From Bias to Better Care: Cultural Competency in Primary Care

HOUSSEIN CHAHROUR, SANJEEVAN MATHIALAGAN, MARIM IBRAHIM, ARMAN AZAD, & MARISSA SINGH

General Practice Society, University College Cork, Ireland

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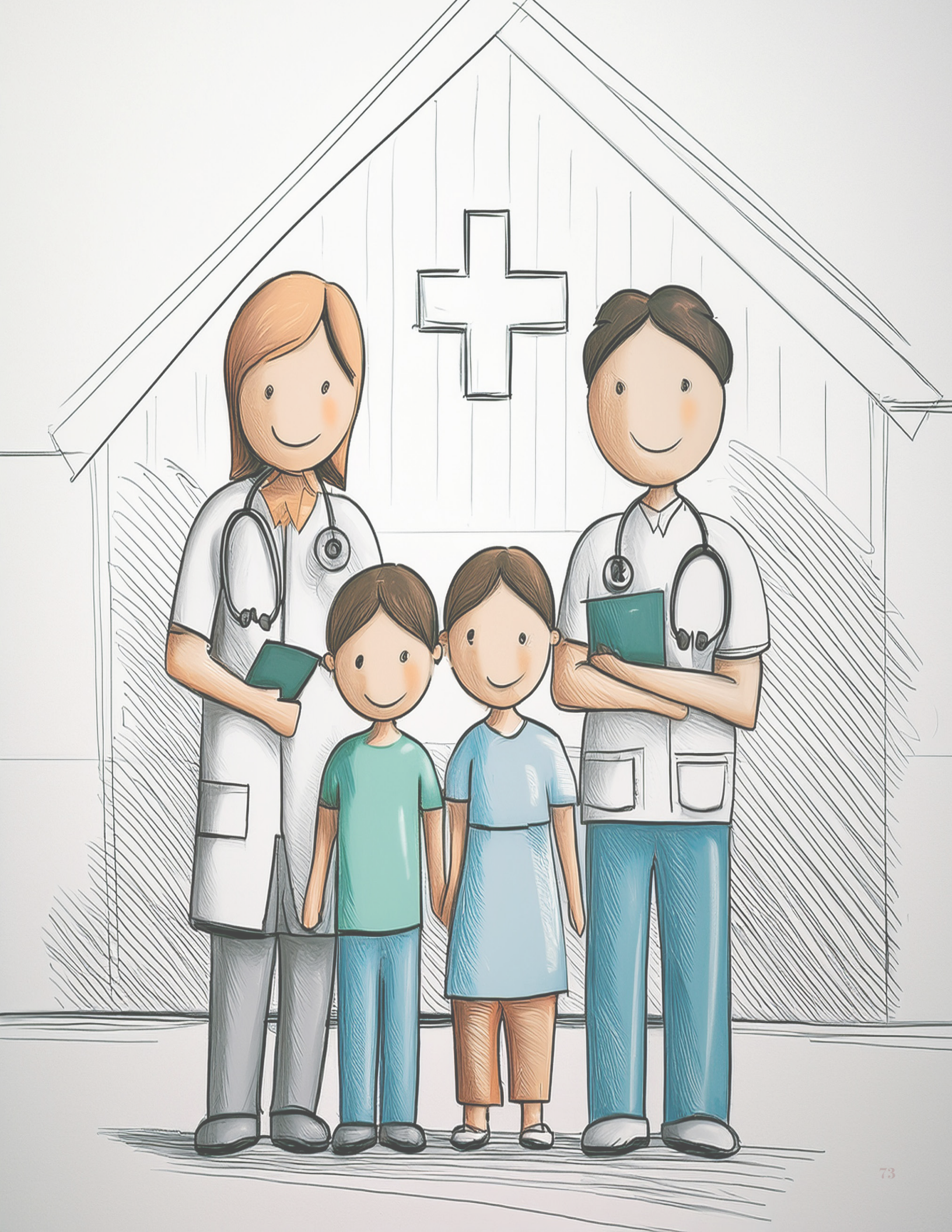
Cultural Implicit bias in healthcare presents a serious problem with potential profound implications for patients. As Ireland's population continues to diversify, so too does the need to address the consequences brought forth by implicit bias. There are particularly high chances that the general practitioner is taken as the first point of contact for many patients with various complaints. Implicit bias can influence clinical judgment in a very significant way due to unconscious attitudes or stereotypes that influence decisions made between doctor and patient. As indicated by recent works, such as that by FitzGerald and Hurst (2017), investigating implicit bias within the healthcare setting, it is unconscious stereotypes that act to influence clinicians' perceptions and behaviours. These manifest themselves in many ways, such as in diagnostic evaluations, in treatment recommendations, and even in the amount of empathy provided to patients from diverse backgrounds (Blair et al., 2013). While much of the existing literature focuses on the United States and other contexts, unique cultural and systemic features within Ireland's healthcare landscape raise specific reasons to take a closer look at implicit bias among Irish GPs.

