



## Characteristics of Health Educators Desired by Inner-city Health Clinic Patients: A Case Study

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### ABSTRACT

A group ( $n=170$ ) of inner-city, predominantly African American, health clinic patients were asked to identify the characteristics they desired in a new clinic health educator. A plurality (44%) of the patients perceived a bachelor's degree would be a sufficient level of education. The vast majority of patients claimed the sex of the health educator (84%) and the race of the educator (82%) did not matter. Additionally, a majority of patients perceived that the age of the educator (53%) and whether the educator was a parent (62%) did not matter. However, the majority of patients (52%) did believe that a new health educator should be a role model for healthful living. Such findings stand in stark contrast to similar studies on patient preference for health care provider congruence for selected demographic characteristics.

During the first half of the 1900s, Americans perceived America to be a great “melting pot” society. Individual and unique cultural and racial differences were expected to be replaced with a more “generic American identity.”<sup>1</sup> Assimilation was the common outcome expected of all who came to America, including the original inhabitants (e.g., Native Americans) of this land. However, in the latter part of the 20<sup>th</sup> century, “American pluralism has emerged with a definite emphasis on ethnic identity and cultural diversity, in part because of growing recognition that we are who we are because of our cultural heritage” (p. 18).<sup>1</sup> This diversity has, at times, resulted in ethnic and racial enclaves that have been both havens as well as forms of social isolation for their residents. The results of this isolation have been reduced interactions between diverse groups, cultural opaqueness, discrimination, and marginalization resulting in a rich mosaic of diversity in America.

On the more negative side of the isolation of diverse groups has been the perpetuation of prejudice and stereotyping of individuals.<sup>2</sup> Health care professionals in this pluralistic society often have not been trained in dealing with patients from such culturally diverse backgrounds.<sup>3</sup> These issues of diversity have resulted in subtle forms of prejudice and inadequate treatment of patients resulting, in part, from an ethnocentric philosophy arising from a dearth of culturally trained, competent health care professionals.

The aforementioned professional limitations have resulted in some patients desiring greater congruence between themselves and their health care providers on selected characteristics such as race, ethnicity, sex, age, sexual orientation, etc. A considerable quantity of research has been reported on patient preferences for congruency between them and their health care providers on a variety of demographic characteristics. For example, female physicians

are more likely than male physicians to see female patients.<sup>4</sup> Women prefer seeing female physicians presumably because they are more likely to have greater insight into sex-specific concerns and because they are less likely to engender patient embarrassment.<sup>5,6</sup> However, other studies have indicated that patients rate experience and specialty as more important than physician sex.<sup>7,8</sup> Another study found that women's satisfaction was more positive if they had a female physician; however, physicians' gender was not associated with men's satisfaction.<sup>9</sup>

The 2001 Commonwealth Fund's report, *Health Care Quality Survey*, found that

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African Americans, Hispanics, and Asians reported higher rates of communication difficulties with health care providers than did Caucasian patients.<sup>10</sup> Especially noteworthy was that 15% of African Americans believed they would have received better care if they belonged to a different race or ethnicity. In fact, African Americans were almost twice as likely (16% versus 9%) as their white counterparts to report having been treated with disrespect during a recent health care visit. Thus, it should not be surprising to learn that racial/ethnic minorities are far more likely than whites to desire and have a minority physician.<sup>11,12</sup> Minority patients who have racial/ethnic and language concordance with their physicians are more satisfied with their care and rate their encounters as more participatory.<sup>13</sup> In contrast to the aforementioned study of adult patients, a recent study of pediatric patients with provider racial/ethnic concordance found that parents did not perceive their children had better health care experiences than the children who were discordant with their pediatricians for race/ethnicity.<sup>14</sup>

Like other health professions, one of the goals of health education is to improve the health of every person in society, regardless of age, sex, race, ethnicity, socioeconomic status, or sexual orientation. Yet, without specific training in cultural competence, health educators may make the same types of ethnocentric errors made by other health professionals. Thus, because so few health educators are trained in cultural competence,<sup>15</sup> should agencies who hire health educators hire only health educators who are demographically like their constituents? Do patients expect their health educators to be demographically similar to them?

The purpose of this study was to assess predominately African American inner-city health clinic patients' perceptions of key demographic characteristics essential for hiring a new health educator for their clinics. The previous health educator, an African-American female, had resigned to accept a new position. The majority of the governing board of the clinics, composed of eight African Americans and eight Cau-

casians, believed they had to hire an African American, preferably master's degree level, because this is what their patients would desire. In order to determine if this was true, the decision was made by the board to assess patients' perceptions of the characteristics a new health educator should possess. This study reports the results of that survey.

