

ARE COMMUNITY HEALTH CENTERS SPACES FOR PATIENT-CENTERED CARE?  
USING INTERSECTIONALITY TO UNCOVER THE QUALITY OF PHYSICIAN CARE  
FOR HISPANIC/LATINX SUBGROUPS

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## Abstract

Community health centers are private non-profits, federally designed to provide quality and affordable healthcare for disadvantaged populations in the United States. Many of these community-based clinics have built into their mission statements, calls for patient-centered care: the practice of respecting a patients' unique lived experiences. As Hispanic/Latinx are one of the largest groups served by this institution, and the largest minority group within the United States, it is vital that academic studies evaluate their quality of care. This paper addresses whether community health centers actively promote patient centered-care for Hispanic/Latinx female and SES subgroups.

This paper is built upon a rich tradition of scholarship that has explored the quality of care using theories on patient-centered and paternalistic qualities of care within the United States healthcare system. While most of these works have used single-axis frameworks, more modern studies have incorporated theories of intersectionality. However, avenues of study remain largely unexplored.

Only a few studies have been published on the role of community health centers in promoting patient-centered care. Fewer have utilized data from the 2014 Health Center Survey- a comprehensive report on patient sociodemographic profiles, health outcomes, and quality of care. Despite this rich source, there has yet to be any published study on whether Hispanic/Latinx patients, across a wide spectrum of intersecting statuses, have reported patient-centered care at these clinics.

Ordered logistic regression was used to determine the quality of doctor-patient interaction for Hispanic/Latinx groups (n=882) by gender, nativity, language, and socioeconomic statuses. Alpha and factor analysis was employed to aggregate the following measures into a single-12-point doctor-patient interaction scale that is used as the dependent variable: whether the doctor listened carefully to them, showed respect for patient input, provided easy-to-understand information, and spent adequate time with the client.

Hispanic/Latinx across all categories reported positive doctor-patient interaction, compared to all other racial groups (n=2,042). The categories of female (p=.435), poor (p=.401), in poverty (p=.401), and unemployed (p=.611) showed no significant correlation. Hispanic/non-English speaking (p=.000\*\*) and Hispanic/foreign-born (p=.000\*\*) subgroups reported better quality of care.

While these findings show that being Hispanic/Latinx, as well as the intersecting categories of non-English speaking and foreign-born are associated with positive doctor-patient interaction, future studies should be done to determine the underlying patterns behind these findings. In addition, it is vital that such studies continue to utilize both doctor-patient interaction and intersectionality theories. Further policies aimed at promoting patient-centered care at community health centers must also take into consideration the effects of multiple forms of adversity across all racial/ethnic categories.

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## **List of Abbreviations**

CHC(s)- Community Health Center(s)

FPL- Federal poverty level

HS- High school

HRSA- Health Resources and Services Administration

OLOGIT- ordered ordered logistic regression

SES- Socioeconomic status

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## **CHAPTER 1: INTRODUCTION**

Mendel and Scott (2010) declared that we live in a time of unprecedented change within the American healthcare industry. As community-based medical institutions emerge and build into their core mission statements, the importance of patient-centered care, the United States stands to create a system that values the lived experience of patient and minimizes the effects of status discrimination. Community health centers (CHCs) stand as examples of this movement (Mendel and Scott 2010).

CHCs are private non-profit, federally managed healthcare institutions within the United States. They were created as an act of Congress to target unequal access to healthcare among the poor, rural, and socially disadvantaged. Built into these institutions are standards of care that promote patient centered-care aimed at mitigating the effects of classism, racism, and sexism. (HRSA 2014; 2018b).

To examine the effectiveness of such changes within the American healthcare delivery system, academics need to constantly incorporate theoretical frameworks within and outside of traditional sociology. Using the 2014 Health Center Patient Survey, this paper maps the relationship between intersectionality and doctor-patient interaction in order to determine if Hispanic/Latinx communities experience lapses in quality of care. Marrying Crenshaw's intersectionality with discourses on doctor-patient interaction process highlighted by Foucault, Waitzkin, Parsons and others, this paper seeks to determine if CHCs are spaces for patient-centered care for Hispanic/Latinx who have additional levels of disadvantage. This paper addresses the following questions:

1. Do Hispanic/Latinx experience worse doctor-patient interaction compared to other racial groups?
2. Can intersectionality reveal within-group differences in the quality of doctor-patient interaction for Hispanic/Latinx with respect to gender, nationality, language, and SES?
3. How do these processes inform patient-centered care at community health centers?

## **CHAPTER 2: BACKGROUND**

### **Theories on Doctor-Patient Interaction**

According to the literature, the doctor-patient interaction process takes two forms: collaborative/patient centered care or the paternalistic model. The collaborative /patient centeredness model encourages patient input, promotes cultural sensitivity, encourages continuous institutional quality improvement (Mendel and Scott 2010). Within the paternalistic quality of care, the physician is the only legitimate authority on a patient's health, status differences by race, gender, or socioeconomic status (SES) lead to unequal communication between doctor and patient, and patients' own lived experiences are discounted (Parsons 1951; Foucault 1973; Waitzkin 1989). Both models have been carefully studied within the modern healthcare context.

The paternalistic model, first discovered by Parsons (1951) and expounded by Foucault (1971), first uncovers the presence of status discordance between doctor and patient. Parsons sees this process as largely functional, as paternalistic care is the result of the social construction of health around a dominant culture's value-systems (1951). It is these value systems that shape the different roles of patient and doctor. According to Parson, within the Western context, both patient and physicians are driven by the same need to return to a state of healthfulness or normality. This creates a doctor-patient interaction process by which the patient accepts the authority of the doctor in order to conform to cultural demands and needs (Parsons 1951).

While Foucault (1973) acknowledges that differences in power exist between doctor and patient, he does not embrace the Parsonian functionalism. Foucault (1973) believed the practice of medicine is one in which healthcare is more about tightly controlling ideas of "truth," than the actual elimination of disease. Medical professionals lay claim to medical truths by capitalizing on a form of "rational language," a type of medical discourse (Foucault 1973). This discourse creates a status discordance between the physician and patient. The patient merely becomes an object of discovery using overcomplicated medical knowledge.

