factors involved in why patients might refuse more effective treatment. Investigation can begin in the examination room. Physicians can probe further to find out why a patient might refuse an affordable higher level of treatment.

The following are examples of patient interpretations of individual clinical experiences and the overall nature of the healthcare system. The examples come from the ***Institute of Medicine Report on Health Care Disparities 2001***:

- **Healthcare System Organization and Operation can lead to differences in care:**

The doctor comes in and says, "Why is he on oxygen?" I was recovering from surgery. He's looking at the chart and he says, "The insurance doesn't cover it. Take it off." Just like that. I'm right there, and I'm thinking "Wow, that's pretty harsh if it comes from a doctor." That was unfair I thought. **(Hispanic focus group participant)**

The patient in this quote is reacting to the physician's behavior. The physician is making a decision based upon the patient's limited health insurance coverage. The physician's behavior communicates a lack of compassion and a lack of respect for the patient, as well as a lack of professionalism.

The quote from this patient becomes the perception that the patient will take into the examination room. This perception then becomes a potential barrier and is likely to influence the clinical encounter in a negative way.

PREJUDICE IS NOT ALWAYS RECOGNIZED OR DELIBERATE

> ***If you speak English well, then an American doctor, they will treat you better. If you speak Chinese and your English is not that good, they would also kind of look down on you. They would [be] kind of prejudiced.*** **(Chinese-American focus group participant)**

The above patient perceives language as a barrier to that patient gaining respect from a physician and becomes a potential barrier to a successful clinical encounter.

The above quotes reflect some specific patient experiences and perceptions of the American healthcare system. These perceptions will create barriers in the Emergency Department because patients bring these opinions with them when they enter the examination room. They then face healthcare providers in an emergency department circumstance where precise care can be needed quickly and communication is vital. The challenge of the ED physician is to remove any barriers and work toward the ultimate goal, which is achieving a successful clinical encounter.

Culture and Epidemiology: Influence on Clinical Encounters

Epidemiology shapes clinicians' approaches to disease prevention and treatment. However, culture ideology also impacts epidemiology, creating barriers to identifying the true etiology of disease. In exploring racial ideology and the explanations of health inequalities among middle class Whites, Muntaner found that "White Americans tend to attribute their own health to a lifestyle choice and to biology rather than to social factors. This perspective lacks a broader and more rigorous epidemiologic investigative approach, and can therefore " profoundly affect the types of questions that are addressed in epidemiology and public health research." This approach is based on a very narrow segment of a diverse population, and assumes a homogeneous standard of living, access, and opportunity for everyone. "In the clinical encounter, this view can negatively impact

physician decision-making and the treatment of chronic and acute disease. A doctor attributing a patient's disease or illness to lifestyle choices, and failing to explore all possible etiologies thoroughly will most likely result in a stagnant disease state for the patient, because the true complexity of disease remains unexamined. Historical epidemiologic studies in the United States report a disproportionate prevalence of hypertension among Black people. Minorities are also deemed more likely to be non-compliant. Consider a physician who briefly encounters a Black patient for the first time in the examination room. The patient has been diagnosed with hypertension and the physician prescribes medication to treat the patient's hypertension, without further investigation. When the patient returns for subsequent follow-up visits without improvement in his blood pressure, his physician might suspect that the patient is "non-compliant". The physician reflects on the prevalence of hypertension among African Americans. He assumes that the patient has hypertension because he is Black so he will continue to screen Black patients for hypertension without further investigation. There might be several explanations for the patient's condition not improving, such as diet indiscretions, social stressors, financial constraints affecting medication affordability or other barriers. Assumptions preclude appropriate intervention.

"The way in which epidemiology is studied in this country has affected the manner in which we study disease," says Dr. Camara Jones, a physician, epidemiologist, and the Research Director for the Center on Social Determinants of Health at the Centers for Disease Control. She states "Race–associated differences in health outcomes are routinely documented in this country - yet the true reasons for differences remain poorly explained. Instead of vigorously investigating the basis of differences in healthcare outcomes, we tend to simply adjust for race in our analysis or restrict our studies to a single "racial" group." Information gathered from traditional "abbreviated" epidemiologic studies is thus perpetuated and used by physicians in their clinical practice. This practice adds fuel to the degree of failed clinical encounters because the necessary answers for an epidemiologic basis of disease based on race are never fully explored in order to benefit minorities. Decision-making, therefore, becomes based more on

abbreviated investigations, resulting in flawed and incomplete information given to patients and less than opportune diagnoses.

Common Pitfalls of Patient-Physician Encounters

Stereotyping: A Self-Fulfilling Prophecy

Stereotyping is one common pitfall that occurs in the clinical encounter. Conscious or subconscious stereotyping about whether patients will comply with treatment plans and follow up with appointments can convey the message that the doctor does not expect the patient to cooperate. This expectation then becomes a self-fulfilling prophecy for the patient. If a physician does not believe the patient will comply with a higher standard of care, the decision-making process will choose a lower standard of care. This is not unlike education. When teachers believe that students are low achievers, teachers will set the bar for achievement at a lower level, will teach at that level and the level of achievement will be comparable.