Marginality and implicit biases in healthcare contribute to significant disparities in patient care and health outcomes. Disparities related to marginality can explain differences in health outcomes and quality of life (Havranek et al., 2015). Hall et al. (2015) found that implicit biases harm patient–provider interactions, treatment decisions, and patient adherence. Cooper et al. (2012) reported that physician bias consistently leads to discriminatory care, with patients rating physicians who have higher implicit bias as less patient-centered. Blanchard & Lurie (2004) showed that patients who felt they would have received better treatment if they were another race were less likely to get recommended chronic disease screenings, follow medical advice, or seek care promptly. Furthermore, Blair et al. (2013) found that higher provider bias correlated with lower patient ratings of interpersonal treatment, knowledge of patient context, communication, and trust. In England, ethnic minority patients have repeatedly reported lower satisfaction with primary care, mainly due to service-related factors rather than patient characteristics (Magadi & Magadi, 2022). This spotlights the need to address structural and contextual issues in healthcare to improve patient experiences and outcomes.

The dilemma in primary-care disparities in underserved communities has given rise to different solutions to be enacted to varying levels of success (Vanderbilt, Dail, & Jaberi, 2015); one being the targeted recruitment of medical students likely to practice in rural areas (Evans et al., 2020; Vanderbilt, Dail, & Jaberi, 2015). However, literature shows students' idealistic inclinations toward the service of underserved communities decline during education and training (Smith & Weaver, 2006). A factor being the lack of early exposure and training, given the positive correlation between rural medical electives and students' attitudes in practicing in under-resourced areas (Smith & Weaver, 2006; Kutob et al., 2013). However, nearly half of U.S. family physicians have not received formal cultural/linguistic training in medical school/residency (Mainous et al., 2020). Practical training requires research evidently lacking in underserved communities due to insufficient resources/time, inconsistent global methodology, and lack of community participation (Kumar et al., 2019; Kutob et al., 2013). This cascade of systemic deficiencies is a barrier to bridging the gap in health care for the underserved. Establishing systemic change requires the collective effort of individual physicians, associations, and journals to develop culturally sensitive practices and systems, eventually inducing policy-level change (Kumar et al., 2019; Kutob et al., 2013).

An understanding of various cultures is of particular importance for primary care physicians who are often the patient's first point of contact with healthcare (Rothlind et al., 2021). Failing to appropriately incorporate culture into patient-care and treatment discussions can lead to lower quality care, poorer patient outcomes, and reduced treatment adherence (Brottman et al., 2020; Giger & Davidhizar, 2002). This contributes to health inequities (Brottman et al., 2020). Furthermore, literature shows that many primary care physicians and residents view intercultural interactions as challenging and feel unprepared (Rothlind et al., 2021). Consequently, there is an increasing demand for training (Brottman et al., 2020). This need has further been voiced by education boards such as the Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, Institute of Medicine, and World Health Organization (Brottman et al., 2020). The Liaison Committee on Medical Education has proposed four major pillars of cultural education which include skills, attitudes, awareness, and knowledge (Brottman et al., 2020; Association of American Medical Colleges,



2003). Although exact training schemes and methods are still an area of active exploration, one proposed method of training is the use of virtual patient simulations (Rothlind et al., 2021). Ultimately, there is a need for primary care physicians to undergo formal training and teaching in intercultural care in order to provide appropriate, holistic, patient-centered care.

Primary care physicians hold an important role in health-promotion and equity in healthcare (Williamson, 2024). In marginalized communities, they perform the vital role of promoting health screenings and treatment compliance (Hall et al., 2015). However, despite their importance in these communities, disparity in quality of this care can have significant effects on health-related quality of life (Havranek et al., 2015). Furthermore, while initiatives like targeted medical student recruitment aim to fill this gap, they have not been entirely successful. This is largely due to a lack of formal training for both students and physicians in how to provide culturally competent care (Smith & Weaver, 2006; Kutob et al., 2013; Brottman et al., 2020). Many physicians feel unprepared to provide this type of care, highlighting the need for adequate training on this topic (Rothlind et al., 2021). Although there is no consensus on what type of training is best, greater investment into these training programs is necessary to provide better quality healthcare to minority groups. For the future, we must continue to examine the importance of primary care in marginalized communities, and the efficacy of initiatives to promote this care and cultural competency at large. Through this understanding we can ensure better access and quality of primary care to communities that need it most.