According to Foucault (1973), the use of complicated medical language, means the doctor can claim that the medical encounter is merely positivistic and not driven by subjective desires. This false positivity hides the fact that the patient is still currently seen as an object- a space that can be touched and seen, rather than heard. This means the lived experiences of the patient is suppressed by pseudo medical objectivity (Foucault 1973).

Waitzkin (1989) took Foucauldian theory further by discussing the ways in which ideological norms are related to the institution of healthcare. According to Waitzkin, (1989) medicine is exerted differently between various institutional settings. However, the ideology behind these different interactions remain the same within Western medicine (1989). The ideologies of social class difference in the form of racism, sexism, and ageism are reproduced within the medical encounter (Waitzkin 1989). Waitzkin believed it is the responsibility of the scholar to expose how those ideologic structures emerge within the medical encounter and shape the doctor-patient interaction process (Waitzkin 1989).

Parsons (1951) and Foucault (1973) provide the foundation on which contemporary literature on doctor-patient interaction is currently taken place. Parsons, in addition to highlighting the function of health behavior, unmasked the differential power relations between the doctor and patient (1951). Foucault, on the other hand believes this process is shaped by physician control over discourses on medical knowledge (1971). However, both see the physician as existing within a paternalistic role. Emerging scholarship on the American healthcare system appears to confirm a system whereby status differences not only exist but produce dysfunctional experiences within the healthcare system. This confirms both Foucauldian and Waitzkin theories.

### **Quality of Care for Minority Groups**

Some contemporary research overwhelmingly points toward a model whereby gender, sexual, racial, and cultural minorities either feel explicitly discriminated against (Anderson and Helm 1979) or experience moderate to significant poorer quality of care compared to non-minority groups. The most widely studied group are those persons of color. African American patients experienced increased perceptions of discrimination (Kandula et al. 2006; Lauderdale et al. 2006; Chen and Yang 2014; Cooper 2012; Cuffee 2013; Gabrielle 2017; Penner et al. 2010). Cuevas, O'Brien and Saha (2016) focused on the relationship between African American patients and perceptions of poor treatment by medical staff at primary care facilities. In one study the



perceptions of care for Hispanics were on par with that of African Americans and Asians (Johnson et al. 2004).

Other factors that may influence the doctor-patient interaction, may be being non-US-born (Abramson, Hashemi, and Sánchez-Jankowski 2015), lacking insurance (Quadagno and Jokinen-Gordon 2013), having less than high school education (Quadagno and Jokinen-Gordon 2013; Weitzman, Chang, and Rynoso 2004), being poor (Anderson and Helm 1979), and female (Yee and Melissa 2011; Mcfarland and Holcombe 2014).

Medical sociological scholarship has produced inconsistent results with Hispanic/Latinx, female, and older adults. One study noted no difference by language and time spent with patients (Tocher 1999; Alvarez-Galvez and Salvador-Carulla 2010). However, in some studies that measured patient satisfaction, Spanish-speaking Latinos reported the lowest patient satisfaction scores among all racial/ethnic groups (Lauderdale et al. 2006; Nápoles et al. 2009; Quadagno and Jokinen-Gordon 2013). Anderson and Helm (1979) and Peck and Connor (2011) found little to no association between being female and rating quality of care as poor. Kelly (2017) found that those 65 and older as well as those with disabilities, regularly challenged the authorities of the physician.

What is the importance of carefully measuring doctor-patient interaction among Hispanic/Latinx? Beach, Keruly, and Moore (2006) highlighted the need for patients to feel respected as a necessary component for medication adherence. Doctors who are more dominant (Johnson et al. 2004a) and did not take time to fully listen (Lynn and Simon 2011), had patients that reported lower medical adherence. Adhering to medical protocol is a necessary component in a patients' self-rated health (Lee and Lin 2010).

In addition, current studies on Hispanic/Latinx communities can blur the lines between paternalistic and patient-centered theories. Julliard et al. (2008) and Craig (2010) found that cultural norms may skew the accuracy of survey data among Hispanic/Latinx patients. When initially surveyed on their quality of care, Hispanic/Latinx patients reported positive doctor/patient interaction. However, deeper probing uncovered a cultural deferment of authority that carries parcels of Parsonian functionalism and deep-rooted social mistrust, characteristic of Waizkin ideologies (Julliard et al. 2008; Craig 2010). This means that cultural deferment to authority overrides accurate disclosure of information.

The social distance between doctor and patient is even wider among Hispanic/Latinx female clients who may not disclose vital medical information due to deep cultural shame (Julliard et al. 2008). Such findings by Julliard (2008) and Craig (2010) must be considered in future scholarship. Lastly, studies should pay careful attention to the subtle ways in which race and other forms of disadvantage may intersect to produce or exacerbate unequal access to quality care.

### **Intersectionality**

Integrating intersectionality in doctor-patient interaction scholarship could enhance our understanding of how multiple statuses intersect to form the totality of a patients' experience within CHCs. In addition, creating this transtheoretical perspective could serve to improve the quality of care for disadvantaged groups- a core mission of the CHC program.

An intersectional lens requires scholars to transcend traditional one-category/ "single-axis frameworks" (Crenshaw 1989: 140). This methodology requires scholars to confront the reality that individuals always occupy multiple social statuses, some of which are disadvantaged, subordinated, and often invisible (Crenshaw 1989, 1991, 1995; Purdie-Vaughns and Eibach 2008; Cole 2009).

According to Crenshaw (1991; 1995), intersectionality follows several pathways: *structural*, *political*, *representational*, and *experiential*. Under *structural*, an individual with multiple social statuses is marginalized either socially or legally (Crenshaw 1991). *Political intersectionality* is the process of one "splitting one's political energies between two sometimes opposing political agendas" (1991:1252). This means that social groups compete with one another to see whose issues become more dominant and valid within the political sphere. *Representational intersectionality* proposes the need for othered groups to be recognized within the cultural imagination (Crenshaw 1991). Finally, *experiential* intersectionality means an individual's experiences cannot be broken down into the components of being a member of a single, exclusive category (i.e. being black or a woman). Being a member of multiple disadvantaged statuses, produces unique experiences (Crenshaw 1995).

