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The Dynamics of Patient-Physician Interactions and Their Impact on Health Disparities in Cancer Care Among Marginalized Populations: A Comprehensive Scoping Review

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Abstract

Background: Health disparities in cancer care pose significant challenges. These disparities arise from a complex interplay of socioeconomic factors, discrimination, and inadequate healthcare access, leading to suboptimal clinical outcomes. This review aims to synthesize existing literature on patient-physician interaction among diverse patient identities in cancer care, emphasizing the impact of these dynamics on treatment experiences.

Methods: A comprehensive scoping review was conducted using major academic databases, including PubMed, Google Scholar, and EBSCO Discovery. The focus was on studies addressing disparities in cancer care related to race/ethnicity, age, sexual orientation gender identity (SOGI), and disabilities. A total of 37 publications were included in the analysis, highlighting the nuances of the patient-physician rapport across various marginalized groups.

Results: The findings underscore that racially and ethnically minoritized patients often experience communication barriers, reduced access to timely and aggressive treatment, and diminished trust in healthcare providers. Additionally, elderly patients and individuals with disabilities exhibited similar challenges in engaging with healthcare providers, further exacerbating health inequities.

Conclusion: This review highlights the urgent need for improved patient-physician communication strategies that are culturally and contextually sensitive to enhance the quality of cancer care for marginalized populations. Interventions aimed at fostering trust and encouraging patient engagement are essential in mitigating health disparities. Future research should focus on multi-perspective assessments of the patient-physician relationship to inform equitable healthcare practices.

Keywords: Health Disparities, Patient-Physician Interaction, Cancer Care, Marginalized Populations, Communication Barriers

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1. Introduction

Due to ongoing health inequities, health equality is a critical public health need. Disparities in cancer care are particularly concerning, given cancer is among the foremost causes of mortality globally [1]. The inequalities literature illustrates variations in cancer incidence, screening, quality of treatment, clinical outcomes, and clinical trial participation due to many socioeconomic determinants of health [2-5]. Populations experiencing disparities in cancer care have traditionally encountered structural inequalities in employment, housing circumstances, education, imprisonment rates, and healthcare access [5]. Moreover, societal hierarchy and institutional policies based on discrimination have led to the systematic marginalization and minoritization of these groups. Cancer-related clinical outcomes in these groups result from a complex interaction of psychological concerns, environmental variables, and healthcare access and quality, with the fundamental biology of cancer [6,7].

The discourse surrounding health and healthcare disparities frequently emphasizes variations among racial and ethnic groups; however, disparate health outcomes are evident across numerous marginalized populations, including individuals with low socioeconomic status (SES), those identifying as sexual orientation and gender identity (SOGI) minorities (e.g., gay, transgender), females or older adults (> 65 years), residents of rural areas, or individuals with disabilities [8-10]. Despite advancements in cancer detection and treatment leading to a reduction in overall incidence and death, certain vulnerable patient populations continue to face elevated risks of cancer diagnosis and mortality. For instance, while the incidence of breast cancer is comparable, the death rates associated with breast cancer are significantly elevated in Black women compared to White women [11]. Moreover, the incidence rates of colorectal, lung, and cervical cancer are elevated in rural Appalachia relative to urban Appalachia [12].

Although substantial institutional and cultural changes are necessary, it is equally crucial to address inequities at the patient level. The transition in cancer treatment from a disease-centered model to a patient- or relationship-centered one may help mitigate cancer-related health inequities by enabling caregivers to customize their approach according to essential cultural variables [13]. Consequently, elements of patient-centered care (PCC) that substantially impact the cancer experience and can be easily adjusted according to specific patient requirements may represent a neglected approach to bridging this gap. A favorable patient-physician connection is an element of patient-centered care (PCC) linked to enhanced outcomes, such as increased patient satisfaction, adherence to treatment protocols, less decisional regret over treatment, and greater adjustment to a cancer diagnosis [14-16]. An unfavorable patient-physician connection may lead to discordant treatment objectives and unfulfilled emotional and spiritual requirements, hence elevating the risk of bad clinical outcomes, including death and recurrence rates [17, 18]. A comprehensive knowledge of the patient-physician interaction in underrepresented communities may enhance therapeutic results. The objective of this review is to analyze and classify the existing information about the patient-physician interaction among marginalized patient identities in the realm of cancer care.

