# Satisfaction with and Perceived Cultural Competency of Healthcare Providers: The Minority Experience

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It is well known that nonwhite minority participation in clinical research is lower than their representation in the community. The goal of this study was to assess satisfaction of minority community members in Omaha with the care received and cultural competency of healthcare providers. We sought input from Omaha minority communities on how to improve the care they received and asked why they did not participate in healthcare research. Seventy-two minority members representing African Americans, Hispanic Americans, Native Americans, Sudanese, and Vietnamese; and eight whites were surveyed. The results of this study indicated that the majority of our respondents were satisfied with the care they received, but for a small percentage, language, communication and/or culture contributed to dissatisfaction. In addition, some respondents did not think the provider was culturally competent, i.e., not sufficiently knowledgeable about their racial, ethnic and/or cultural background. Some participants indicated that they preferred a provider of similar racial, ethnic and/or cultural background, and/or thought some diseases were better treated by a provider of the same racial, ethnic and/or cultural background. Regardless of the cultural competency of the provider, the overwhelming majority of our respondents (with the exception of African Americans) indicated a willingness to participate in healthcare research.

In conclusion, this study found that satisfaction with healthcare providers was not associated with perceived cultural competency and that the cultural competency of the provider did not affect patient willingness to participate in healthcare research; however, we acknowledge that the Hawthorne effect may be in operation.

**Key words:** cultural competency ■ researchers ■ community ■ minority population ■ health disparities ■ trust ■ satisfaction

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## INTRODUCTION

Despite the overall improvement of health in the American population, statistics has shown that there is a disparity in the health of certain racial groups. Infant mortality rates for African Americans and Native Americans are twice those of whites, heart disease is 40% higher for blacks than for whites, and Hispanic and Native Americans have a higher rate of diabetes than non-Hispanic whites.[1-2] In addition, maternal mortality for African-American women is almost three times that of the nation. This pattern of disparity is evident in both healthcare utilization and outcome.[3]

## The Problem

Many African Americans distrust the healthcare establishment. This is frequently attributed to the Tuskegee study, conducted from 1932–1973. Poor, black males were recruited for observation but not informed of or offered treatment for active syphilis. Recent studies have shown that blacks are less trusting of healthcare providers than whites.[4-5] However, in order to decrease health disparities, it is necessary for blacks and other minorities to trust the healthcare system and to participate in healthcare research. Lack of trust in healthcare provider is an impediment to participation.[6]

Researchers have found that trust is associated with listening, information provided, time spent and participation in decision-making.[4] Physicians who show comforting and caring behavior, encourage questions and provide answers are associated with trust.[7] Patients with low levels of trust are less satisfied with their care.[8]

Some studies have indicated that trust is greater when the provider is of the same race. Patient's rat-

ing of doctor's care and effort are higher when patient and doctor are both African-American.[9] However, these results contradict an earlier study that found no preference for physicians of the same race but did find physician nonverbal behavior associated with satisfaction and trust.[10] Continuity of care has also been associated with trust for African-American females. Women who rated their doctors high on being able to take care of all their healthcare needs were more trustful of their physician.[11] Higher trust was also associated with use of recommended preventive services.[12] Women with less trust in their physician were less willing to follow his/her advice.[13] Female patients trust female physicians more than male physicians and rated them higher on time spent with and concern shown for patients.[14] Patients who consult a doctor they trust have higher levels of satisfaction.[15]

Lack of trust is just one impediment to the participation of African Americans and other minorities in healthcare research.[16] Shavers-Hornaday et al. found that poor access to primary care, the failure of researchers to recruit African Americans actively, alienation of minority healthcare professionals, lack of knowledge about clinical trials and cultural barriers contribute to low African-American participation in healthcare research.[6] More recent research has shown African Americans less willing to participate in healthcare research if they attribute high importance to the race of the physician when seeking medical care, believed that minorities or the poor bear most of the risks of medical research and were familiar with the Tuskegee Study.[17-18]

