EXPLORATORY STUDY ON THE INTERNATIONAL MEDICAL GRADUATE – PATIENT RELATIONSHIP: PATIENT'S PERCEPTIONS OF THE QUALITY OF CARE DELIVERED BY HIS OR HER NON-NATIVE DOCTOR

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Objective: This study examined the influence of social distance upon the patients' perceptions of the quality of care delivered by their non-native international medical graduates (NNIMGs) in an inner-city primary care residency program. Within the inner city, there is a growing trend of NNIMGs providing health care services, thereby creating a situation of maximal social distance with respect to nativity, race, and socioeconomic status.

Design: Two female NNIMG residents, one from India and one from China, were the focus of ten hour-long in-depth interviews with patients who participated in this exploratory qualitative research.

Results and Conclusions: Structural supports, communication processes, and status equalization effects emerged as three self-reported influences on the assessment of care that were particular to their physician's NNIMG status. The physician's NNIMG status seemed to exert a status equalization effect that reduced social distance and subsequently increased the perception of the quality of care. (*Ethn Dis.* 2012;22(1):79–84)

Key Words: Quality of Care, Urban Issues, Relationships, Patient-provider, Ethnicity, Race

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INTRODUCTION

The cultural landscape of modern medicine is increasingly more diverse as those with a medical education, and nativity outside the United States, non-native international medical graduates (NNIMGs), become an increasingly larger proportion of those physicians practicing in the United States. In 2007, international medical graduates (IMGs) (ie, non-US medical education) were: 26% of the practicing physicians in the United States; 58% of whom were in primary care; and currently, three of every five first year residents in family medicine.[1]

Non-native international medical graduates are often of a different race, ethnicity, and nativity than their patients who refer to them as my foreign doctor. In 2008, 14% of IMGs were native US citizens; however, India, the Philippines, and Mexico provide medical education to approximately 35% of the total IMG population.[1] With this growing difference in the social characteristics of physicians and their patients, surprisingly little attention has been given to understanding how patients perceive their doctors' differences, especially with regard to nativity, and how that influences their assessment of the quality of care they receive.[2–4] It has been well documented that those who have negative perceptions of their provider relationship are less likely to adhere to treatment protocols or to seek medical attention.[5–7] This article presents an exploratory investigation of the impact of social difference, also referred to as social distance, upon the perception of quality of care within one inner-city clinic.

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THE INNER-CITY CLINIC

The inner-city clinic provides an ideal opportunity to research the impact of social distance. There is a growing trend of IMGs filling in the gap of unmet need for medical services in underserved areas of the country.[1,8] Ideally, NNIMGs provide a safety net function by caring for the uninsured and indigent population in health profession shortage areas. In fact, IMGs are concentrated in areas where there is a higher rate of impoverishment and higher proportion of minority group members, such as urban centers,[9] and other underserved rural and remote practice locations.[10] Of particular interest in this research is the inner-city whose neighborhoods are often characterized by inadequate resources, insufficient housing, substandard schools, and similar factors.

Primary care clinics often provide the only accessible health care within these neighborhoods. The poor, who are disproportionately minority, have be-

come concentrated in the inner city neighborhoods.[11] At these clinics, patients, united in poverty, are frequently cared for by NNIMG residents. Within this urban mélange, national, racial and class differences are maximized within the relationship between predominantly IMG residents, many whom are Asian, all whom represent upper-class aspirations, and their poor White and African American patients. Given the increasing numbers of NNIMGs practicing in the inner-city clinics, our primary research question emerged: what impact does social distance between patients and their health care providers have on the patients' perception of the quality of care delivered?

THE PATIENT'S PERCEPTION

Only recently have researchers become interested in the patient's perception as an important dimension of the assessment of the overall quality of care within the health care system.[12] The Institute of Medicine's (IOM's) definition of quality that has achieved relative consensus[13] is, ''the degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge;''[14] known as STEEEP, a quality health care system involves being: safe (ie, not causing harm), timely (ie, avoiding unnecessary waits and harmful delays), effective (ie, based on sound scientific knowledge), efficient (ie, not wasteful), equitable (ie, not varying in quality because of patient characteristics), and patient-centered (ie, responsive to individual preferences, needs, and values).[14] The IOM definition integrates objective measures of care with subjective perceptions of patients as found in the last of the components of quality health care, patient centeredness. We argue, as do others, that the quality of the health care system cannot be determined without including the patient's perspective.[12]

One reason for the paucity of research is that the perspective of the disenfranchised has been difficult to obtain. The barriers for inclusion of the disadvantaged in research has been well documented[15–17] and include mistrust of research and researchers, transportation, economic restrictions and time constraints. The growing trend to include users of health care in research is premised upon the belief that the knowledge and experience that users bring is invaluable in improving the medical system.[18] This impact of racial, ethnic, social class and nativity discordance between patients in the inner-city and their physicians must be addressed to understand the quality of the health care delivery system within these urban centers.