2. Methods

We performed extensive searches in major discovery and web-based platforms, including WorldCat, Google Scholar, and EBSCO Discovery. In EBSCO Discovery, the discipline-specific databases examined included Academic Search Complete, PubMed/MEDLINE, APA PsycInfo, SocIndex, CINAHL, and PsycARTICLES.

3. Disparities in health linked to race/ethnicity within the patient-physician interaction

Patients from racially and ethnically minoritized groups have several obstacles to receiving adequate treatment, which exacerbate inequities associated with cancer. Minoritized patients may encounter restricted access to health services [19-23]. For instance, American Indian/Alaska Natives are unable to get certain specialized medical services at tribal clinics and must instead navigate a complex application procedure with Contract Health Services [24, 25]. Language issues may hinder patients' access to treatment and their overall experience; several hospital systems may lack qualified translators to facilitate patient-physician communication. Despite the patient’s proficiency in English, issues may still arise in comprehensively assimilating all disease-related information conveyed during a brief typical cancer clinic consultation. Cultural issues, such as the heightened stigma surrounding depressed symptoms in Hispanic populations, might impede access to treatment [26]. Ultimately, minoritized patients exhibit widespread distrust of the medical system stemming from previous trauma, abuses, and contemporary biases. Studies indicate that racially and ethnically minoritized patients frequently receive less aggressive, timely, and guideline-adherent cancer treatment (e.g., conservative management instead of radical prostatectomy for prostate cancer), even when accounting for confounding variables such as cancer type, stage at diagnosis, access to care, and socioeconomic status [27-29].

Racial prejudice and other detrimental race-related attitudes among healthcare practitioners lead to treatment inequities and negatively impact the patient-physician interaction. Evidence indicates that oncology providers, predominantly White, perceive racial and ethnic minority patients as fewer effective communicators than their White counterparts, resulting in a tendency to exhibit greater verbal dominance and reduced patient-centeredness in discussions regarding cancer treatment [30]. These biases may lead some physicians to provide certain treatment alternatives and/or to phrase treatment options distinctly. From the patient's viewpoint, elements such as perceived discrimination, racial prejudice, and general distrust of the provider and healthcare system correlate with reduced healthcare usage and follow-up, delays in getting treatment, and increased treatment nonadherence [31]. Moreover, delays in diagnosis and treatment correlate with advanced stages of presentation, thereby reducing possible survival chances [32]. There are substantial obstacles to establishing linguistically and culturally suitable patient-physician connections for racially and ethnically marginalized patients, increasing their risk for adverse outcomes.

Our assessment of research involving racially and ethnically minoritized patients emphasized the need for physicians to address culturally particular requirements while still catering to the essential universal needs of all patients. In the patient-physician interaction, these requirements included communication and confidence between the patient and physician. Numerous research indicates substandard patient-physician communication among racially and ethnically minoritized patients, particularly highlighting that Black women have the most significant communication deficiencies [33]. In comparison to White women, Black women were less likely to have their informational requirements satisfied by their cancer provider [34]. The absence of communication may directly influence treatment choices and, therefore, survival outcomes. Research conducted by Sheppard et al. showed that Black women who had improved communication with their doctors had approximately fourfold increased likelihood of commencing clinically recommended chemotherapy as a component of their cancer treatment, after adjusting for any confounding factors [35]. Gordon et al. conducted research in which patient-physician interactions were videotaped and analyzed by an impartial third party, revealing racial disparities in information-sharing habits. Black patients got less information from their doctors and were less engaged in treatment discussions compared to White patients [36].

Numerous research examined obstacles to successful communication between patients and physicians about racially and ethnically minoritized individuals, including time constraints, patient health literacy, and language problems [26]. Oncologists exhibiting higher scores on unconscious racial prejudice assessments engaged in briefer, less patient-centered contacts with racial minority patients [27]. Siminoff and colleagues also indicated that doctors allocate more time to relationship-building activities with White patients compared to non-White patients [37, 38]. Medical distrust correlated with diminished satisfaction with doctors' competencies, less patient self-efficacy, a decline in positive coping mechanisms, and worse quality of life [39, 40]. An adverse correlation existed between the duration before chemotherapy commencement and confidence in their physician among Black patients. Increased confidence in a provider led to a decreased delay in the commencement of treatment [35].