## METHODS

### Sample

The clinic administration permitted, at most, 100 adults (those 18 years of age or older), to be approached at each of two urban community health centers for a total of 200 respondents. We were limited to this number because the administration was worried the data collection process would be a burden to the front desk staff. Community health centers, also called "neighborhood health centers," originated in the mid-1960s as part of the "war on poverty."<sup>16</sup> They were designed to meet the health care needs of the medically indigent who live in urban or rural areas. They are considered part of the "safety net" for the nation's economically disadvantaged populations. Typically, two-thirds of the individuals served by such clinics are below federal poverty guidelines.<sup>16</sup> In the urban clinics in which these data were collected, over three-fourths of the population were below federal poverty guidelines, approximately 90% were African American, and about three-fifths were females.

The two health clinics were part of a three clinic inner-city (n=350,000) urban health system in a Midwest community. The staff for the two clinics combined were as follows: one CEO (African American), eight physicians (four were African American, one was Asian, and three were from the Middle East or the Philippines), six nurses (two were Caucasian and six were African American), one dentist (African American), one dental hygienist (African American), one lab technician (African American), and one pharmacist (Caucasian). The vast majority of the office staff was African American. Due to a high turnover rate, the

specific composition of office staff could vary every few months.

### Instrument

A one-page questionnaire with 12 items was developed by clinic staff and one of the researchers. The questions were based on Beisecker's suggestion that a small list of key variables (age, gender, race/ethnicity, education, and values) be used to study differences in patient and provider characteristics.<sup>17</sup> The instrument was checked for content validity by the clinic administration and was sent to a panel of four health educators who were survey researchers. Minor wording changes were recommended and one item was dropped at the request of the clinic administration.

A sample of 15 individuals at the third clinic in the system was used as a pilot test. The individuals agreed that comprehension and readability of the questionnaire was found to be acceptable. The group was paid a \$5.00 incentive each time they completed the questionnaire. The questionnaire was given to these patients twice, one week apart, to establish stability reliability and percent agreement was found to be 83%.

### Procedure

The questionnaires were distributed by the front desk staff (African Americans) at the clinics. Patients were informed that they should not put any identifying marks on the questionnaire and that completion was voluntary. When the patient was finished with the questionnaire, he or she returned the form to a box at the front desk. Observation of the process at several different occasions found high compliance with the process. If any patients declined to complete the survey, they were tracked only by frequency in order to obtain a response rate and to satisfy clinic administration concerns regarding the process being a potential burden for the front desk staff.

### Data Analysis

Data analysis was performed using SPSS 12.0 for Windows. The data from the questionnaires were entered into an SPSS database. Descriptive statistics (frequencies, means, and standard deviations) were



calculated for each questionnaire item. Categorical data analysis was performed using odds ratios.

## RESULTS

### Demographics of Respondents

A total of 200 patients were approached and 170 returned completed surveys (85%). A plurality (32%) of respondents were 60 years of age or older, and the vast majority were female (77%), and African American (91%) (Table 1). In addition, 53% reported attending college or were college graduates. A comparison with the clinic population found the sample to consist of a higher percent of females (77% vs. 58%), had a greater prevalence of college coursework (53% vs. 22%), and were older (60 years of age or older) (32% vs. 25%).

**Table 1. Demographic Characteristics of Respondents**

Characteristic	N	%
Age:		
20 or younger	11	7
20–29	12	7
30–39	24	14
40–49	31	18
50–59	32	19
60 or older	55	32
Sex:		
Male	35	21
Female	131	77
Race/Ethnicity:		
Asian	0	0
Black/African American	155	91
Hispanic/Latino	3	2
White/Caucasian	7	4
Education Level:		
11 <sup>th</sup> grade or less	29	17
High school graduate	51	30
Attended college	47	28
College graduate	43	25
N= 170		

### Characteristics Desired in a Health Educator

Patients were asked to identify the characteristics they desired in a new clinic health educator. More specifically, they were asked about the education level, sex, age, race, role model behavior, and whether the educator should be a parent (Table 2). A plurality (44%) of the patients perceived a bachelor's degree would be a sufficient level of education for a health educator. The vast majority of patients claimed the sex of the health educator (84%) and the race of the educator (82%) did not matter. Additionally, a majority of patients perceived that the age of the educator (53%) and whether the educator was a parent (62%) did not matter. However, the majority of patients (52%) did believe that a new health educator should be a healthy role model.

A series of chi-square analyses was conducted to see if the patients' perceptions of the education level (2x4), age (2x4), and role model status (2x3) of the health educator were perceived differently by the sex of the patient. No significant differences ( $p \leq .05$ ) were found. Another series of chi-square analyses of the same characteristics by the age (<40 vs. 40+ years of age) of the patients found one significant difference ( $\chi^2 = 7.49$ ,  $df = 2$ ,  $p = .02$ ). Those 40 years of age and older were more than twice as likely ( $OR = 2.80$ ,  $95\% CI = 1.01-7.75$ ) as those patients under 40 years of age to desire that the health educator be middle aged (40–59 years of age). The final series of chi-square tests assessed the aforementioned three characteristics of a health educator by the education level of the patients (high school or less vs. some college coursework or graduate), and one significant difference ( $\chi^2 = 6.22$ ,  $df = 2$ ,  $p = .045$ ) was found. Patients with more education were more likely than those with less education ( $OR = 1.89$ ,  $95\% CI = 1.02-3.53$ ) to perceive that the age of the health educator did not matter.