Creighton University's Office of Health Sciences: Multicultural and Community Affairs (HS-MACA), in an attempt to increase the participation of African Americans and other minorities in healthcare research, conducted a study to assess satisfaction with healthcare providers among minorities in the Omaha community. HS-MACA wanted two questions answered: 1) are minority healthcare clients satisfied with healthcare services within the Omaha medical community, and 2) why minority healthcare clients do not participate in healthcare research in larger numbers. Because trust has been shown to be related to satisfaction,[15,19,20] we sought to assess satisfaction and not trust. Moreover, existing physician trust scales[21-23] were inadequate for our multicultural population. Preliminary analysis of the data revealed that more than 30% of our sample received their healthcare in the emergency room, not a doctor's office. Physician trust scales usually assume continuity of care with a single provider, something that is not possible with emergency room treatment. It was therefore necessary to develop an instrument, the Community Assessment Instrument (CAI), that took this into consideration. This instrument assesses patient satisfaction, patient perception of healthcare providers' cultural competency and minorities' willingness to participate in healthcare research. HS-MACA theorized that if minority clients are satisfied with their care, this satisfaction would be related to cultural competency of the healthcare provider, and that satisfaction and cultural competency would imply trust between provider and minority patient. If there is trust, perhaps minority patients would be more willing to participate in healthcare research when the opportunity occurs.

**Table 1. Race/ethnicity and gender**

| Race | Female # (%) | Male # (%) | Total # (%) |
|---|---|---|---|
| Missing data | | | 1 (1.3) |
| African-American | 5 | 6 | 11 (13,8) |
| Hispanic-American | 12 | 8 | 20 (25.0) |
| Native-American | 9 | 4 | 13 (16.3) |
| Sudanese | 7 | 10 | 17 (21.3) |
| Vietnamese | 4 | 6 | 10 (12.5) |
| White American | 7 | 1 | 8 (10.0) |
| Total | 44 (55.0) | 35 (43.8) | 80 (100) |

**Table 2. Race/ethnicity and marital status**

| Race | Divorced # (%) | Married # (%) | Separated # (%) | Single # (%) | Widowed # (%) | Total # (%) |
|---|---|---|---|---|---|---|
| Missing data | 0 | 0 | 0 | 0 | 0 | 1 (1.3) |
| African-American | 6 | 0 | 1 | 4 | 0 | 11 (13.8) |
| Hispanic-American | 1 | 14 | 3 | 2 | 0 | 20 (25.0) |
| Native-American | 2 | 4 | 0 | 6 | 1 | 13 (16.3) |
| Sudanese | 0 | 13 | 1 | 2 | 1 | 17 (21.3) |
| Vietnamese | 1 | 7 | 0 | 2 | 0 | 10 (12.5) |
| White | 1 | 3 | 2 | 1 | 1 | 8 (10.0) |
| Total | 11 (13.8) | 41 (51.3) | 7 (8.8) | 17 (21.3) | 3 (3.8) | 80 (100) |

## Research Design

The CAI was developed to assess the Omaha minority communities' satisfaction with healthcare providers and their knowledge and willingness to participate in healthcare research. The CAI consisted of over 70 survey items that were pilot-tested on 12 members of the minority community before being administered to 80 members of the minority and majority community. The minority community included African Americans, Hispanic Americans, Native Americans, Sudanese and Vietnamese. The last two groups are recent immigrants to the Omaha area. The majority community were whites/Caucasians and were included as a reference group.

## Data Collection

Key community organizations that had significant representation of a given minority group were contacted and asked to host a study session. Hosting required the use of their neighborhood facility, provision of refreshments and recruitment of 10 participants. In order to assure at ≥10 participants at each study session, we solicited confirmation from ≥12 potential participants. All participants who arrived at the designated site were included in the study. The only requirement for participation was that the participant had visited a healthcare provider in the Omaha community within the last 12 months preceding the session.

If the study population's first language was not English, the host organization was responsible for providing interpreters, except for the Hispanic and Vietnamese groups, whose interpreters were affiliated with Creighton University Medical Center (CUMC). The interpreters stood next to the study presenter and focus group facilitator and translated every sentence to ensure consistency among all the study groups. Bilingual staff affiliated with the host organization was also available to provide additional assistance to respondents. The Sudanese women and men's groups created the most challenge. Interpreters were needed for the Nuer, Dinka and Arabic languages. In addition, many of the men and all of the women needed assistance in completing the questionnaire. Many of the Sudanese females had no formal education so the bilingual staff had to record their answers; as a consequence, these participants have similar answers.