The use of a common language and the inclusion of a patient's social network, such as family and other significant community figures, have shown efficacy in reducing racial and ethnic differences in therapy. English-speaking Latina patients were more likely than Spanish-speaking Latina patients to follow up with their physician after breast cancer surgery and to express greater satisfaction with their treatment [32, 41]. A qualitative study by Williams et al. revealed that Black cancer patients emphasized the necessity for their physicians to establish a rapport and communicate effectively with them and their family members, as well as the need for providers to customize their communication strategies according to their understanding of and relationships with each family member [42].

4. Patient-physician rapport and age-associated health inequalities

Senior patients have obstacles in obtaining participative treatment from their healthcare professionals. Physicians often provide less information, allocate less time, and exhibit less involvement with elderly patients compared to younger patients throughout the treatment process [43]. Moreover, elderly people are less inclined to be aggressive, inquire with their physicians, and engage actively in treatment decision-making discussions [44-47]. An assessment of the impact of physician-patient interactions on older patients (age ≥ 55) indicates that the primary element of this connection is informational assistance. Patients with elevated perceived support exhibited enhanced breast cancer awareness, a reduced probability of treatment delay, and an improved chance of receiving breast-conserving surgery. Significantly, patient age did not exert influence in the multivariable analysis [47].

5. Patient-physician rapport and health inequalities Linked to sexual orientation and gender identity

Recent studies indicate that elevated frequencies of hazardous health behaviors, such as smoking, may lead to increased incidence rates of some malignancies among SOGI persons. Concerning the patient-physician interaction, there is no data illustrating the significance of patients revealing their sexual orientation to their doctors. Patients who do not identify as heterosexual typically have difficulties in discussing their sexual orientation with cancer doctors, who seldom inquire about patients' sexual orientation [84].

This study examined two papers centered on SOGI patients, namely those with entirely lesbian participant groups afflicted with breast cancer. The disclosure of sexual orientation was a significant factor for patients and impacted the patient-physician interaction [49, 50]. A qualitative study conducted by Boehmer and colleagues identified three themes related to the patient-physician relationship: physicians' interpersonal behaviors (e.g., eye contact); communication with partners and their involvement in medical appointments, when relevant; and the inclusion of patients in decision-making processes. Patients expressed their discontent with clinicians adopting a paternalistic attitude [51]. Moreover, in comparison to heterosexual women, lesbian participants had elevated stress levels upon diagnosis and decreased satisfaction with their medical treatment [52].

Sociocultural norms related to gender significantly impact health and access to healthcare services. Historical mistreatment of women in medical research has led to the development of several therapy regimens tailored for males, which, when administered to women, may yield detrimental effects [9]. Moreover, gendered communication patterns and interpersonal dynamics may profoundly influence a woman's healthcare experience, particularly her connection with her physician [53]. Traditional power dynamics and communication styles between male clinicians and female patients may diminish patient participation and participative treatment decision-making, hence impacting the patient-physician relationship and disease trajectory [53]. Health inequalities are exacerbated when women belong to additional disadvantaged groups, leading to cancer-related disparities stemming from the intersectionality of several identities (e.g., gender, age, race, sexual orientation, and disability) [54].

Both studies indicated a disparity in views between patients and their doctors about diagnosis and therapy. Brufsky and colleagues identified a communication disparity between women and their oncologists; women with metastatic breast cancer deemed discussions regarding long-term treatment planning as highly significant in their interactions, while oncologists assigned it lesser importance [51]. Research conducted by Coran and colleagues found no differences between women and men regarding their likelihood of having concordant evaluations of their encounters with doctors [55].

6. Patient-physician rapport and health inequalities associated with disabilities

Individuals with impairments are often neglected, despite growing evidence of unequal cancer treatment results. Various intersecting sociocultural variables may impact these results, including physical impediments to accessing healthcare facilities (e.g., lack of transportation, non-accommodating buildings or equipment), elevated poverty rates, and diminished health literacy [56, 57]. Furthermore, clinicians may lack inclusivity in their treatment methodologies, such as modifying medical tests to suit differently abled individuals or ascribing new or exacerbated symptoms to the identified impairment, a phenomenon referred to as “diagnostic overshadowing” [58]. These problems include not only physical disability but also intellectual and psychological conditions. In the absence of provider attention, intellectual and psychiatric disabilities may impede patients' comprehension of information conveyed during clinical interactions, thereby obstructing their capacity to discuss treatment options, preferences, and particular concerns with their physician. This communication failure may result in diminished trust, less satisfaction with care, and worse patient adherence to follow-up and treatment.