## DISCUSSION

The findings of this study, that the majority of inner-city health clinic patients did not express a need for health educator-

patient demographic congruence, stand in stark contrast to the findings of similar studies on patient preferences for congruence in demographic characteristics of health care providers. There are a number of potential explanations for these findings. First, the patients who responded disproportionately had some college coursework. Thus, it is possible that better educated respondents felt less threatened by demographic discordant health educators, or that the increased education provided some confidence in their ability to deal with health educators with limited multicultural insights. Second, the health clinics were composed of predominately African American staff, including the clinic CEO. Thus, patients may have felt less threatened by the hiring of a demographically discordant health educator (e.g., Caucasian) because such a position would be controlled by a predominately African American clinic staff. If more of the administration had been white, then possibly the African American patients would have felt differently about the characteristics they wanted in a health educator. Third, because health educators may not be seen as important to health as a physician or nurse, these patients may have been more willing to accept a demographically discordant health educator. Fourth, the majority of patients may not have had many interactions with the previous health educator. If so, they may not have known exactly what the role of a health educator was and what impact such a professional would potentially have on their health. However, informal discussions with patients indicated they perceived a health educator as "the person who talks with you (or groups) about health issues and gives you things to read about your health problem." Such a description was characteristic of the task performed by the health educator in that clinic. Thus, the hiring of a health educator may not have been a salient concern for these patients. Fifth, because the majority of these patients were economically disadvantaged and they often had long waits in the clinic to see a physician, dentist, or social worker, they may have perceived any



help, regardless of background characteristics, as helpful since most of them had more pressing health concerns.

Additionally, there were two circumstances in which the patients preferred specific characteristics when hiring a health educator. First, they preferred to have the health educator be 40–59 years of age, an age characteristic of almost 50% of the respondents. This may indicate that the patients wanted to talk with someone more mature regarding health information issues. In contrast, the second circumstance indicated that those who were better educated had no preference regarding the age of the health educator. This may indicate that those better educated were more concerned with the educational background than the age of the health educator.

The limitations of this study need to be considered. First, because the clinic administration limited the number of patients which could be approached, a power analysis was not conducted to assure adequate sample size for generalizability of the results. Second, the greater prevalence of college coursework by respondents limits the external validity of the findings to other inner city patients of color. Third, to the extent that other variables were not assessed that may have been perceived to be important (eg., whether the health educator needed to be indigenous to the community), this could have been a threat to the internal validity of the findings. Researchers are encouraged to replicate this study with larger more representative samples in other locations to further confirm the generalizability of these findings.

### **Translation to Health Education Practice**

It would be imprudent to assume that the findings of this study could be used to abandon the limited cultural sensitivity and competence training which exists for health educators.<sup>15</sup> The lack of coordinated recruitment of students of color and limited training in multiculturalism in health education training programs suggests, at best, an attitude of benign neglect towards these issues.<sup>18</sup> Furthermore, the data indicate that

Characteristic	N	%
What level of education should the health educator have?		
• Basic college degree (Bachelor's degree)	75	44
• Advanced college degree (Masters degree)	41	24
• Trained at doctoral level (PhD)	21	12
• Amount of college is not important	31	18
What sex would you recommend we hire?		
• Female	18	11
• Male	7	4
• Does not matter	143	84
What age should the health educator be?		
• Young adult (25–39 years of age)	41	24
• Middle age (40–59 years of age)	36	21
• Older age (60 or older)	36	21
• Does not matter	90	53
What race should the health educator be?		
• Asian	0	0
• Hispanic/Latino	2	1
• Black/African American	29	17
• White/Caucasian	0	0
• Does not matter	139	82
The health educator should be a role model for healthful living (he or she should not smoke, have normal weight, eat a healthy diet, etc.)		
• Agree	88	52
• Disagree	20	12
• Makes no difference	56	33
Should the health educator be a parent with experience in raising children?		
• Yes	47	28
• No	10	6
• Makes no difference	106	62
N= 170		

almost one in five patients preferred a health educator of color. Thus, the opportunity for these patients to seek assistance from demographically congruent health educators is an important goal for health education training programs.

The results of this survey caused the board of the inner-city health clinic to reassess its description for a patient health

educator. Yet, this study raises as many questions as it answers. Will the patients be as satisfied with health educators who are demographically discordant as they are with demographically concordant health educators? Will patient compliance with health education information be equal with both types of educator? Will the quality of the health education services be equal between



both types of educator? These questions all should be addressed in further research.

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