At the beginning of each study session, respondents were given an overview regarding the purpose of the study and asked to sign a consent form. When all consent forms had been collected, the survey instrument was distributed. Respondents were given approximately 30 minutes to complete the form. However, the time period varied with the minority group's English language proficiency. It took approximately 90 minutes for the Sudanese women's group to complete the questionnaire. The Sudanese women's group was the only group that exceeded the allotted time period. Each woman needed the assistance of an

**Table 3. Race/ethnicity and education**

| Education in Years | African-American # (%) | Hispanic-American # (%) | Native-American # (%) | Sudanese # (%) | Vietnamese # (%) | White # (%) | Total # (%) |
|---|---|---|---|---|---|---|---|
| ≤9 | 0 | 4 (5.3) | 0 | 5 (6.7) | 0 | 0 | 9 (12.0) |
| 10–11 | 0 | 7 (9.3) | 3 (4.0) | 3 (4.0) | 5 (6.7) | 0 | 18 (24.0) |
| 12 (HS grad/GED) | 2 (2.7) | 2 (2.7) | 4 (5.3) | 5 (6.7) | 0 | 3 (4.0) | 16 (21.3) |
| 13 (some college) | 6 (8.0) | 0 | 4 (5.3) | 3 (4.0) | 1 (1.3) | 3 (4.0) | 17 (22.7) |
| 14–15 (AA/AS) | 0 | 1 (1.3) | 2 (2.7) | 0 | 2 (2.7) | 0 | 5 (6.7) |
| 16 (BA/BS) | 1 (0.13) | 2 (2.7) | 0 | 1 (1.3) | 1 (1.3) | 2 (2.7) | 7 (9.3) |
| 17–18 (MA/MS) | 1 (1.3) | 1 (1.3) | 0 | 0 | 0 | 0 | 2 (2.7) |
| ≥19 (PhD, MD, JD) | 0 | 1 (1.3) | 0 | 0 | 0 | 0 | 1 (1.3) |
| Total | 10 (13.3) | 18 (24.0) | 13 (17.3) | 17 (22.7) | 9 (12.0) | 8 (10.7) | 75 (100) |

**Table 4. Race/ethnicity and English**

| English Is First Language | African American # (%) | Hispanic American # (%) | Native American # (%) | Sudanese # (%) | Vietnamese # (%) | White # (%) | Total # (%) |
|---|---|---|---|---|---|---|---|
| Missing data | | | | | | | 1 (1.3) |
| No | 0 | 20 (25.0) | 1 (1.3) | 17 (21.3) | 10 (12.5) | 0 | 48 (60.0) |
| Yes | 11 (13.8) | 0 | 12 (15.0) | 0 | 0 | 8 (10.0) | 31 (38.8) |
| Total | 11 (13.8) | 20 (25.0) | 13 (16.3) | 17 (21.3) | 10 (12.5) | 8 (10.0) | 80 (100) |

interpreter to translate the question, explain the possible answers and record the answers on the questionnaire. The Sudanese men's group had 15 people attend, but only nine were part of the study. The six additional men assisted with translating and completing the questionnaire. When it was determined that only nine men completed the consent form, one of the interpreters agreed to be a participant to achieve our goal of 10. Only three of the Sudanese men who participated in this study did not need an interpreter. All respondents were asked to answer the questions to the best of their knowledge and ability and to hold their questions and comments until the focus group was conducted. After the questionnaire was collected from all respondents, a facilitator not affiliated with Creighton University, conducted the focus group. For the Vietnamese and Hispanic groups, the interpreter stood next to the facilitator. For the Sudanese group, the interpreters stood or sat next to his or her language group. The Sudanese and Caucasian focus groups were held at CUMC in the same room where the pilot studies were conducted in June 2003. In addition, the women's Sudanese group was moved to another location because they exceeded the time scheduled for use of the room, and two of the Arabic-speaking males were relocated to the cafeteria to complete the questionnaire while the focus group discussion began.

The Caucasian group presenter was a white female affiliated with CUMC. This is the only group where consistency of presentation was not maintained. The original female presenter, a local African American, resumed her doctoral studies out of state. Furthermore, the Caucasian group was added as a reference group for the study; they were not part of the original research design. We wanted to ascertain if whites had similar experiences with the Omaha medical community as minorities. The analysis of the focus group will be discussed in a separate paper. Respondents were paid $50 for travel expenses. The host organization was compensated $250 for its assistance. IRB approval was obtained for both the pilot study and this study.

## Demographic Information

Table 1 provides us with the ethnic/racial and gender background of the 80 respondents. The sample was 43.8% male and 55% female. One respondent did not indicate his/her gender. Table 2 shows that 51.3% of the sample was married but that none of the African Americans were married. The data also indicated that more females than males were married.

The participants ranged in age from 18–80. However, more than 50% of the respondents were in their 30s or 40s, and 32% had no children living at home age <19. This does not mean they had no children; many had grown children. The study was concerned with minors in the household whose healthcare may have been dependent on the respondent.