Research investigating the impact of anxiety disorders on the patient-physician interaction in cancer treatment was identified. No articles addressed physical or intellectual disability. Spencer and colleagues propose that the patient-physician connection may influence the correlation between anxiety and end-of-life outcomes, such as medical treatment choices and quality of death [59]. Advanced cancer patients who fulfilled DSM criteria for an anxiety disorder had more unsatisfactory interactions with their doctors, characterized by diminished trust levels. Patients expressed less comfort in inquiring with their doctors and a reduced capacity to comprehend and assimilate information conveyed by their physicians. Furthermore, patients with anxiety problems were more inclined to indicate that their physician failed to manage their pain well or provided ineffective treatment alternatives [59].

7. Discussion

To adopt a genuine, equitable, and patient-centered approach to treatment, physicians must include patients and families in discussions that encompass all pertinent medical information and prioritize the patient's wants and preferences [60]. Culture is an essential dimension for ensuring equal, tailored patient care. Providers must acknowledge that culture may operate as the lens through which certain groups engage with the world and, by extension, the healthcare system. Cultural awareness is an essential cornerstone of the physician-patient interaction. If oncology doctors contextualize their discussions and customize their information-sharing strategies according to individual requirements, patients will have enhanced empowerment and engagement in their treatment, therefore fostering trust and strengthening the patient-physician relationship. This scoping review has analyzed and classified the existing information about the patient-physician interaction among marginalized patient identities in the context of cancer care. All 37 publications demonstrated discrepancies in the patient-physician interaction across all 7 disadvantaged patient groups. Nonetheless, most papers focused on racially and ethnically marginalized patients, emphasizing disparities in trust, satisfaction with providers, and quality of treatment. Discrepancies in the communication practices and quality between patients and physicians were often addressed, particularly on variations in information-sharing.

Interventions aimed at enhancing patient-physician communication may serve as a viable approach to mitigating cancer-related inequities and enhancing the care experience for racially and ethnically marginalized patients. Crucial initiatives to tackle this problem have included training on provider-implicit bias and communication skills. Physicians should be ready to broaden their patient-centered practices to include other significant individuals in the patients' lives, such as family and members of the religious community [61]. Racial concordance in the patient-physician interaction significantly enhances minoritized patients' perceptions of their treatment, resulting in increased participation. Racial concordance is especially relevant in cancer care since patients must make critical treatment choices early in the care continuum and establish connections with their physicians [62]. Consequently, addressing the underrepresentation of racially and ethnically marginalized groups in medical and oncology fields will be essential for tackling racial and ethnic inequities in cancer care.

The present research revealed a scarcity of studies addressing additional disadvantaged patient identities, such as SOGI, elderly patients, those of lower socioeconomic position, those residing in rural areas, individuals with disabilities, and variations in sex/gender. Several studies have examined lesbian cancer patients and the significance of disclosing sexual orientation for SOGI patients. Although the results of this research may not apply to other sexual orientation and gender identity minorities (e.g., bisexual individuals), there is evidence indicating that the disclosure of sexual orientation is crucial for patients across other healthcare fields, as it may mitigate the effects of minority stress [48]. A study by Brooks et al. found that elements of the patient-physician interaction, particularly physician communication, facilitated the revelation of patient sexual orientation. Inclusive language and environmental cues of acceptance facilitated disclosure, but heteronormative language (e.g., presuming the patient has an opposite-sex spouse) constituted a barrier [48]. Although these guidelines may be relevant for SOGI persons within the cancer care framework, more study on SOGI patients, especially transgender and other non-cisgender individuals, is necessary.