Most of the previous studies explored the interaction between race and various statuses exclusively through discrimination which follows the pathway of *structural intersectionality* by looking at the various ways in which intersecting statuses produces unequal medical treatment.

Among these is Stepanikova and Oates (2017) who noted that poor and uninsured African Americans reported significantly higher rates of perceived discrimination at the physician's office. This pattern was also noted among Korean populations (Jang and Chiriboga 2005). Others located the ways in which persons of color with less than a high school education reported higher discrimination (Weitzman, Chang and Rynosso 2004; Williams et al. 2010). This can be further exacerbated by gender, as lesser-educated African American women were more likely to report higher levels of overt discrimination (Wiltmore et al. 2009).

In addition, persons of color who speak a language other than English at home were more likely to report poorer doctor-patient interaction (Williams et al. 2011). Tan et al. (2016) found that physicians were more likely to consider Asian Americans who speak a language other than English at home, "naïve" about their own healthcare. Age can be a further barrier for non-English speaking Asians, who report lower quality of care (Jan and Chiriboga 2005).

There are a few intersectional studies on the quality of care for Hispanic/Latinx subgroups. Even fewer discuss it within in *experiential perspective*. Craig's (2010) qualitative study on Latino/Hispanic's perceptions of the quality of healthcare noted that in the initial passthrough, respondents reported greater satisfaction. However, with further differentiation by income, those with lower income expressed poorer quality of care (Craig 2010). The relationship between lower SES and Hispanic/Latinx was noted in other studies (Johnson et al. 2004). In addition, other studies discovered that those Hispanic/Latinx who do not speak English at home report unmet needs (Deros, Escarce and Lurie 2007; Nápoles et al 2009).

This paper utilizes survey data that aggregates a providers' 'respect for the patient, their ability to listen, whether they spent adequate time with the patient, and spoke in an accessible language into a single 12-point scale. According to Wallace et al. (2009), the use of scales is rarely studied. No studies have been done both applying this method and utilizing theories of intersectionality to explore doctor-patient interaction. This study is important, because it allows scholars to go beyond looking at gender, class, and race privileges as separate categories, and it allows people to more effectively challenge systems of oppression, together (Creshaw 1989). By noting how Hispanic/Latinx subgroups experience inequalities in the doctor-patient interaction process, this study additionally aims at improving those *structural* barriers to proper healthcare to disadvantaged groups. Additionally, as a result of the preponderance of literature, I hypothesize the following:

1. Hispanic/Latinx will experience poorer doctor-patient interaction when compared to other racial/ethnic groups
2. The relationship between poor doctor-patient interaction and Hispanic/Latinx subgroups will be significant for the following categories: female, non-English speaking, foreign, and lower SES

## **CHAPTER 3: METHODS**

### **Subjects (2014 Health Center Survey)**

This paper presents an analysis of how race/ethnicity (Hispanic/Latinx) intersects with various sociodemographic characteristics to produce differing experiences in medical care at CHCs. Community health centers are federally-managed, private non-profit health clinics designed to serve racially, economically and spatially underserved populations (Health Centers Consolidation Act of 1996 Sec 5 subsection 330). At CHCs, no patient can be denied based care based on their inability of pay, services must be rendered based on a sliding-fee schedule, and each board of directors must be comprised of 51% of patients (Health Centers Consolidation act 1996 Sec 5 subsection 330 amendment D.) To ensure the core mission of the program is met, each CHC must submit yearly reports of patient health outcomes and sociodemographic characteristics.

Every 4 years, the Health Resources and Services Administration (HRSA), the federal agency tasked with managing the CHC program, releases a Health Center Patient Survey of several federal-nonprofit agencies including migratory and homeless shelters. Only data from CHCs will be analyzed in this study.

The core mission of the CHC program is to “overcome geographic, cultural, linguistic, and other barriers,” to provide health care to disadvantaged groups (HRSA 2014). By analyzing the 2014 survey, this paper seeks to be in line with the mission of the CHC program. In addition, it specifically highlights the ways in which current univariate discussions of Latino medical care obscures the health needs of intra-group Hispanic populations.

The 2014 Health Center Patient Survey is designed to be a nationally representative sample of 169 community health centers, chosen based on region, urban/rural, size, age, gender, SES and racial composition (HRSA 2014 Codebook). Using multi-stage sampling, the questionnaires are self-weighted and minority groups are oversampled. Surveys were conducted on-site by a primary investigator (PI) who gave face-to-face interviews in the following languages: English, Spanish, Vietnamese, Chinese, and Korean. With an initial goal of 3,630 completed surveys, 88.7% responses were completed (n=3,219). The 2014 Health Center Patient survey is a comprehensive questionnaire, unparalleled in any healthcare institution in the United States. This survey is divided into 18 modules, totaling 760 questions detailing a patient’s

sociodemographic characteristics, access and quality of care, objective health measures, and self-rated health.

### **Study Design**

Tabulation was run and dummy variables were created for every variable coded. 288 missing values and skipped questions were dropped, creating a uniform response rate of 2,931. Ordered logistic regression (ologit) was used to determine the relationship between independent and dependent variables.

The study is separated into 12 tables. Table 2 showed the descriptive statistics. Table 3 indicated the direct effect between the independent variable (Hispanic/Latinx) and the scale used to determine the quality of doctor-patient interaction. Within this table, Hispanic/Latinx was compared to all other races. Tables 4-11 looked at significance of Hispanic/Latinx subsamples by gender, nativity, language, and SES. The comparison categories are those Hispanic/Latinx who do not share those characteristics.

### **Independent Variables**

Hispanic/Latinx was recoded from the original data as the independent variable for this study. In the original data, there were five separate racial/ethnic categories: White, Black, Asian, Other, and Hispanic/Latinx. White, Black, Asian, and Other were combined into a single reference/dummy category for table 3. Hispanic/Latinx was not recoded.

Within-group differences were measured in tables 4-11. In order to do this, subsample variables were created for Hispanic/Latinx with the following intersections: female, foreign-born, non-English speaking, and lower SES. The reference categories for each of these variables were the Hispanic/Latinx who were either male, US born, English-speaking, and/or had higher SES.