**Table 5. Rate care received from doctor with race**

| Race | No Response #(%) | Unsatisfactory # (%) | Below Adequate # (%) | Adequate # (%) | Good # (%) | Excellent # (%) | Total # (%) |
|---|---|---|---|---|---|---|---|
| | 1 (1.3) | 0 | 0 | 0 | 0 | 0 | 1 (1.3) |
| African-American | 1 (1.3) | 0 | 0 | 5 (6.3) | 4 (5.0) | 1 (1.3) | 11 (13.8) |
| Hispanic-American | 1 (1.3) | 1 (1.3) | 0 | 3 (3.8) | 6 (7.5) | 9 (11.3) | 20 (25.0) |
| Native-American | 0 | 0 | 1 (1.3) | 3 (3.8) | 4 (5.0) | 5 (6.3) | 13 (16.3) |
| Sudanese | 2 (2.5) | 2 (2.5) | 1 (1.3) | 0 | 4 (5.0) | 8 (10.0) | 17 (21.3) |
| Vietnamese | 0 | 0 | 0 | 0 | 7 (8.8) | 3 (3.8) | 10 (12.5) |
| White | 0 | 0 | 1 (1.3) | 1 (1.3) | 2 (2.5) | 4 (5.0) | 8 (10.0) |
| Total | 5 (6.3) | 3 (3.8) | 3 (3.8) | 12(15.0) | 27 (33.8) | 30(37.5) | 80 (100) |

**Table 6. Rate care received from nurses with race**

| Race | No Response #(%) | Unsatisfactory # (%) | Below Adequate # (%) | Adequate # (%) | Good # (%) | Excellent # (%) | Total # (%) |
|---|---|---|---|---|---|---|---|
| | 1 (1.3) | 0 | 0 | 0 | 0 | 0 | 1 (1.3) |
| African-American | 0 | 0 | 1 (1.3) | 4 (5.0) | 5 (6.3) | 1 (1.3) | 11 (13.8) |
| Hispanic-American | 0 | 1 (1.3) | 0 | 4 (5.0) | 9 (11.3) | 6 (7.5) | 20 (25.0) |
| Native-American | 0 | 0 | 0 | 3 (3.8) | 5 (6.3) | 5 (6.3) | 13 (16.3) |
| Sudanese | 1 (1.3) | 2 (2.5) | 0 | 1 (1.3) | 3 (3.8) | 10 (12.5) | 17 (21.3) |
| Vietnamese | 0 | 0 | 0 | 3 (3.8) | 4 (5.0) | 3 (3.8) | 10 (12.5) |
| White | 0 | 0 | 0 | 0 | 4 (5.0) | 4 (5.0) | 8 (10.0) |
| Total | 2 (2.5) | 3 (3.8) | 1 (1.3) | 15 (18.8) | 30 (37.5) | 29 (36.3) | 80 (100) |

Table 3 represents the education distribution by race/ethnicity. Five individuals did not answer this question or said "none." "None" is interpreted as no formal education. All education tables are based on a sample size of 75 instead of 80. One male had a doctorate, two respondents had master degrees and seven respondents had bachelor degrees. The majority of the respondents had a high-school education or more. All of the African-American and white respondents were high-school graduates. More than half of these two groups had some college or a college degree.

Table 4 indicates that English was not the first language for the majority of the respondents. Non-English languages spoken included Arabic, Dinka, Nuer (Sudanese), Dakotaxh (Native-American), Spanish and Vietnamese. Twenty-four or 53% of our non-English speaking population had less than a high-school education in comparison to only three or 10% of the English-speaking population.

Although the study was conducted by personnel affiliated with CUMC, only 65% or 52 of the respondents had been treated by a CUMC provider. In addition, only 43% or 33 said the last visit to a healthcare provider was at a CUMC facility or provider. The results of this study are not indicative of the care received at CUMC specifically, but the Omaha medical community generally.

## Hypotheses

1. Minority community members are not satisfied with their healthcare.
2. Minority community members have difficulty communicating with healthcare providers.
3. Minority community members find that healthcare providers are not adequately knowledgeable about their ethnic group and culture.
4. Minority community members prefer healthcare providers who are of the same ethnic, racial and/or cultural background.
5. Minority community members have never participated in healthcare research.
6. Minority community members do not want to participate in healthcare research.

We entered this study with the expectation that minorities within the Omaha community were not satisfied with healthcare providers and therefore were hesitant to participate in healthcare research. Six hypotheses were formulated; survey items were developed to test each one of these hypotheses. The target population included African Americans, Hispanic Americans and Native Americans. The health disparities of these groups have been well documented; they have higher rates of diabetes, heart disease and infant mortality.

