

The Relationship Between Patient-Centeredness and Cultural Competence Among Primary Care Physicians in the Southern US



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INTRODUCTION

Both patient-centeredness (PC) and cultural competence (CC) could reduce health care inequities.^{1,2} While distinct concepts, they are related,^{1,3} though there is no research exploring their correlation among primary care providers. In order to advance health equity training among health care providers, it is important to examine the correlation between the two concepts. It was hypothesized that there would be a significant relationship between PC and CC among primary care physicians (PCPs); there would be a stronger correlation between PC (caring) and CC than for PC (sharing) and CC; and there would be a relationship between demographic variables and PC/CC variables.

METHODS

Following Morehouse School of Medicine Institutional Review Board approval, a convenience sample of 92 PCPs (family medicine, internal medicine) was recruited in late 2012–early 2013 in the Southern US region. An online questionnaire was distributed to PCPs to test the above-mentioned hypotheses.

PC was measured using the 18-item self-report Patient-Practitioner Orientation Scale (PPOS), consisting of two subscales: (1) *sharing* (shared decision-making/information sharing) and (2) *caring* (discussion of psychosocial issues in medical consultations, treating the patient as a whole person).⁴ CC was assessed using the 25-item self-report Cultural Competence Assessment (CCA), also including two subscales: (1) *CC awareness/sensitivity* and (2) *CC behaviors*.⁵

At the time the research was conducted, Dr. Xanthos was an Assistant Professor at Morehouse School of Medicine.

Prior Presentations The preliminary results of this study were presented as a poster at the Morehouse College Health Disparities Symposium, April 17, 2013, Atlanta, GA.

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Descriptive statistics were computed for the variables of interest; Pearson's correlation analysis was used to test the strength of the association between PPOS and CCA scores; and the scores were assessed for a relationship with the demographics (years since medical school graduation, gender, cultural identity, and previous cultural competence training) using a one-way ANOVA (PASW Statistics 18, SPSS).

RESULTS

The sample consisted of 52 (56.5%) women and 40 (43.5%) men; 58 (63.7%) were White, 18 (19.8%) were Black/African-American, 13 (14.3%) were Asian, and 2 (2.2%) identified with more than one group (Table 1). The average number of years since graduation from medical school was 20.37 and 83.7% of PCPs (77 participants) had participated in CC training (Table 1). The mean PPOS score (patient-centeredness) was 4.88 (highest possible score is 6) and the mean CCA score (cultural competence) was 3.75 (highest possible score is 5).

There was a moderate correlation between PC and CC scores among the PCPs ($r = 0.403, p < 0.0005$). The “caring” element of PC was more closely associated with CC ($r = 0.417, p < 0.0005$) than the “sharing” component of PC ($r = 0.277, p = 0.007$). There was a significant relationship between CC scores and CC training ($F(1,77) = 4.65, p = 0.034$); however, the other demographic covariates did not show an association with PC/CC scores.

Table 1 Demographic Characteristics of PCPs

Variables	N = 92
Years since graduation from medical school, mean (SD)	20.37 (11.17)
Gender, n (%)	
Male	40 (43.5)
Female	52 (56.5)
Cultural identity*, n (%)	
White	58 (63.7)
Black/African-American	18 (19.8)
Asian	13 (14.3)
From multiple races	2 (2.2)
Cultural competence training†, n (%)	
Yes	77 (83.7)
No	14 (15.2)

*There was one missing response for this question

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DISCUSSION

This is the first study to explore the relationship between PC and CC among PCPs, and confirms a modest correlation between the two. The finding that CC was less correlated with PC (sharing) than PC (caring) suggests that CC may be less associated with shared decision-making than with the other aspects of PC. This is supported by the literature^{3, 6} which indicates that CC does not address the sharing of power in the physician-patient relationship (though this is a core component of PC); rather, academic commentary suggests that CC focuses on the acquisition of knowledge about cultural groups.^{3, 6} In short, the literature and study findings indicate that while shared decision-making is a key element of PC, it may not be a universal feature of CC.

Some limitations of the study should be noted. First, the sample size of physicians was relatively small; future research would benefit from a factor analysis of the questions from the PPOS and CCA, using a larger sample. Second, the potential for self-selection bias among the study participants was another limitation; it is possible that physicians who were more patient-centered/culturally competent were more likely to participate in the survey. Finally, participant responses were self-reported, and therefore, it is difficult to ascertain how well these scores reflect the providers' actual behavior and skills.

In order to promote health equity, there is a need for further study of PC and CC concepts, training programs, and curricula. Quantitative and qualitative methods should be utilized to further clarify the two constructs; identify best practices; and determine the effectiveness of training programs on improving health outcomes among diverse populations.

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Compliance with Ethical Standards:

Conflict of Interest: The author declares that she does not have a conflict of interest.

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