A 12-point scale measuring the quality of doctor-patient interaction was created as the dependent variable in this study. In the original survey, respondents were asked to rate their quality of care using four separate questions (table 4). These answers were given on a scale from: “never”, “sometimes”, “usually”, and “always”. Chronbach’s alpha was used to determine the consistency of all variables. An alpha factor of .83 indicates a valid scale with strong internal consistency. Factor analysis showed that most of the variables load into one factor. As table 1 (below) indicates, almost all variables are close in internal consistency. All variables were then

coded into a 12 scale-level variable labeled patient centeredness. This measures a patient's perception of physician respect, time spent, accessible language, and ability to listen.

Table 1. Doctor-Patient Interaction Scale Alpha and Factor Analysis

<b>Variable</b>	<b>Alpha</b>	<b>Factor</b>
"In the last 12 months, how often did this doctor or other health professional listen carefully to you?"	.83	.74
"In the last 12 months, how often did this doctor or other health professional give you easy to understand information?"		.69
"In the last 12 months, how often did this doctor or health professional show respect for what you had to say?"		.74
"In the last 12 months, how often did this doctor or health professional spend enough time with you?"		.75

This study utilizes the standard control variables that have been known to influence the relationship between race and quality of care. Within this paper, male is used as the reference/dummy category. Marital status was originally coded as: married, domestic partner, widowed, divorced, separated, and never married. Domestic partner, widowed, divorced, separated, and never married are aggregated into a single reference/dummy category as never married.

Other social characteristics used within this study are: foreign-born status, primary language spoken at home, age, and disability. Respondents were asked to identify "were you born in the US? Yes or No?" Those who identified as US born (Yes) are used as controls in the long models. "No" is the reference category. The question: "Do you speak a language other than English at Home?" was recoded as Yes=1 No=2. Those who spoke a language other than English at home are utilized within the models and those who speak English are the reference category. The original data denoted nine different age categories ranging from "0" to "75 and older." Those under the age of 18 were dropped from this analysis. The remaining age categories were condensed into 4 categories presented in table 6. Those age 18-35 are not used in the models. Those aged 35-50, 51-64, and 65+ are used in the analysis. Within the original data, respondents were asked to identify problems difficultly dressing or bathing, getting in or out of chairs, going to the restroom, and walking/climbing stairs as key components of a functional disability. These

questions were originally coded as separate variables. They were recoded for this analysis as a single variable of disability. A dummy variable was created for those who did not note a disability.

Several SES categories are also utilized within this analysis. These are: income, number of persons supported by said income, educational attainment, employment, and insurance status. Income was originally coded as “less than or equal to 100% federal poverty level”, “101 to 138%”, “139-199%”, “200 to 299%”, “300-399%”, and “400% and above.” Three categories were created for this analysis: less than or equal to FPL (poverty), 101-138% (poor), and 200 and above. Those with incomes 200% and above are used as a reference category, with poverty and poor used in the long models. Following this category, the original survey asked respondents: “including you, how many family members did that income support for the last calendar year?” the original categories range from 1 to more than 5. Those with more than 1 family member was recoded into a single category “2+”, with those less than 2 as the reference category. Education was originally coded into two separate categories of “less than high school or GED” and “More than high school.” The former was kept as controls for the long models and those with more than a high school degree are used as a reference category for education.

As a part of the section on socioeconomic status, respondents were asked “what were you doing last week?”. The original categories were: 1: working at a job or business, 2: with a job or business, but not at work 3: looking for work, 4: working, but not for pay, at family owned business, and 5: not working at a job or business and not looking for work. Those working (for pay or not) were coded as employed and used as the reference category. All others were aggregated into not employed and used in the models as controls.

Each insurance variable was originally coded into separate categories that asked respondents to list any insurance they had in the last 12 months. They were: current insurance covered by employer, Medicare, Medicaid, state health insurance exchange, purchased directly from insurance company, through military, or uninsured. I recoded these variables into one insurance variable, private, public and uninsured as categories. Public-based insurance and uninsured are used as controls in the models while private-based insurance is used as a reference category.

Lastly, the categories of average wait time, time spent as a patient, and location of the clinic were used in this analysis as control. Rural clinics, those who spent less than one year as



patients of the CHC, and those who had to wait more than 15 minutes after scheduled appointment time were used as controls. Those whose clinics are in an urban center, those who were patients for more than one year, and/or never experienced greater than a 15-minute wait to see the doctor were used as reference categories.

## **CHAPTER 4: Results**

A preliminary analysis of the frequencies and means in table 2 (appendix a) shows that Hispanic/Latinx patients represent 30% of the total number of respondents. Of those respondents, a greater number reported better doctor-patient interaction when compared to all other races (10.62/10.29 mean). The following categories that are useful in this analysis also reported better means by the scale: those born in the US (10.47/10.20), those who primarily spoke English at home (10.46/10.28), the poor, those with greater than a high school education (10.47/10.27), and male (10.46/10.37). However, the mean by the scale used in this study indicates that the experience was generally positive (average score of 10/12).

When compared through interaction, the preliminary mean by scale yield several interesting results. First, those Hispanic/Latinx who identify as foreign-born report better interactions with a mean of 10.66 respectively. This similar pattern is observed for Hispanic/Latinx respondents who are female (10.64/10.59), those with less than a high school degree (10.65/10.59), and those who are poor when compared to the wealthiest (10.85/10.46). The Hispanic/Latinx who speak English at home (10.67/10.40) and/or have private insurance over public insurance (10.77/10.53) report better interaction. Those who are employed have moderately greater interaction (10.64/10.60)

### **Hispanic/Latinx Doctor-patient Interaction scores**

Hypothesis 1: Hispanic/Latinx will experience poorer doctor-patient interaction when compared to other racial/ethnic groups was tested and the results are presented in table 3, located on the next page. In model 1 (table 3), the odds of a Hispanic/Latinx reported better interaction when compared to all other races was .294 higher when compared to all other racial/ethnic categories. With additional control variables introduced in model 2, Hispanic/Latinx maintained a positive coefficient at .634, with an alpha score of .000\*\*\*. These findings indicate that the null hypothesis is rejected. Hispanic/Latinx reported better doctor-patient interaction when compared to all other racial/ethnic groups. Additionally, model 2 indicated that the variables less than a high school education (-.002\*), English not a primary language (-.002\*), and not born in the US (-.024\*) are all associated with poor doctor-patient interaction when compared to the reference categories.