The present review found no papers examining the influence of patient physical limitations on patient-physician interaction; nonetheless, evidence indicates that these patients face cancer-related health inequities. those with impairments have a higher likelihood of succumbing to breast cancer compared to those without disabilities. Additionally, women with disabilities have indicated physical obstacles to care, including the inaccessibility of examination tables and treatment apparatus such as infusion chairs and radiological equipment (e.g., mammography machines) [63]. Patients with impairments diagnosed with early-stage, non-small cell lung cancer are less inclined to opt for surgical surgery. Addressing patient impairments is particularly crucial in cancer treatment, since over 50% of older adults (> 60 years) have a recorded handicap, with the typical age of cancer diagnosis being 66 years. Therefore, while evaluating inclusive strategies, the confluence of age and disability-related requirements must be addressed concurrently. Investigating the interaction between patient impairments, age, and the evolution of the patient-physician relationship will be a crucial focus for future research and healthcare policy, particularly as the "baby boomer" group ages and disability rates rise [63]. Regrettably, there is a notable deficiency of research on the impact of intersectionality in health care. Strategies for customizing patient-centered treatment will remain inadequate unless we recognize and comprehend how the junction of several identities concurrently and equally affects patient obstacles and experiences in healthcare.

Among all publications included in this study, few assessed both patient and physician viewpoints. Many of those who responded saw a discrepancy between the perceptions of patients and their physicians. This discovery corroborates an earlier study conducted by our team, which indicated that the majority of our comprehension of the patient-physician interaction is derived from patient self-reporting [64]. Although this viewpoint is undeniably significant, the patient-physician interaction cannot be comprehensively represented by one perspective. In a prior review concerning the methodologies employed to assess the patient-physician relationship, we advocate for the adoption of a “relational lens” or framework. This approach redirects the emphasis from the individual as the primary unit of analysis to the dyad, facilitating an examination of interaction patterns among the patient, family members, and physician, rather than solely the attitudes and behaviors of an individual [64]. Multi-perspective data would provide a comprehensive knowledge of both patient and physician viewpoints, hence informing the creation of future interventions and clinical practices aimed at resolving cancer-related health inequalities. Moreover, several provider categories, such as social workers and family therapists, include a clear dedication to social justice and helping marginalized populations in their training and ethical guidelines [65]. Incorporating providers with expertise in psychosocial-spiritual care, including chaplains, palliative care specialists, and patient navigators, into an integrated healthcare team can enhance the patient-physician relationship and improve patients' experiences of care. Enhancing interprofessional skills is a crucial approach to providing equitable, culturally congruent patient-centered care to disadvantaged individuals [66].

This review included certain limitations that must be acknowledged when evaluating the findings. Conducting comprehensive assessments for these particular targeted communities will be a crucial subsequent step in our study. The present review concentrated on the cancer care context; however, studies regarding marginalized patients and the patient-physician relationship exist in other illness contexts not encompassed in this review, which could further elucidate the correlation between patient identities and their interactions with providers.

8. Conclusion

Despite being restricted, the evidence from the present analysis indicates that disadvantaged cancer patients have barriers to establishing optimal patient-physician interactions. From the patient's viewpoint, enhancing this connection involves superior communication, trust, and culturally appropriate treatment. The findings from the current review can guide future research and clinical practice on how providers can modify their interactional strategies with various marginalized patients to enhance the patient-physician relationship, potentially reducing the risk of negative health outcomes and contributing to the alleviation of disparities among marginalized cancer patients.