Another reason for the lack of research attention to this topic is the sensitive nature of articulating difference. It is well-known that participants in research tend toward socially desirable responses.[19–21] Of particular concern to these researchers is whether or not productive and meaningful conversations about nativity differences can occur within the research setting.

Even with these constraints, there has been some limited research to date on concordance that has focused mainly on race. The racial concordance literature suggests that difference or discordance lowers the patient's assessment of the quality of care.[2,22–24] Malat et al[3] demonstrated that 16% and 22% of their sample believed that racially concordant physicians better understood their health problems and would make them feel more comfortable, respectively. However, another study found no difference in trust of providers when comparing racially concordant with discordant patients with HIV.[25]

Some limited research also has included social class and nativity concordance. Social class has been rarely assessed in concordance studies, although Malat[2] attempted to dissect the differences between Whites and Blacks and satisfaction with their health care by introducing socioeconomic status. She concluded that higher socioeconomic status and not racial concordance accounts for a portion of the time difference spent with one's health care provider, a more objective measure of quality of care; however, she did detect an influence of racial concordance and socioeconomic status for Whites' higher respect for their health care providers.[2] Notably, Malat et al[3] found that nearly one-third of their sample believed that US doctors better understood their health problems, however, they conclude with a need for more research on nativity. Overall, a significant percentage of patients do believe that concordance, in general, or nativity concordance, more specifically, is an important determinant of the quality of care. What might be the source of these views?

One controversial belief that may underlie a patient's perceptions of his or her NNIMG is that the quality of care delivered by IMGs is not comparable to their US medical graduate (USMG) counterparts.[26,27] Recent research indicates that the quality of care delivered by IMGs is not substandard and may be superior.[28,29] However, IMGs are still discriminated against in residency program selection processes,[30] perhaps due to the perception of those within the medical community that programs with IMGs are inferior.[31] The presence of IMG physicians may unwittingly contribute to the growing perception of disparity in health care quality between those at the bottom of the social opportunity structure and those higher up. If those in the medical community have negative feelings about the impact of the presence of IMGs on the image of the quality of care being provided, how might their patients feel? For the purpose of this exploratory research, our objectives were quite limited and focused on one question: What are the patient's perceptions about the quality of care delivered by his or her NNIMG physicians? By providing a voice to those disenfranchised patients in the

inner-city, we hope to begin laying the groundwork for an understanding of how difference influences the perception of the quality of care.

RESEARCH METHODS

This research is part of a larger exploratory project on the influence of trust on the physician-patient relationship. Weber[32] asserts that global differences may reduce the chances of the encounter producing the kinds of interaction that result in trust creation, a key component of the doctor-patient relationship[33–35] that influences assessments of quality.

Sampling

We used a purposive and convenient, non-probability sampling design to choose our physicians and patients. The only way in which most patients know of their physician's NNIMG status is through distinct blending of racial (eg, Asian) and cultural traits (eg, an accent indicative of English not being the primary language). For this reason, we chose two female NNIMG residents, one native to China and one native to India who agreed to participate. These physicians did not know which patients were interviewed.

We chose ten culturally and racially diverse patients from the appointment rosters of the two NNIMGs. Our final sample included: six females and four males; four Whites, five Blacks, and one Native American; all were of lower socioeconomic status; four had a high school education, three had less than a high school education, two had more than a high school education, and one had completed a four year college degree; and, finally, one was in her 20s, four were in their forties, two were in their fifties, two were in their sixties and one was in her seventies.

One of the major limitations of this research is the small sample size. This sample indeed may not represent the range of perspectives about nativity and quality of care, with self-selection being a strong possibility. However, we chose to stop, or should we say pause, at this point because of the wealth of information in the ten interviews that were completed. By no means did we believe we had reached theoretical saturation,[36] but we did have a wealth of data, enough to begin laying the ground[37] for understanding difference and quality of care.

Human Subjects Review

This research received IRB approval from the primary researcher's university and from the medical center that housed the residency program. Informed consent was obtained from each patient and they received forty dollars to participate. The participating physicians were not allowed access to the interviews.

The Setting

Situated in a very poor neighborhood in a small city, the hospital affiliated clinic, wherein the patients received medical care and participated in the interview, housed the family medicine residency program. In 2000, within this urban census tract within this metropolitan statistical area, 32.2% of the population aged >25 years did not have a high school diploma, 88.6% were native born, 51% were White, 51.4% were not in the labor force, and 39.2% of the families lived below the poverty line. Clients who frequented this clinic reflected the diversity of the surrounding neighborhood.