Table 3. Hispanic/Latino Doctor-Patient Interaction Scores

Variable	Model 1: Direct Effect		Model 2: Controls	
	Coef	P> z	Coef	P> z
<u>Independent</u> Hispanic/Latinx	.294	.000**	.634	.000**
<u>Control</u> Not Born in US			-.260	.024*
Female			.050	.538
At FPL			-.149	.118
Poor			.016	.887
Less than HS			-.238	.002*
English not primary language			-.335	.004*
Public insurance			.109	.404
Uninsured			.087	.533
Unemployed			-.084	.321
35-50			.289	.003*
50-64			.542	.000**
65+			.401	.000**
Not married			-.033	.705
2+ household			.163	.062
Rural			.080	.315
Functional Disability			.049	.582
Wait Time >15 min			-1.14	.000**
Patient at CHC >1 year			.003	.972

\*p<.05 \*\*\*p<.001

## Intersectional social statuses and Doctor-patient scores

According to the table 5 (below), foreign-born Hispanic/Latinx experienced better care across all models with a significance of .000\*\*. This same pattern was observed among non-English speaking (or Hispanics who speak a language other than English at home) Hispanic/Latinx groups in table 6. The association between female Hispanics was not significant across all models in table 4. The null hypothesis was rejected for hypothesis 2 that Hispanic/Latinx with intersecting social statuses will report poorer interaction.

Table 4. Quality of Care Hispanic/Latinos by Female Gender

	Model 1:		Model 2: All Controls	
	Coef	P> z	Coef	P> z
Hispanic/Latinx(n=882)	.181	.214	.532	.001*
Female	-.142	.116	.011	.903
Hispanic/Latinx Female (n=637)	.162	.349	.142	.425

Notes: \*p<.05 \*\*\*p<.001. The following control variables were used in all control models, across all tables: not born in US, Non-English Speaking, uninsured, unemployed, At FPL, poor, less than HS, ages 35-50, 50-64, and 65 and older, not married, 2 or more persons in the household, rural, functional disability, wait time less than 15 minutes, and patient at CHC for less than one year. Of those in table 4, not born in the US (-.024\*), non-English (-.004\*), less than HS (-.003\*), 35-50 (.003\*), 50-64 (.000\*\*), 65(.000\*\*), and wait time of more than 15 minutes (-.000\*\*) were significantly associated with doctor-patient interaction scores.

Table 5. Quality of Care Hispanic/Latinos by Foreign-Born

	Model 1:		Model 2: All Controls	
	Coef	P> z	Coef	P> z
Hispanic/Latinx (n=882)	.050	.652	.233	.096
Foreign-Born	-.822	.000**	-.687	.000**
Hispanic/Latinx Foreign-Born (n=531)	1.01	.000**	.812	.000**

Notes: \*p<.05 \*\*\*p<.001. Of the controls used in table 5, \*, less than HS (-.001\*), 35-50 (.007\*), 50-64 (.001\*\*), 65+ (.000\*\*), and wait time of more than 15 minutes (-.000\*\*) were significantly associated with doctor-patient interaction scores.

Table 6. Quality of Care Hispanic/Latinos by Non-English

	Model 1:		Model 2: All Controls	
	Coef	P> z	Coef	P> z
Hispanic/Latinx (n=882)	-.019	.904	.130	.435
Non-English	-.748	.000**	-.599	.000**
Hispanic/Latinx Non-English (n=160)	.964	.000**	.778	.000**

Notes: \*p<.05 \*\*\*p<.001. Of the controls used in table 6, less than HS (-.002\*), 35-50 (.005\*), 50-64 (.000\*\*), 65+ (.000\*\*), and wait time of more than 15 minutes (-.000\*\*) were significantly associated with doctor-patient interaction scores.

### Intersectional SES and Doctor-patient scores

Tables 7-12 tested the second hypothesis that Hispanic/Latinx by SES statuses will report lower doctor-patient interaction scores. Tables 8-11 indicated that, poor, FPL (poverty), unemployment, and neither insurance categories were associated with doctor-patient interaction scores. The findings suggest that in the long model (table 12) for Hispanic/Latinx who have less than a high school education the odds of better doctor-patient interaction was .363 higher when compared to Hispanic/Latinx who do not, with a weak association of .029\*. The null hypothesis is rejected for all SES interactions.

Table 7. Quality of Care Hispanic/Latinos by FPL

	Model 1:		Model 2: All Controls	
	Coef	P> z	Coef	P> z
Hispanic/Latinx (n=882)	.274	.001*	.551	.000**
At FPL	-.257	.002*	-.138	.122
Hispanic/Latinx FPL (n=540)	.209	.190	.138	.401

Notes: \*p<.05 \*\*\*p<.001. Of the controls in table 7, foreign-born (-.026\*), non-English (-.004\*), less than HS (-.004\*), 35-50 (.004\*), 50-64 (.000\*\*), 65+ (.000\*\*), and wait time of more than 15 minutes (-.000\*\*) were significantly associated with doctor-patient interaction scores.

Table 8. Quality of Care Hispanic/Latinos by Poor

	Model 1:		Model 2: All Controls	
	Coef	P> z	Coef	P> z
Hispanic/Latinx (n=882)	.183	.137	.552	.000**
Poor (\$11,670-\$16,105)	.106	.333	.022	.852
Hispanic/Latinx Poor (n=161)	.106	.606	.139	.401

Notes: \*p<.05 \*\*\*p<.001. Of the controls in table 8, foreign-born (-.020\*), non-English (-.005\*), at fpl (-.002\*), less than HS (-.002\*), 35-50 (.003\*), 50-64 (.000\*\*), 65+ (.000\*\*), and wait time of more than 15 minutes (-.000\*\*) were significantly associated with doctor-patient interaction scores.

Table 9. Quality of Care Hispanic/Latinos by Unemployment

	Model 1:		Model 2: All Controls	
	Coef	P> z	Coef	P> z
Hispanic/Latinx (n=882)	.263	.063	.582	.000**
Unemployed	-.061	.480	-.109	.514
Hispanic/Latinx Unemployed (n=546)	.091	.571	.085	.611

Notes: \*p<.05 \*\*\*p<.001. Of the controls in table 9, foreign-born (-.024\*), non-English (-.004\*), less than HS (-.002\*), 35-50 (.003\*), 50-64 (.000\*\*), 65+ (.000\*\*), and wait time of more than 15 minutes (-.000\*\*) were significantly associated with doctor-patient interaction scores.