References

1. Cancer Disparities - National Cancer Institute. https://www.cancer.gov/about-cancer/understanding/disparities. Accessed 17 Dec 2020
2. Sakellariou D, Rotarou ES (2020) Cancer disparities for people with disabilities: bridging the gap. J Natl Compr Cancer Netw 18:1144–1146.
3. DeSantis CE, Miller KD, Goding Sauer A et al (2019) Cancer statistics for African Americans, 2019. CA Cancer J Clin 69:211–233.
4. McGuire FR (2014) Physicians' Attitudes about Recommending Surgery for Early Stage Lung Cancer and Possible Reasons for Racial Disparities. Journal of Health Disparities Research and Practice 7(3):5
5. Ward E, Jemal A, Cokkinides V et al (2004) Cancer disparities by race/ethnicity and socioeconomic status. CA Cancer J Clin.
6. Wisdom JP, McGee MG, Horner-Johnson W et al (2010) Health disparities between women with and without disabilities: a review of the research. Soc Work Public Health.
7. Newman LA, Kaljee LM (2017) Health disparities and triple-negative breast cancer in African American women: a review. JAMA surgery 152(5):485–493
8. Beckie TM (2012) A systematic review of allostatic load, health, and health disparities. Biological research for nursing 14(4):311–346
9. Healthy People 2020 (2010) An Opportunity to Address Societal Determinants of Health in the U. S.
10. American Cancer Society (2020) Cancer Facts & Figures 2020. Atlanta
11. Maly RC, Stein JA, Umezawa Y et al (2008) Racial/ethnic differences in breast cancer outcomes among older patients: effects of physician communication and patient empowerment. Heal Psychol.
12. Lengerich EJ, Tucker TC, Powell RK et al (2005) Cancer incidence in Kentucky, Pennsylvania, and West Virginia: disparities in Appalachia. J Rural Heal.
13. Sprague S (2009) Relationship centered care. J S C Med Assoc 105:135–136.
14. Kitson A, Marshall A, Bassett K, Zeitz K (2013) What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. J Adv Nurs 69:4–15.
15. Roter D (2000) The enduring and evolving nature of the patient-physician relationship. Patient Educ Couns 39:5–15
16. Street RL, Gordon H, Haidet P (2007) Physicians’ communication and perceptions of patients: is it how they look, how they talk, or is it just the doctor? Soc Sci Med 65:586–598.
17. Winner M, Wilson A, Ronnekleiv-Kelly S et al (2017) A singular hope: how the discussion around cancer surgery sometimes fails. Ann Surg Oncol 24:31–37.
18. Janes, L. A., Lussiez, A. D., Anderson, M., Bamdad, M. C., & Suwanabol, P. A. (2022). Decisional regret among patients undergoing colectomy. Diseases of the Colon & Rectum, 65(12), 1542-1549.
19. Pham MT, Rajić A, Greig JD et al (2014) A scoping review of scoping reviews: advancing the approach and enhancing the consistency. Res Synth Methods.
20. Arksey H, O’Malley L (2005) Scoping studies: towards a methodological framework. Int J Soc Res Methodol Theory Pract.

21. Racial / Ethnic Minorities Agency for Healthcare Research and Quality. https://www.ahrq.gov/topics/racial-ethnic-minorities.html. 2020
22. Disability and Health Overview | CDC. https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html. 2020
23. Kellermeyer L, Harnke B, Knight S (2018) Covidence. J Med Libr Assoc 106(4):580
24. Esnaola NF, Ford ME (2012) Racial differences and disparities in cancer care and outcomes. Where's the rub? Surg. Oncol Clin 21(3):417–437
25. Hohl S, Molina Y, Koepl L et al (2016) Satisfaction with cancer care among American Indian and Alaska Natives in Oregon and Washington State: a qualitative study of survivor and caregiver perspectives. Support Care Cancer.
26. Krok-Schoen JL, Fernandez K, Unzeitig GW et al (2019) Hispanic breast cancer patients' symptom experience and patient-physician communication during chemotherapy. Support Care Cancer.
27. Penner LA, Dovidio JF, Gonzalez R et al (2016) The effects of oncologist implicit racial bias in racially discordant oncology interactions. J Clin Oncol.
28. Johnston EM, Blake SC, Andes KL et al (2014) Breast cancer treatment experiences by race and location in Georgia's women's health Medicaid program. Women's Heal Issues.
29. Shavers VL, Brown ML (2002) Racial and ethnic disparities in the receipt of cancer treatment. Journal of the National Cancer Institute 94(5):334–357
30. Song L, Weaver MA, Chen RC et al (2014) Associations between patient-provider communication and sociocultural factors in prostate cancer patients: a cross-sectional evaluation of racial differences. Patient Educ Couns.
31. Mullins MA, Peres LC, Alberg AJ et al (2019) Perceived discrimination, trust in physicians, and prolonged symptom duration before ovarian cancer diagnosis in the African American Cancer Epidemiology Study. Cancer.
32. Ashing KT, George M, Jones V (2018) Health-related quality of life and care satisfaction outcomes: informing psychosocial oncology care among Latina and African-American young breast cancer survivors. Psychooncology.
33. Cho, G., & Chang, V. W. (2022). Patient-provider communication quality, 2002–2016: a population-based study of trends and racial differences. Medical care, 60(5), 324-331.
34. Anderson JN, Graff JC, Krukowski RA, et al (2020) "Nobody Will Tell You. You've Got to Ask!": an examination of patient-provider communication needs and preferences among Black and White women with early-stage breast cancer. Health Commun.
35. Sheppard VB, Isaacs C, Luta G et al (2013) Narrowing racial gaps in breast cancer chemotherapy initiation: the role of the patient-provider relationship. Breast Cancer Res Treat.
36. Gordon HS, Street RL, Sharf BF, Souchek J (2006) Racial differences in doctors' information-giving and patients' participation. Cancer.
37. Siminoff LA, Step MM (2005) A communication model of shared decision making: accounting for cancer treatment decisions. Health psychology 24(4S):S99
38. Kaiser K, Rauscher GH, Jacobs EA et al (2011) The import of trust in regular providers to trust in cancer physicians among white, African American, and Hispanic breast cancer patients. J Gen Intern Med.
39. Palmer NRA, Kent EE, Forsythe LP et al (2014) Racial and ethnic disparities in patient-provider communication, quality-of-care ratings, and patient activation among long-term cancer survivors. J Clin Oncol.
40. Maly RC, Liu Y, Leake B et al (2010) Treatment-related symptoms among underserved women with breast cancer: the impact of physician-patient communication. Breast Cancer Res Treat.
41. Pichardo, M. S., Irwin, M. L., Sanft, T., Ferrucci, L. M., Ginader, A., Nguyen, T. H., ... & Molina, Y. (2023). A qualitative study identifying challenges resulting from complex evidence on lifestyle factors and cancer: perspectives from Black and Latina cancer survivors and healthcare providers. Supportive Care in Cancer, 31(2), 111.
42. Williams SW, Hanson LC, Boyd C et al (2008) Communication, decision making, and cancer: what African Americans want physicians to know. J Palliat Med 11:1221–1226.