The Interview

We used as qualitative, inductive research methodology to design and conduct an hour-long in-depth interview with each patient. By using the in-depth interview, we hoped the voice of those who utilized the clinic would emerge. Previous studies on concordance had focused mainly on a questionnaire-based survey, whether computer assisted,[25] face-to-face,[2] or telephone.[3] The focus group was also used.[38,39] We chose the in-depth interview with the hope that we could go "below the surface." The interview was audio recorded, transcribed, and uploaded into NVivo 8 for analysis. We followed a standard data analysis protocol which required thematic and relational categorization. The interviewers were an African American woman and a biracial (ie, Caucasian and Asian) woman.

Measuring Quality of Care

These researchers were interested in the patients' perception of the quality of care as indicated by the perceived competence of their physicians. In order to investigate the topic of the physician's differences and how that affected the quality of care, our primary interview question was: Your physician is from _____. How do you think that affects her ability to take care of you? The interviewer allowed the participants to lead the interview in the direction they desired, following up with probes and further questions as appropriate.

RESULTS AND DISCUSSION

Although the research interview covered the topic of trust in general, the reporting of our exploratory results is narrowly focused on those responses that referred to their physician's NNIMG status or were explicitly evoked by the interview prompt indicated above. Preceptor support and the difficulties of articulating race provided the context of this research.

Perceptions of the Quality of Care

All of the patients rated their trust in their physicians quite high, except for one patient whose first visit with her physician did not go well due to a disagreement about medical treatment. This high rating is not uncommon in studies of patient satisfaction. For example, Malat[2] reported 94.7% and 86.6% of her overall sample rated as

excellent or good measures of treatment with "dignity and respect" and "spent enough time," respectively. Whereas the patients' ability to accurately assess their physician's competence is uncertain, it was clearly communicated during these interviews that the patients believed that they could accurately make that assessment. The idea of preference of NNIMGs appears to contradict the literature on concordance[3] that suggests people prefer a physician of their own race, although, among our participants, this preference was for NNIMGs rather than American doctors. In the overall interviews, three foci emerged in the assessment of quality from the patient's perspective that seemed particular to the physician's NNIMG status: structural support, communication, and status-equalization.

Structural Support

Knowledge that the IMG had to undergo training and testing provided assurance to patients on the quality of care they were receiving. Again, increasing the visibility of the structural support given to assure quality IMG residents to patients is an important practical insight. Changes by the Educational Council for Medical Graduates (ECMG) that included taking the same medical knowledge exam of US medical graduates (USMLE), passing a standardized English language proficiency test (TOEFL or the ECFMG English test), and taking a clinical skills assessment (CSA) have increased the standards for IMGs to practice in the United States.[30]

Communication

A well-known issue surrounding the care provided by IMGs whose native language is not English is the ability of the patient to understand. Medical jargon provides many obstacles to understanding for most patients with limited medical education, however, understanding a foreign accent places additional strain on the communication process. In general, the ability to adequately communicate seemed to be an underlying concern even if it was not realized openly at this particular clinic. Communication skills are necessary for building rapport and go far beyond technical understanding as NNIMGs struggle to understand more subtle meanings evoked by their patients.[40] Competent interpersonal skills, including communication, are critical to maximize patient satisfaction.[41] Increased efforts to screen applicants for English proficiency through the use of standardized exams such as the TOEFL may indeed be having an effect.

Status Equalization

Finally, the most surprising tentative conclusion was that their physicians' differences appear to exert a status equalization effect that reduced social distance. Patient #2, a Black female in her 60s, brings up her physician's difference quite early in the interview before the topic is introduced by the interviewer when being asked about how she chose the clinic and doctor:

> "…Anyway since the last three doctors I've had I just knew that I want from experience of having the other doctors in the past I decided that I wanted a young Indian female doctor."
> "Because they seem to pay more attention to me. Well I had one when I was over to X [another clinic], and she acted like she didn't like the touch of me even, you know what I mean. But they do it because they have to."
> "And when I came here when I talked to the first Indian doctor that I had and all the others including today, they had time to stop and listen and evidently she stops and listens, yet that's why she's so late lately….."

She believed her previous physician did not want to touch her; she also believed that her current physician from India did not seem to have this problem. One message embedded in the perceived unwillingness to touch the patient is that the patient is somehow soiled or dirty, and of lesser status. Being poor may have put her out of reach of her previous physicians, but she somehow now believes that she is indeed touchable by her Asian-Indian physician.