We also included in this study recent immigrants whom we knew from the media, or word of mouth, were experiencing language or cultural difficulties with the medical community: the Sudanese and Vietnamese populations. These two groups are

**Table 7. Would you want to see the same or different healthcare provider?**

| Race | No Response # (%) | Different # (%) | Same # (%) | Total # (%) |
|---|---|---|---|---|
| Missing data | 1 (1.3) | 0 | 0 | 1 (1.3) |
| African-American | 0 | 1 (1.3) | 10 (12.5) | 11 (13.8) |
| Hispanic-American | 3 (3.8) | 1 (1.3) | 16 (20.0) | 20 (25.0) |
| Native-American | 0 | 2 (2.5) | 11 (13.8) | 13 (16.3) |
| Sudanese | 3 (3.8) | 0 | 14 (17.5) | 17 (21.3) |
| Vietnamese | 0 | 1 (1.3) | 9 (11.3) | 10 (12.5) |
| White | 0 | 2 (2.5) | 6 (7.5) | 8 (10.0) |
| Total | 7 (8.8) | 7 (8.8) | 66 (82.5) | 80 (100) |

**Table 8. Able to complete papers/forms and race**

| Race | No Response # (%) | No # (%) | Yes # (%) | Yes Help HELP # (%) | Total # (%) |
|---|---|---|---|---|---|
| Missing data | 1 (1.3) | 0 | 0 | 0 | 1 (1.30 |
| African-American | 2 (2.5) | 2 (2.5) | 7 (8.8) | 0 | 11 (13.8) |
| Hispanic-American | 8 (10.0) | 2 (2.5) | 10 (12.5) | 0 | 20 (25.0) |
| Native-American | 2 (2.5) | 0 | 10 (12.5) | 1 (1.3) | 13 (16.3) |
| Sudanese | 4 (5.0) | 7 (8.8) | 6 (7.5) | 0 | 17 (21.3) |
| Vietnamese | 1 (1.3) | 2 (2.5) | 7 (8.8) | 0 | 10 (12.5) |
| White | 1 (1.3) | 0 | 7 (8.8) | 0 | 8 (10.0) |
| Total | 19 (23.8) | 13 (16.3) | 47 (58.8) | 1 (1.3) | 80 (100) |

recent arrivals to Omaha. Although the Vietnamese have been in Omaha since the 1970s, they are still not completely assimilated and continue to utilize folk medicine. The Sudanese have arrived within the last 10 years. Their healthcare needs and folk medical practices are still being assessed. However, their concerns for "excessive" Caesarean sections, a disproportionate number of their women being diagnosed with mental illness, and long waits for medical care because an interpreter is not available is the reason for their inclusion in this study.

The white population was included as a reference group. The question arose whether whites of lower socioeconomic status were satisfied with healthcare or had similar experiences as blacks and other minorities. Although we did not collect information on income, all of the white and African-American participants were high-school graduates; this is not true for the rest of our sample.

## Findings

**Minority community members are not satisfied with their healthcare.** This hypothesis is not supported by our data. Only nine respondents (11.3%) reported dissatisfaction, six with care provided by the physician and four the nurse. One of the nine was dissatisfied with both the physician and nurse (Tables 5 and 6). The overwhelming majority of our respondents were satisfied with care they received. When these same respondents were asked if they would go to the same healthcare provider the next time they became ill, 66 or 83% said yes. Only seven respondents said they would want to see a different provider (Table 7). Although nine respondents were dissatisfied with doctor and/or nursing care, only seven said they would not go to the same provider again. All of the ethnic and racial groups were represented in the dissatisfaction with provider except for the Vietnamese and white group. And yet of the white group, two would go to a different provider the next time; and of the Vietnamese group, one would seek a different provider.

Reasons for dissatisfaction among the participants include the following:

Three Native Americans:
1. Doctor said there was nothing wrong with her but she was still hurting.
2. Doctor said she didn't have an infection but she did.
3. Patient was not satisfied that care received was professionally adequate.

Three Sudanese:
1. Rated both doctor and nurse as unsatisfactory but gave no comment
2. Doctor didn't treat her well; he told her he didn't understand her problem.
3. Patient said she had to wait long and saw too many different doctors.