References

1. Association of American Medical Colleges, Liaison Committee on Medical Education. Functions and structure of a medical school: standards for accreditation of medical education programs leading to the MD degree. Liaison Committee on Medical Education; 2003.
2. Blair, I. V., Steiner, J. F., Fairclough, D. L., Hanratty, R., Price, D. W., Hirsh, H. K., Wright, L. A., Bronsert, M., Karimkhani, E., Magid, D. J., & Havranek, E. P. (2013). Clinicians' implicit Ethnic/Racial bias and perceptions of care among Black and Latino patients. The Annals of Family Medicine, 11(1), 43–52. https://doi.org/10.1370/afm.1442.
3. Blair, Irene V., et al. "Clinicians' implicit ethnic/racial bias and perceptions of care among Black and Latino patients." The Annals of Family Medicine 11.1 (2013): 43-52.
4. Blanchard, J., & Lurie, N. (2004). R-E-S-P-E-C-T: patient reports of disrespect in the health care setting and its impact on care. PubMed. https://pubmed.ncbi.nlm.nih.gov/15353162/.
5. Brottman MR, Char DM, Hattori RA, Heeb R, Taff SD. Toward cultural competency in health care: a scoping review of the diversity and inclusion education literature. Academic Medicine. 2020 May 1;95(5):803-13. Available from: https://journals.lww.com/academicmedicine/fulltext/2020/05000/Toward_Cultural_Competency_in_Health_Care__A.37.aspx.
6. Cooper, L. A., Roter, D. L., Carson, K. A., Beach, M. C., Sabin, J. A., Greenwald, A. G., & Inui, T. S. (2012). The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. American Journal of Public Health, 102(5), 979–987. https://doi.org/10.2105/ajph.2011.300558.
7. Evans, D., Jopson, A., Andrilla, C. H., Longenecker, R., & Patterson, D. (2020). Targeted Medical School Admissions: A Strategic Process for Meeting Our Social Mission. Family Medicine, 52(7), 474–482. https://doi.org/10.22454/FamMed.2020.470334.
8. FitzGerald, Chloë, and Samia Hurst. "Implicit bias in healthcare professionals: a systematic review." BMC medical ethics 18 (2017): 1-18.
9. Giger JN, Davidhizar R. The Giger and Davidhizar transcultural assessment model. Journal of Transcultural Nursing. 2002 Jul;13(3):185-8. Available from: https://journals.sagepub.com/doi/abs/10.1177/104596020013003004.
10. Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., & Coyne-Beasley, T. (2015). Implicit Racial/Ethnic Bias among health care professionals and its influence on health care outcomes: A Systematic review. American Journal of Public Health, 105(12), e60–e76. https://doi.org/10.2105/ajph.2015.302903
11. Havranek, E. P., Mujahid, M. S., Barr, D. A., Blair, I. V., Cohen, M. S., Cruz-Flores, S., Davey-Smith, G., Dennison-Himmelfarb, C. R., Lauer, M. S., Lockwood, D. W., Rosal, M., & Yancy, C. W. (2015). Social determinants of risk and outcomes for cardiovascular disease. Circulation, 132(9), 873–898. https://doi.org/10.1161/cir.0000000000000228.
12. Kumar, R., Bhattacharya, S., Sharma, N., & Thiyagarajan, A. (2019). Cultural competence in family practice and primary care setting. Journal of Family Medicine and Primary Care, 8(1), 1–4. https://doi.org/10.4103/jfmpc.jfmpc_393_18.
13. Kutob, R. M., Bormanis, J., Crago, M., Harris, J. M., Senf, J., & Shisslak, C. M. (2013). Cultural competence education for practicing physicians: Lessons in cultural humility, nonjudgmental behaviors, and health beliefs elicitation. The Journal of Continuing Education in the Health Professions, 33(3), 164–173. https://doi.org/10.1002/chp.21181.
14. Magadi, J. P., & Magadi, M. A. (2022). Ethnic inequalities in patient satisfaction with primary health care in England: Evidence from recent General Practitioner Patient Surveys (GPPS). PLoS ONE, 17(12), e0270775. https://doi.org/10.1371/journal.pone.0270775.
15. Mainous, A. G., Xie, Z., Yadav, S., Williams, M., Blue, A. V., & Hong, Y.-R. (2020). Physician Cultural Competency Training and Impact on Behavior: Evidence From the 2016 National Ambulatory Medical Care Survey. Family Medicine, 52(8), 562–569. https://doi.org/10.22454/FamMed.2020.163135.
16. Rothlind E, Fors U, Salminen H, Wändell P, Ekblad S. Virtual patients reflecting the clinical reality of primary care–a useful tool to improve cultural competence. BMC Medical Education. 2021 May 11;21(1):270. Available from: https://link.springer.com/article/10.1186/s12909-021-02701-z.
17. Smith, J. K., & Weaver, D. B. (2006). Capturing medical students' idealism. Annals of Family Medicine, 4 Suppl 1(Suppl 1), S32-37; discussion S58-60. https://doi.org/10.1370/afm.543.
18. Vanderbilt, A. A., Dail, M. D., & Jaberi, P. (2015). Reducing health disparities in underserved communities via interprofessional collaboration across health care professions. Journal of Multidisciplinary Healthcare, 8, 205–208. https://doi.org/10.2147/JMDH.S74129.
19. Williamson G. Healthcare access disparities among marginalized communities Global Perspectives in Health, Medicine and Nursing. 2024;3(1):11-122.