Physicians tend to perceive African Americans and those of lower socioeconomic status more negatively. Van Ryn e al[4] reported that physicians rated those of lower socioeconomic status more negatively on lack of self-control, irrationality, intelligence, compliance, lifestyle choices, career demands, responsibility for family and social support. Burgess et al[42] propose that the time pressure, fatigue, and information overload found in the health care clinic may indeed contribute to cognitive processes that result in stereotypes being manifested in verbal and nonverbal messages, whether consciously or not. When these messages are contradictory, the patient assumes that the nonverbal message is the true one. So, the patient's perception of the difficulty that the physician has with touching her influenced her decisions about her doctor and her perception of the quality of care that she received.

Another patient, a Black male in his 60s(#3), is concerned after first meeting his new physician when he discovers that she was Asian:

> "Whether I should go back or not. And she was a … Japanese or whatever you know. Sort of appeared… Do I want to go back but then I thought to myself, you know, who am I to judge, you know, so."

His uneasiness about having an Asian physician was assuaged by his referencing his own predicament. Judging someone else implies that one knows better than another, or is better than another. Perhaps having been judged oneself, along racial lines, makes this elderly Black man feel that it's improper to do the same. It is not uncommon for

African Americans, as well as Whites, to have prejudices against Asians,[43] what is surprising is that this patient appears to self-identify when deciding to continue as her patient.

Patient #4, a female who was Native American, was pleased about her Asian Indian physician and also thought it was positive. As she stated:

> ''Indian to Indian. I'm Indian. Doesn't affect me at all. I love the cosmopolitan. Please. Because everybody here is from somewhere else anyway. Please. No. [I've never felt uncomfortable.]
> Why should they? I think more of them from the US make me more uncomfortable than the foreign doctors.''

That she should feel comfortable with her Asian Indian doctor and not comfortable with her US doctors supports the racial concordance literature only if one agrees with the patient that being Native American Indian is like being an Asian Indian. That she, a Native American, should feel more similar to an Asian Indian is interesting and indicates that perceived racial concordance may trump national distinctions. Common identity may be a key to understanding how concordance, whether racial or nativity based, generates greater satisfaction with the health care provider.[44]

One White male patient in his 40s (#6) prefers his NNIMG physicians. He explained:

> ''Well I got to say in the situation that they come from with their countries economy and stuff like that and the living conditions. And I know they want to make a better life for themselves and their family and they have to try harder.''
> ''It's not easy. You know, I'm not a minority. Things have been easy for me and for my opinions I use to work in a hospital too. It's just that I find that they seem that they have to push themselves to equal up to you know the white man's world. It's admirable, you know, it really is.''

That his physician should be striving to achieve what he believes he has, an easy life in the United States, is in part based upon stereotypes as many NNIMGs come from wealthy backgrounds. However, he is in a position wherein he has the desired goal – living in the United States as a White man, something that negates his lower status in the United States as being impoverished. This White male patient identifies with the perceived struggle of his NNIMG physician. This identification appears to create perceived concordance where there is actually racial, socioeconomic, and nativity discordance.

SUMMARY AND CONCLUSIONS

Our tentative finding from our exploratory interviews indicates that patients who reflect the inner city milieu do not believe they are receiving poor quality care because of their physicians' NNIMG status. Patients do believe they can judge the quality of the care that they are getting and that this is what should concern them when seeking treatment at their clinic. Probably the most startling finding was that their physician's NNIMG status appeared to reduce the social distance between these impoverished patients who are of different races, nationalities, and social classes than their physician. Being at the low end of the opportunity structure in the United States, patients felt closer in status to their NNIMG physicians who were non-White and of foreign origins than to the most obvious alternative, a White male physician from the United States.

Our tentative finding from our exploratory interviews indicates that patients who reflect the inner city milieu do not believe they are receiving poor quality care because of their physician's NNIMG status.

Clearly, the most obvious shortcoming of this research is its exploratory nature and the small number of interviews. Specifically, the introduction of a potential sex bias by only using two women, and also the introduction of a racial bias by using only Asian physicians must be addressed in a larger research project. However, as with any qualitative inductive study, ten interviews do provide a wealth of data that sets the ground from which to build a coherent theoretical and conceptual approach about the process being studied, clearly just the beginning of a much larger conversation. The next logical step is for further interviews to be performed to more fully mine the topic of the patient's perceptions of difference and how that influences patient outcomes.

The idea that nativity discordance minimizes the effects of racial discordance among inner-city impoverished patients is an interesting one. If this is indeed true, then the increasing proportion of NNIMGs practicing in the inner city may have a positive influence on the perception of the quality of care and subsequently have a positive effect on health care practices. The process of self-identification with another who is clearly different provides a possible mechanism to reduce discordance, thereby increasing the perception of the quality of care.

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