These unconscious pitfalls continue to occur and impede successful clinical encounters and positive clinical outcomes. Studies have shown that Black patients with acute myocardial infarction are less likely than Whites to receive coronary interventions. *The Institute of Medicine Report (IOM) 2002* found that significant, consistent, and rigorous research demonstrated disparities in healthcare and decision-making by race, even when insurance status, income, age, and clinical profiles were comparable. Hypothetically, this means that, if a physician has two patients who are Supreme Court Justices, the patients have identical clinical profiles. Hypothetically, both patients have coronary artery disease with identical coronary artery lesions in the same location and they have identical symptoms. Hypothetically, the physician refers the White patient for Coronary Artery Bypass Grafting. The physician recommends medical management (taking pills) for the Black patient. This research (IOM Report) indicated that minorities in America were more likely to receive a lower quality of healthcare services. The IOM Report attributes these disparities in treatment to multiple causes. 1) the organization and operation of healthcare systems administratively, 2) “patients’ attitudes and behaviors,” and 3) “healthcare providers’ biases, prejudices, and uncertainty when treating

minorities." Raising awareness of physicians and patients is necessary to avoid pitfalls. Longitudinal studies are necessary to determine outcomes of disparities in treatment.

Dialogue Important in the Examination Room

Dialogue during the clinical encounter should be open-ended and encourage all questions. Such interaction is an opportunity for both the patient and physician to learn more about each other and the healthcare issue. Labeling patients as non-compliant, irresponsible, careless, or unconcerned in lieu of inquiring about the exact causes for failed treatment plans or lack of knowledge to continue them successfully creates a barrier that impacts physician and patient trust. It is most important to avoid making any patient feel either ashamed or inept.

Important questions to ask patients include:

1. I notice that you were not able to take your medication. What would make taking it easier for you?
   What would you say is the reason you were not able to take your medicine?
2. Should we have created a better plan for you? Can you suggest a better plan or how to implement your current plan better?
3. What would you suggest we do to create a plan that will successfully work for you?
4. Here are some suggested options for treatment. Do any of them sound like something you could do easily?
5. What do you think the problem is? Is it the medication, the schedule of care, lack of communication or another issue we can discuss?
6. What do you think is causing your current symptoms?
7. To patients with multiple complaints: "What is the one thing that made you say to yourself, I'm going to the hospital?"
8. Do you have any questions that I can answer today about how you feel now?

Conclusion

The clinical encounter is the most sensitive and important step in the healthcare process. Today, culture is always an active element in the clinical encounter in the examination room. In any examination room, there are at least two cultures actively determining what is heard, understood, and interpreted by both the doctor and the patient. One culture belongs to the patient, and the other belongs to the healthcare provider. It is imperative, therefore, that the healthcare provider be aware of these different cultures, even more so than the patient because the success or failure of the clinical encounter depends most directly on the provider. The provider must connect with the patient, must educate the patient, and of course treat the patient. The patient also is visiting the physician on the physician's "home turf." Hence the responsibility of establishing a comfortable environment has to be the provider's. The healthcare provider is responsible for what the patient takes away from the encounter in the examination room, namely a sense of connection, trust, education, knowledge, empowerment, and most importantly, a sense of compassionate care. The provider is thus responsible for five elements of the clinical encounter: establishing a "safe" environment, providing clinical "ambiance", offering EDUCATION, "making a deal," and "sealing the deal."

Steps to Achieve Successful Clinical Encounters

1. ***Understand the Meaning of a Bi-Directional Culture***
    - Culture is defined as a "shared, learned symbolic system of values, beliefs and attitudes that shapes and influences perception and behavior. It is a "mental blueprint" or a "mental code." Everyone has a culture.
    - Therefore, as the patient and physician face each other in the examination room, they encounter each other by using their respective mental cultural codes as they communicate.
    - Everything that is observed and heard in the encounter is filtered through these respective mental codes or cultures. Be keenly aware of the ongoing nature of this interaction.

- Always try to maintain an awareness of biases and dismiss any prior judgments.

2. ***Establish an Environment of Mutual Respect by Introducing a Partnership***
    - Articulate to your patient that you want to work together so the patient will learn more about and understand his or her diagnosis, and treatment.
    - Articulate that you will work together to create a discharge plan that will be effective.
    - Articulate that the plan will be both convenient and possible for the patient to follow.
3. ***EDUCATE: Teach Both the Diagnosis and the Treatment to the Patient***
    - Educate your patient comprehensively about any diagnosis you offer.
    - Use language and terms that the patient can easily understand.
    - Use simple, clear examples or analogies to help explain complex concepts.
4. ***Make the Deal: Partner the Discharge Planning***
    - Create a discharge plan jointly with your patient. Ask the patient whether the plan is feasible for him or her?
    - Be flexible. Modify/adjust standard treatment plans to accommodate the patient's resources, situation and abilities.
    - Create a plan that the patient is able to understand and follow easily and completely.
5. ***Seal the Deal: Check for Complete Patient Understanding***

    Ask the patient:

    "After you leave, and someone asks you what the doctor said, what will you say?"

    If the patient is unable to tell you what the doctor said, return to Step #3 above and educate the patient further.

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