Table 10. Quality of Care Hispanic/Latinos by Uninsured

	Model 1:		Model 2: All Controls	
	Coef	P> z	Coef	P> z
Hispanic/Latinx (n=882)	.336	.000**	.629	.000**
Uninsured	-.001	.990	.080	.599
Hispanic/Latinx Uninsured (n=308)	-.119	.491	.020	.913

Notes: \*p<.05 \*\*\*p<.001. Of the controls in table 10, foreign-born (-.026\*), non-English (-.004\*), less than HS (-.002\*), 35-50 (.003\*), 50-64 (.000\*\*), 65+ (.000\*\*), and wait time of more than 15 minutes (-.000\*\*) were significantly associated with doctor-patient interaction scores.

Table 11. Quality of Care Hispanic/Latinos by Public Insurance

	Model 1:		Model 2: All Controls	
	Coef	P> z	Coef	P> z
Hispanic/Latinx (n=882)	.290	.019*	.758	.000**
Public Insurance	.024	.792	.153	.260
Hispanic/Latinx public insurance (n=499)	.006	.969	-.192	.258

Notes: \*p<.05 \*\*\*p<.001. Of the controls in table 11, foreign-born (-.016\*), non-English (-.005\*), less than HS (-.002\*), 35-50 (.003\*), 50-64 (.000\*\*), 65+ (.000\*\*), and wait time of more than 15 minutes (-.000\*\*) were significantly associated with doctor-patient interaction scores.

Table 12. Quality of Care Hispanic/Latinos by less than HS

	Model 1:		Model 2: All Controls	
	Coef	P> z	Coef	P> z
Hispanic/Latinx (n=882)	.125	.233	.475	.000**
Less than HS	-.362	.000*	-.347	.000**
Hispanic/Latinx Less than HS (n=443)	.465	.003*	.363	.029*

Notes: \*p<.05 \*\*\*p<.001. Of the controls in table 12, foreign-born (-.011\*), non-English (-.007\*), 35-50 (.005\*), 50-64 (.001\*\*), 65+ (.000\*\*), and wait time of more than 15 minutes (-.000\*\*) were significantly associated with doctor-patient interaction scores.

## **CHAPTER 6: Discussion**

### **Implications of Hispanic/Latinx Doctor-Patient Interaction Scores**

This study addresses the first research question: do Hispanic/Latinx experience worse doctor-patient interaction when compared to other racial groups? According to this study Hispanic/Latinx reported better quality of care. However, further questions remain: are these findings biased by recent exposure to the US healthcare delivery system? It is unclear whether those sampled are recent migrants who may use their native healthcare system as a reference group when measuring the quality of care at CHCs. The CHC clinic may convey levels of modernization and healthcare expertise not witnessed within their native spaces.

In addition, the model 2, table 3 indicated that this pattern does not hold by SES. The findings on the relationship between education and respectscale indicated that the collaborative model of care does not apply to those with less than a high school education. Data indicated the ordered logit for those with less than a high school education was .335 less than those with a high school diploma or higher, with an alpha level significance of .002 (model 2, table 3). What may explain the significant link between both lower educational attainment and poor doctor-patient interaction?

Paternalistic theories may explain this phenomenon. Foucault stated the medical encounter is a space in which various forms of rational language are used (1971). Confounding medical jargon can exacerbate patient confusion and perceptions of social distance between themselves and doctors. For persons with poor educational backgrounds, medical discourse can be highly confusing and disempowering. In addition, this level of significance due to education, may be explained by Peck and Conner (2011) who found that status discordance between doctor and patient can affect the quality of care: “the higher the status difference between doctors and patients, the higher the likelihood of a physician-dominated encounter” (559).

Other single-axis categories were found to be associated with poorer doctor-patient interaction. Among those are patients who identify as non-us born (“where you born in the US?”). The data showed a weak association with poor quality of care in table 3, model 2 (-.260/.024\*). These findings are stronger in table 12, model 2 when Hispanic/Latinx with poor quality of education was measured with all interaction variables (-.298/.011\*). Future studies should address the intersection between poor education and foreign-born status on doctor-patient interaction.

Among the important social variables, those who are non-English (speak a language other than English at home) reported significantly poorer interaction in all tables. In table 2, model 2, those who are non-English speaking at home, the ordered logit is  $-.335$  with an alpha level significance of  $.004^*$ . These findings speak to the various ways in which language has been shown in previous literature to affect the quality of doctor-patient interaction (Kandula et al. 2006; Wallace et al. 2009; Quadagno and Jokinen-Gordon 2013).

### **Importance of Intersectionality**

This study did not show that intersectionality can reveal within-group differences in the quality of doctor-patient interaction for Hispanic/Latinx with respect to gender, nationality and SES (research question two). Utilizing Crenshaw's theories of *structural intersectionality* does not apply to Hispanic/Latinx using the 2014 Health Center Patient Survey.

However, these findings do not preclude the possibility of within group differences by different racial categories. First, it is possible that the oversampling of disadvantaged groups at CHCs- women, the poor, those foreign-born, and those who speak non-English may hinder effective quantitative analysis. McCall (2005) noted that studies which focus on a single methodology are highly suspect. Qualitative studies should be done in the future to ensure that the totality of experiences regarding *experiential* intersectionality has any effect on those *structural* barriers to quality of care among Hispanic/Latinx subgroups.

Second, further research should be done using the data from this and future surveys, focusing on other racial/ethnic groups and their intersecting statuses. Work on African Americans and Asians are ripe for future research. Such studies are needed in order to address if the collaborative model of care applies evenly across all racial/ethnic groups at CHCS.

### **Patient-Centered Care at CHCs**

This study provided further insight into how intersectionality can inform patient-centered care at community health centers (research question three). While findings indicated no link between Hispanic/Latinx (and interacting variables) and poor doctor-patient interaction, several questions remain. First did this study explain the totality of the Hispanic/Latinx experience as patients at CHCs?