**Table 9. The interpreter did an adequate job**

| Race | No Response # (%) | No # (%) | Yes # (%) | Total # (%) |
|---|---|---|---|---|
| Missing data | 1 (1.3) | 0 | 0 | 1 (1.3) |
| African-American | 11 (13.8) | 0 | 0 | 11 (13.8) |
| Hispanic-American | 11 (13.8) | 0 | 9 (11.3) | 20 (25.0) |
| Native-American | 12 (15.0) | 0 | 1 (1.3) | 13 (16.3) |
| Sudanese | 9 (11.3) | 1 (1.3) | 7 (8.8) | 17 (21.3) |
| Vietnamese | 7 (8.8) | 2 (2.5) | 1 (1.3) | 10 (12..5) |
| White | 8 (10.0) | 0 | 0 | 8 (10.0) |
| Total | 59 (73.8) | 3 (3.8) | 18 (22.5) | 80 (100) |

**Table 10. Healthcare provider familiar with cultural background**

| Race | No Response # (%) | Don't Know # (%) | No # (%) | Yes # (%) | Total # (%) |
|---|---|---|---|---|---|
| Missing data | 1 (1.3) | 0 | 0 | 0 | 1 (1.3) |
| African-American | 0 | 4 (5.0) | 1 (1.3) | 6 (7,5) | 11 (13.8) |
| Hispanic-American | 0 | 1 (1.3) | O | 19 (23.8) | 20 (25.0) |
| Native-American | 0 | 0 | 4 ( 5.0) | 9 (11.3) | 13 (16.3) |
| Sudanese | 1 (1.3) | 3 (3.8) | 12 (15.0) | 1 (1.3) | 17 (21.3) |
| Vietnamese | 0 | 0 | 6 (7.5) | 4 (5.0) | 10 (12.5) |
| White | 0 | 0 | 0 | 8 (10.0) | 8 (10.) |
| Total | 2 (2.5) | 8 (10.0) | 23 (28.8) | 47 (58.8) | 80 (100) |

Two Hispanics:
1. Doctor treated her badly because she didn't speak the language.
2. Doctor had a bad attitude and was misinformed.

One African American:
1. Doctor failed to diagnose her asthma because the doctor rushed through the exam.

**Minority community members have difficulty communicating with healthcare providers.** Though the majority of the respondents were satisfied with the care they received, our results suggest that there is room for improvement in doctor/ patient interaction and communication. The data support the hypothesis that for some minorities, a language barrier creates problems when seeking healthcare services. Communication, whether written or spoken, has some effect on the care. More than 70% of the respondents were asked to complete forms at their last visit to a healthcare provider, but only 59% were able to do so without help. Whites were the only group that did not need assistance in completing the form (Table 8). Fifteen respondents said they needed an interpreter at their last visit, seven used a relative. When asked if the interpreter did an adequate job, here are the findings: one Sudanese and two Vietnamese said no (Table 9). This may have contributed to the dissatisfaction with healthcare for the Sudanese, but the Vietnamese did not express dissatisfaction with healthcare received.

**Minority community members find that healthcare providers are not adequately knowledgeable about their ethnic group and culture.** Linguistic competency is not the only way to measure communication problems. Cultural competency was assessed from the patient-client perspective. The majority of the respondents think that the last healthcare provider that they visited was familiar enough with their cultural background to treat someone of their ethnic or racial group. However, 29% or 23 of our respondents disagreed: four Native Americans, 12 Sudanese, six Vietnamese and one African-American (Table 10). Only one Hispanic said he did not know, and three Hispanics said they were not comfortable with the healthcare provider's medical knowledge of their illness (Table 11).

Lack of cultural understanding and sensitivity by providers also contributes to problems of communication, establishment of trust and satisfaction. Only 51% of the respondents said that the doctor asked them what they thought caused their illness. Thirty-one said the doctor did not ask. And only 25 said that the doctor asked what treatment they thought they should receive. In addition, 22 of our respondents said the doctor made no attempt to communicate with them through language and/or gestures. Thirty-seven said no visual aids were used. Six felt that the healthcare provider "spoke down to them." Four said the doctor used "too many big words." Eighteen said they were not able to talk to the nurse, and 14 said they had difficulty talking to the doctor. Even

**Table 11. Comfortable with healthcare provider's medical knowledge of illness**

| Race | No Response # (%) | Don't Know # (%) | No # (%) | Yes # (%) | Total # (%) |
|---|---|---|---|---|---|
| Missing data | 1 (1.3) | 0 | 0 | 0 | 1 (1.3) |
| African-American | 1 (1.3) | 2 (2.5) | 1 (1.3) | 7 (8.8) | 11 (13.8) |
| Hispanic-American | 2 (2.5) | 0 | 3 (3.8) | 15 (18.8) | 20 (25.0) |
| Native-American | 0 | 0 | 2 (2.5) | 11 (13.8) | 13 (16.3) |
| Sudanese | 1 (1.3) | 3 (3.8) | 1 (1.3) | 12 (15.0) | 17 (21.3) |
| Vietnamese | 0 | 1 (1.3) | 1 (1.3) | 8 (10.0) | 10 (12.5) |
| White | 0 | 0 | 1 (.13) | 7 (8.8) | 8 (10.0) |
| Total | 5 (6.3) | 6 (7.5) | 9 (11.3) | 60 (75.0) | 80 (100) |