43. Williams SL, Haskard KB, DiMatteo MR (2007) The therapeutic effects of the physician-older patient relationship: effective communication with vulnerable older patients. Clinical interventions in aging 2(3):453
44. Roter D, Hall JA (2006) Doctors talking with patients/patients talking with doctors: improving communication in medical visits. Greenwood Publishing Group
45. Hall JA, Roter DL, Katz NR (1988) Meta-analysis of correlates of provider behavior in medical encounters. Med Care.
46. Peck BM (2011) Age-related differences in doctor-patient interaction and patient satisfaction. Curr Gerontol Geriatr Res.
47. Maly RC, Leake B, Silliman RA (2004) Breast cancer treatment in older women: impact of the patient-physician interaction. Journal of the American Geriatrics Society 52(7):1138–1145
48. Brooks H, Llewellyn CD, Nadarzynski T et al (2018) Sexual orientation disclosure in health care: a systematic review. Br J Gen Pract.
49. Boehmer U, Case P (2006) Sexual minority women's interactions with breast cancer providers. Women Heal.
50. Matthews AK, Peterman AH, Delaney P et al (2002) A qualitative exploration of the experiences of lesbian and heterosexual patients with breast cancer. Oncol Nurs Forum.
51. Brufsky AM, Ormerod C, Bell Dickson R, Citron ML (2017) Understanding the needs of patients with metastatic breast cancer: results of the make your dialogue count survey. Breast J.
52. McLeod JD, Lawler EJ, Schwalbe M (2014) editors. Handbook of the social psychology of inequality. Springer
53. Coran JJ, Koropeckyj-Cox T, Arnold CL (2013) Are physicians and patients in agreement? Exploring dyadic concordance. Heal Educ Behav.
54. Krahn GL, Walker DK, Correa-De-Araujo R (2015) Persons with disabilities as an unrecognized health disparity population. Am J Public Health.
55. Lezzoni LI, Kilbridge K, Park ER (2010) Physical access barriers to care for diagnosis and treatment of breast cancer among women with mobility impairments. Oncol Nurs Forum.
56. Sakellariou D, Anstey S, Polack S et al (2020) Pathways of disability-based discrimination in cancer care. Crit Public Health 30:533–543.
57. Spencer R, Nilsson M, Wright A et al (2010) Anxiety disorders in advanced cancer patients: correlates and predictors of end-of-life outcomes. Cancer.
58. Balogh EP, Ganz PA, Murphy SB et al (2011) Patient-centered cancer treatment planning: improving the quality of oncology care. Summary of an Institute of Medicine Workshop. Oncologist 16:1800–1805
59. Kagawa Singer M, Dressler W, George S et al (2016) Culture: the missing link in health research. Soc Sci Med 170:237–246.
60. Mead EL, Doorenbos AZ, Javid SH, Haozous EA, Alvord LA, Flum DR, Morris AM (2013) Shared decision-making for cancer care among racial and ethnic minorities: a systematic review. American journal of public health 103(12):e15–29
61. Cooper-Patrick L, Gallo JJ, Gonzales JJ et al (1999) Race, gender, and partnership in the patient-physician relationship. J Am Med Assoc.
62. Beesley H, Goodfellow S, Holcombe C, Salmon P (2016) The intensity of breast cancer patients' relationships with their surgeons after the first meeting: evidence that relationships are not "built" but arise from attachment processes. Eur J Surg Oncol 42:679–684.
63. Iezzoni LI (2011) Eliminating health and health care disparities among the growing population of people with disabilities. Health Aff.
64. Iezzoni LI, Ngo LH, Li D et al (2008) Treatment disparities for disabled Medicare beneficiaries with stage I non-small cell lung cancer. Arch Phys Med Rehabil.
65. Siegel RL, Miller KD, Jemal A (2018) Cancer statistics, 2018. CA Cancer J Clin.