Schnittker (2004) found that across social groups, most Americans reported positive interactions with their health professionals. This pattern is observed in table 2, whereby



Hispanic/Latinx reported a doctor/patient interaction scale mean score of 10.62/12 by doctor/patient interaction. This score differed little from those of other races (10.29/12).

However, subsequent studies found that patient-centered care is not applied evenly across racial/ethnic groups. This is especially evident when qualitative methods are employed. While Hispanic/Latinx reported positive doctor/patient interaction at CHCs, the works of Julliard et al. (2008) and Craig (2010) illuminated further possibilities. Julliard et al. (2008) noted that Hispanic/Latinx patients who initially rated their doctors highly, admitted to not disclosing critical medical information for fear of stigma. This led to uncomplicated interactions between doctor-patient. Craig (2010) noted that among certain Hispanic/Latinx groups, there is a cultural deference toward authority that explained initial high satisfaction ratings. However, upon deeper probing many of these respondents admitted that their doctors made them feel uncomfortable. Some even stated that if they could, they would return to Mexico for care (Craig 2010). It is entirely possible that a single survey cannot capture the cultural nuances that further complicates the doctor-patient interaction process.

Secondly, how can CHCs learn from this study and continue to practice a crucial component of patient-centered/collaborative care: continuous quality improvement? Public health scholars, policymakers, and scholar activists in medical sociology should not assume that these findings indicated that patient-centered care has been fully achieved for Hispanic/Latinx populations. Better measures that capture cultural nuances and addresses both *experiential* and *structural* forms of intersectionality which can make CHCs better equipped to serve the needs of all disadvantaged groups should be considered in future surveys. In addition to those limitations mentioned by Julliard et al (2008) and Craig (2010), other weaknesses within this study remain.

### **Limitations**

This study is not generalizable to the entire United States healthcare population. A selection-effect may be occurring. Patients at CHCs make up only 8% of the total healthcare usage within the United States (National Association of Community Health Centers 2018). The original survey also oversampled minorities and the poor who are already at risk of experiencing poorer quality of care and lowered health outcomes (Link and Phelan 1995). While some of the theories utilized in this research are important across healthcare institutions, the findings can only be used toward locating critical deficiencies within the CHC program.

Point-in-time accounts also limit the quality of data. Future research should be funded that addresses data longitudinally. This would mean incorporating sociological theories on the life-course perspective. Without longitudinal data, the effects of accumulative adversity and allostatic load among intersecting statuses cannot be measured (King 1988).

The original coding of the Hispanic/Latinx category is highly problematic. The 2014 Health Center Patient Survey categorized persons with Spanish ancestry as Hispanic/Latinx. Patients were originally asked: “are you of Hispanic, Latino or Spanish Origin?” Palloni and Morenoff (2001) criticized previous scholarship on Hispanic/Latino health outcomes for combining persons of Spanish (Spain) and non-White Hispanic/Latinx from the Americas into a single category. Doing so, obscures the different geographical, cultural, and historical contexts that differentiate the medical experiences of these two groups (Palloni and Morenoff (2001).

In addition, several scholars have pointed to the problematic use of racial categories in survey data. Stoler (1996), Balibar and Wallerstein (1991), and the works of Miles (1993), ruptured the continual reliance of racializing categories in current sociological research. Balibar (1991) noted how discourses on migration stifles those meaningful differences by space. By creating the pan-ethnic category of Hispanic/Latinx, data such as those used in the 2014 Health Center Patient Survey, risks forgoing those differences by region of origin within the Americas (Palloni and Arias 2003).

The 2014 Health Center Patient survey also did not measure physician disposition. Korsch (1968, 1972) found an association between a doctor’s “bed-side manner” and patient satisfaction. It may be possible that the scale used in this study captured some aspects of the physician disposition. However, without clear questions, I cannot make a clear assertion.

Despite measuring physician language, this survey also did not measure a physicians’ racial status. This is an essential part of measuring racial/ethnic concordance. Studies by Philips, David and Jang (2012) and Brown et al. (2016) indicated that racial/ethnic concordance between doctor and physician may improve the overall quality of care. Concordance by race and ethnicity has shown to encourage the disclosure of health data and increase a doctor’s attentiveness to the patients’ needs and concerns (David and Jang 2012; Brown et al. 2016). CHCs should include doctors’ sociodemographic profiles in future surveys.

While the data collected in 2014 Health Center Patient Survey differentiates between urban and rural clinics, it does not offer regional or neighborhood-level statistics. The study of

space is an emerging part of medical sociology. This is driven by Louis Wirth (1938) whose seminal work “Urbanism as a Way of Life” explored how the process of urbanism exacerbates economic precarity and erodes social cohesion.

In addition, regional-level differences in access and health outcomes have been found to exist. According to Zeng et al. (2015), cross-sectional data indicated disparities in cancer, stroke, cardiovascular disease, and COPD by region. Disparities by availability of care continued to exist as well. HRSA (2018a) noted that by region, the American deep-south has the most severe physician shortage (-3,802). This physician shortage can lead to increased wait times, shorter doctor’s visits, and an inability to be seen in a timely manner; all of these are measures of poor patient-centered care.

While this paper studied quality of care by urban/rural designation, it did not delve into a deeper analysis of neighborhoods. W.E.B DuBois (1899), first studied the relationship between sociopolitical racism, neighborhood disadvantage and race. The exploration of segregation by DuBois has inspired other scholars to study how ethnic enclaves are spaces where racial health outcomes are empirically measured (Wilson 1987). Robert et al. (2010) noted how “research on neighborhood reminds us that individuals live in a variety of social and spatial contexts, and that these contexts are important to shaping health and well-being” (124). By focusing exclusively on whether the patient has visited an urban or rural clinic, the 2014 Health Center Patient Survey not only obscured those patients whose clinic is in a different space from where they live, it did not capture differences by neighborhood or census tracts.

In addition, the 2014 survey did not capture those institutional norms that have shown to impact a patients’ quality of care (Sardell 1988; Wallace et al. 2009). CHCs occupy a unique status within the American healthcare delivery system. They are non-profit clinics designed to provide culturally competent care. What this culturally competent care entails, differs by community. This means that future research should focus on the relationship between an institutions’ unique community needs and an individual’s experience. This is a process that is best observed through ethnography. Despite these limitations, future work can serve to better our understanding of how disadvantaged groups experience differences in the quality of care.