**Table 12. Certain illness can be better treated by someone of the same ethnic/racial cultural group**

| Race | No Response # (%) | Don't Know # (%) | NA # (%) | No # (%) | Yes # (%) | Total # (%) |
|---|---|---|---|---|---|---|
| Missing data | 1 (1.3) | 0 | 0 | 0 | 0 | 1 (1.3) |
| African-American | 0 | 6 (7.5) | 1 (1.3) | 1 (1.3) | 3 (3.8) | 11 (13.8) |
| Hispanic-American | 1 (1.3) | 1 (1.3) | 0 | 12 (15.0) | 6 (7.5) | 20 (25.0) |
| Native-American | 0 | 3 (3.8) | 0 | 4 (5.0) | 6 (7.5) | 13 (16.3) |
| Sudanese | 1 (1.3) | 3 (3.8) | 0 | 5 (6.3) | 8 (10.0) | 17 (21.3) |
| Vietnamese | 1 (1.3) | 1 (1.3) | 0 | 4 (5.0) | 4 (5.0) | 10 (12.5) |
| White | 1 (1.3) | 0 | 0 | 5 (6.3) | 2 (2.5) | 8 (10.0) |
| Total | 5 (6.3) | 14 (17.5) | 1 (1.3) | 31 (38.8) | 29 (36.3) | 80 (100) |

though the majority of our respondents say they are satisfied with healthcare, there are problems with doctor–patient interaction and/or communication. Perhaps more respondents require the services of an interpreter than are willing to admit, and lack of patient input with diagnosis may be contributing to dissatisfaction with healthcare received. Thom et al. found encouraging questions and providing answers associated with trust and satisfaction.[7,8] There may be more respondents who were less than satisfied with healthcare received but were reluctant to say so on paper. This may be the reason three respondents said they were satisfied with care but would seek a different provider next time. Silence or unexpressed dissatisfaction may have manifested itself in responses to questions testing the fourth hypothesis.

**Minority community members prefer healthcare providers who are of the same ethnic, racial and/or cultural background.** The data support a preference for healthcare providers of the same racial and/or ethnic group. When respondents were asked if there were certain illnesses that were better treated by someone of the same ethnic or racial background, 36% or 29 respondents said yes (Table 12). Many respondents thought diabetes was a disease that could be better treated by someone of the same ethnic or racial group because the healthcare provider would be familiar with that racial/ ethnic group's diet.

**Minority community members do not participate in healthcare research. Minority community members do not want to participate in healthcare research.** The data support the first of these two hypotheses. Only seven respondents had ever been asked to participate in a healthcare study (Table 13). These seven participated in an osteoporosis, breast cancer, smoking and homelessness study. This result clearly indicates that a lack of willingness does not account for the low participation in clinical studies. When probed for their reason for participation, they said to improve healthcare and to help others. Furthermore, 70% of respondents said if they were asked, they would participate in a study (Table 14). Their reason for participation was similar to those who had, and included "to learn more about the disease", "to get treatment", "to teach providers about their culture", and "money."

Approximately 25% of our sample said they did not know if they would participate in a healthcare study if asked or said, no, they would not participate if asked. This percentage exceeds the 11.3% that were dissatisfied with healthcare. A disproportionate number unwilling to participate were African Americans. All of the whites said they would participate. Reasons for not participating in a healthcare study included: "it might hurt me", "meds not approved by the FDA" and "scared of the unknown."

## DISCUSSION

The principle purpose of the study was to ascertain if there was an association between satisfaction

**Table 13. Have you ever been asked to participate in a healthcare study?**

| Race | No Response # (%) | No # (%) | Yes # (%) | Total # (%) |
|---|---|---|---|---|
| Missing data | 1 (1.3) | 0 | 0 | 1 (1.3) |
| African-American | 0 | 11 (13.8) | 0 | 11 )13/8) |
| Hispanic-American | 2 (2.5) | 16 (20.0) | 2 (2.5) | 20 (25.0) |
| Native-American | 0 | 12 (15/0) | 1 (1.3) | 13 (16/3) |
| Sudanese | 1 (1.3) | 15 (18.8) | 1 (1.3) | 17 (21.3) |
| Vietnamese | 0 | 10 (12.5) | 0 | 10 (12.5) |
| White | 0 | 5 (6.3) | 3 (3.8) | 8 (10.0) |
| Total | 4 (5.0) | 69 (86.3) | 7 (8.8) | 80 (100) |