66. Caiola C, Docherty SL, Relf M, Barroso J (2014) Using an intersectional approach to study the impact of social determinants of health for African American mothers living with HIV. Adv Nurs Sci 37:287–298.

ديناميكيات التفاعل بين المرضى والأطباء وتأثيرها على الفجوات الصحية في رعاية مرضى السرطان بين الفئات المهمشة: مراجعة شاملة استكشافية

الملخص

الخلفية :تشكل الفجوات الصحية في رعاية مرضى السرطان تحديات كبيرة. تنشأ هذه الفجوات نتيجة تداخل معقد للعوامل الاجتماعية والاقتصادية، والتمييز، ونقص الوصول إلى الرعاية الصحية، مما يؤدي إلى نتائج سريرية دون المستوى المطلوب. تهدف هذه المراجعة إلى تلخيص الأدبيات الحالية حول التفاعل بين المرضى والأطباء في سياق رعاية السرطان، مع التركيز على تأثير هذه الديناميكيات على تجارب العلاج.

الطرق :تم إجراء مراجعة شاملة استكشافية باستخدام قواعد بيانات أكاديمية رئيسية، بما في ذلكPubMed ، Google Scholar، و EBSCO Discovery.ركزت المراجعة على الدراسات التي تناولت الفجوات في رعاية السرطان المرتبطة بالعرق/الإثنية، العمر، الهوية الجنسية والتوجه الجنسي(SOGI) ، والإعاقات. تم تضمين 37 منشورًا في التحليل، مسلطة الضوء على الفروق الدقيقة في علاقة المرضى بالأطباء عبر مجموعات مهمشة مختلفة.

النتائج :تشير النتائج إلى أن المرضى المنتمين إلى أعراق وإثنيات أقليات غالبًا ما يواجهون حواجز تواصل، وانخفاض في الوصول إلى العلاج الفوري والمكثف، وتراجع الثقة في مقدمي الرعاية الصحية. بالإضافة إلى ذلك، أظهر المرضى المسنون والأفراد ذوو الإعاقات تحديات مشابهة في التفاعل مع مقدمي الرعاية الصحية، مما يزيد من تفاقم الفجوات الصحية.

الخلاصة :تؤكد هذه المراجعة على الحاجة الملحة لتحسين استراتيجيات التواصل بين المرضى والأطباء، بحيث تكون ثقافية وسياقية لتعزيز جودة رعاية السرطان للفئات المهمشة. تُعد التدخلات التي تهدف إلى تعزيز الثقة وتشجيع مشاركة المرضى ضرورية لتخفيف الفجوات الصحية. ينبغي على الأبحاث المستقبلية أن تركز على تقييمات متعددة المنظورات للعلاقة بين المرضى والأطباء لتوجيه ممارسات الرعاية الصحية العادلة.

الكلمات المفتاحية :الفجوات الصحية، التفاعل بين المرضى والأطباء، رعاية السرطان، الفئات المهمشة، حواجز التواصل.