### **Future Directions**

CHCs are unique institutions that provide services to the economically, racially, and spatially disadvantaged. Future work on the Hispanic/Latinx population at CHCs may be best

done through institutional ethnography, as it measures the patients' experience in the context of an institutional setting. This speaks to Waitzkin (1989) who stressed the importance of uncovering how medicine is practiced differently within various institutions. In addition, it is through ethnography that the *representational, political and experiential intersectionalities* can best be uncovered.

The institutional ethnographic methodology introduced by Smith (1987; 2005), is a process that exposes the social lives of groups within a single setting. Scholars of this framework use of several methods. These include focus groups, observations, content, and discourse analysis. Phenomenology, observation, and epistemology are needed to understand how individuals make sense of their place within an institution (Smith 2005). Future institutional ethnographic work on Hispanic/Latinx patients at CHCs should also consider the importance of integrating theories of Foucault (1971) and Crenshaw (1989, 1991, 1995).

Longitudinal surveying is another important method to consider. This paper on the how race and its intersecting statuses can affect the quality of doctor-patient interaction can benefit from methods that integrate the life-course perspective. According to this theory, concepts of place and time, timing of events, linked lives, personal and group agency, and cumulative impacts of events all work together to influence an individual's life experience (Elder, Johnson, and Crosnoe 2004). The life course perspective is highly useful as it serves to remind researchers that health and its related factors is not a static phenomenon (Robert et al. (2010).

Point-in-time surveys like the one employed in this study are important in understanding important factors in health, but they cannot inform scholars and policymakers of the most effective way to target health inequalities at different points within an individual's life course. Longitudinal data can reveal how changes in public discourse on minority groups can affect the health of Hispanic/Latinx communities over time (Palloni and Morenoff 2006). The political landscape has also shown to have a profound impact on interpersonal discrimination against migrant groups (Palloni and Morenoff 2006). These processes can inform how doctor-patient interaction may change across space and time.

## **Conclusion**

The Community Health Center program has a long way to go before it can successfully achieve the goals of addressing the unique healthcare needs of disadvantaged groups. While this study indicates that Hispanic/Latinx and their subgroups report higher satisfaction with care,

further questions remain that should be answered in future research. It becomes clear that more research and activism should be done to alleviate the cumulative disadvantage of being poor, less educated, and foreign-born. Until then Mendel and Scott's (2010) vision cannot fully be achieved.

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## Appendix A

Table 2. Descriptive Statistics

Variable	Frequency	Percent	Mean by Scale
<i>Independent Variables</i>			
<b>Race</b>			
Hispanic/Latinx	882	30.09	10.62
All other races	2,049	69.91	10.29
<b>Hispanic/Latino +Were your Born in the US?</b>			
Yes	351	39.80	10.57
No	531	60.20	10.66
<b>Hispanic+Primary Language Spoken at Home</b>			
English	722	81.86	10.67
Not English	160	18.14	10.40
<b>Hispanic+Federal Poverty Level (\$11,670)</b>			
Less than or equal to 100% (at fpl)	540	61.22	10.61
101- 138% (\$11,670-\$16,105) (poor)	161	18.25	10.85
139 +% (\$16,106+)	181	20.52	10.46
<b>Hispanic+Health Insurance</b>			
Private	74	8.39	10.77
Public (Medicaid/Medicare/Tricare)	499	56.58	10.66
None	308	35.03	10.53
<b>Hispanic+Employment Status</b>			
Employed	336	38.09	10.60
Not employed	546	61.91	10.64

Table 2. (Continued) Descriptive Statistics

Variable	Frequency	Percent	Mean by Scale
<b>Hispanic+ Sex</b>			
Female	637	72.22	10.59
Male	245	27.78	10.64
<b>Hispanic+Education</b>			
Less than HS	443	40.64	10.65
More than HS	647	59.36	10.01
<b>Were you Born in the US?</b>			
Yes	2,091	71.34	10.47
No	840	28.66	10.20
<b>Primary Language Spoken at Home</b>			
English	1,849	63.08	10.46
Not English	1,082	36.92	10.28
<b>Federal Poverty Level (\$11,670)</b>			
Less than or equal to 100% (at fpl)	1,665	56.81	10.27
101- 138% (\$11,670-\$16,105) (poor)	517	17.64	10.59
139 +% (\$16,106+)	749	25.55	10.52
<b>Health Insurance</b>			
Private	314	10.71	10.38
Public (Medicaid/Medicare/Tricare)	1,897	64.72	10.41
None	720	24.56	10.35

Table 2. (Continued) Descriptive Statistics

Variable	Frequency	Percent	Mean by Scale
<b>Employment Status</b>			
Employed	1,072	36.57	10.44
Not employed	1,859	63.43	10.36
<b>Highest Education Level</b>			
Less than HS degree/GED	1,090	37.19	10.27
Greater than HS degree	1,841	62.81	10.47
<b>Marital Status</b>			
Married	948	21.31	10.39
Not married	1,984	67.69	10.39
<b>Age</b>			
18-34	677	23.10	10.22
35-50	1,140	38.89	10.41
51-64	730	24.91	10.41
65+	384	13.10	10.63
<b>Functional Disability: Self Care and Mobility</b>			
Yes	756	25.79	10.44
No	2,175	74.21	10.38
<b>Sex</b>			
Female	2,047	69.84	10.37
Male	884	30.16	10.46

Table 2. (Continued) Descriptive Statistics

Variable	Frequency	Percent	Mean by Scale
<b>Number of People Supported by Income</b>			
1	958	32.69	10.27
2+	1,973	67.31	10.45
<b>Location of Clinic</b>			
Urban	1,906	65.03	10.31
Rural	1,025	34.97	10.55
<b>See a Doctor Within 15 Minutes</b>			
Never/Sometimes/Usually	1,885	64.31	9.97
Always	1,046	35.69	11.16
<b>How Long Have You Been a Patient at CHC?</b>			
Less than 1 year	498	16.99	10.43
More than 1 year	2,433	83.01	10.39