**Table 14. If you were asked, would you participate in a healthcare study with race?**

| Race | No Response # (%) | Don't Know # (%) | No # (%) | Yes # (%) | Total # (%) |
|---|---|---|---|---|---|
| Missing data | 1 (1.3) | 0 | 0 | 0 | 1 (1.3) |
| African-American | 0 | 5 (6.3) | 1 (1.3) | 5 (6.3) | 11 (13.8) |
| Hispanic-American | 1 (1.3) | 2 (2.5) | 3 (3.8) | 14 (17.5) | 20 (25.0) |
| Native-American | 0 | 1 (1.3) | 3 (3.8) | 9 (11.3) | 13 (16.3) |
| Sudanese | 1 (1.3) | 1 (1.3) | 2 (2.5) | 13 (16.3) | 17 (21.3) |
| Vietnamese | 0 | 0 | 3 (3.8) | 7 (8.8) | 10 (12.5) |
| White | 0 | 0 | 0 | 8 (10.0) | 8 (10.0) |
| Total | 3 (3.8) | 9 (11.3) | 12 (15.0) | 56 (70.0) | 80 (100) |

with healthcare, provider cultural competency and participation in healthcare research. Clinical investigators at CUMC were concerned with the low participation of ethnic minorities in healthcare research in the Omaha community, they asked the Office of Health Sciences: Multicultural and Community Affairs to explore the reason.

The results of the data are contradictory. Although the respondents indicate they are satisfied with healthcare, they indicate problems with written and oral communication, participation in the treatment and patient–doctor interaction. In addition, although the majority of respondents think that providers of different racial and ethnic group are familiar enough with their culture to treat them, 23 respondents did not. Nine of the respondents were not comfortable with the doctor's medical knowledge of their illness. Twenty-nine respondents think certain illnesses are better treated by someone of the same racial or ethnic group.

The high degree of satisfaction with healthcare in the Omaha medical community is astonishing given the cultural diversity and linguistic challenges. The fact that only a small percentage voice dissatisfaction may be attributed to the quality healthcare that most clients receive regardless of their ethnic or racial background. However, better communication may be the key to reducing and/or eliminating the dissatisfaction expressed by a small minority.

Professional interpreters should be available for all non-English speakers. In addition, providers may need to request an interpreter if s/he suspects the patient is having difficulty with English. We suspect most of the dissatisfaction with care resulted from a misunderstanding/miscommunication between provider and patient. However, all healthcare facilities in Omaha are being challenged to have bilingual and/or multilingual staff for potential non-English-speaking patients.

In addition to linguistic problems, some respondents indicate that the healthcare provider's lack of knowledge regarding their cultural background may have impacted the care they received. There were some illnesses that our respondents thought could be better treated by someone of the same ethnic or racial group. However, most of these respondents realize that there was a shortage of healthcare providers of their ethnic/racial background or who were familiar with their culture. Their willingness to participate in our study may be a reflection of this understanding. They wanted the opportunity to voice their concerns regarding healthcare in Omaha. In addition, many revealed that this was the first time they had ever been asked to participate in a healthcare study. In order for CUMC to increase the number of minority members in healthcare research, they need to make their research known to the community and actively recruit. It may not be sufficient to put an ad in a local newspaper. They must contact local organizations who can share the research objectives with their members.

Needless to say, we would be remiss if we did not suspect the Hawthorne effect operating in this study. The overwhelming satisfaction expressed by the respondents may be related to the study being conducted by a prestigious medical center. During our pilot study, participants revealed that this was the first time they had been asked to participate in a healthcare study and they felt honored. One could assume that participation in the main study had a similar effect; therefore, respondents may have been reluctant to say anything negative about healthcare providers. Respondents' willingness to participate in future studies may be related to monetary remuneration as well as the "VIP" treatment they received during this study.

CUMC has taken the first steps to improve relations between racial and ethnic minorities and healthcare providers in the Omaha community. We have asked the minority community why they are satisfied or dissatisfied with healthcare. We have sought to determine what barriers exist that would impede minority members participation in healthcare research. We have begun the dialog. The most important thing that we have learned from this study is that no matter how satisfied patients/clients say they are, there is always room for improvement in doctor/patient interaction and communication.

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