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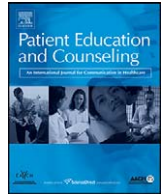
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Patient Perception, Preference and Participation

Kenyan patients' attitudes regarding doctor ethnicity and doctor–patient ethnic discordance

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ABSTRACT

Objective: This study explored Kenyan patients' perspectives on the role of ethnicity in the doctor–patient relationship.**Methods:** 221 participants completed questionnaires on ethnicity in doctor–patient relationships; eight focus groups were held with low- and middle-income urban and rural women.**Results:** About half of participants expressed no preference for doctor ethnicity. Participants rated demographic factors as less important than factors related to the doctor's qualifications, communication skills, and cost of service. Those who did indicate a preference were more likely to prefer Indian doctors for eye problems and Europeans for major surgery, cancer, and heart problems. With less severe medical issues participants were more likely to prefer a doctor who was ethnically concordant with them. Reasons for this centered around communication issues. In contrast, several focus group participants did not want to be treated by doctors from their own ethnic group because of concerns about confidentiality. **Conclusion:** Additional research is needed on negative implications of patient–provider concordance. **Practice implications:** Medical service providers must be aware of concerns about ethnic concordance. Alternatively medical centers that deal with sensitive medical information need to consider hiring staff who are not of the majority ethnic group in their region.

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When patients and doctors hail from different cultural or ethnic backgrounds, effective communication can be difficult [13–15,38,45]. In North American and European settings studies indicate that in comparison with intra-cultural medical interviews, intercultural interviews are characterized by more misunderstanding, less satisfaction, lower patient compliance (for a recent review see [1]), and a range of negative patient outcomes of care [2–5]. Street [6] has identified four major communication-related issues that might contribute to about these negative outcomes. Ethnically discordant patients and providers may: (a) speak different languages or dialects, or use different metaphors and idioms with the same language; (b) have different preferred styles of communicating in medical encounters; and (c) operate out of different explanatory models of health and illness. Finally, (d) providers may hold racist or perceptual biases. These issues may affect patient outcomes not only directly, but also indirectly as they influence the level of trust that patients have in their providers [7].

Relatively little research, however, has addressed the role of ethnicity in the medical interview outside of Northern Europe and North America [10]. Even in the African AIDS epidemic, which has generated hundreds of studies regarding specific cultural values and behaviors that impact prevention and care efforts (See for example Miller et al. [40], Muturi [41], and Rugalema [43] for such discussions specific to Kenya), virtually no attention has been paid to ethnicity as it impacts the patient–provider interaction itself. This is despite the fact that ethnic identity in Africa is a critical component of the modern African situation [8], as ethnically based conflicts in Uganda, Rwanda, Burundi, Sudan, and more recently Kenya, make all too clear. What studies have been published on the topic in the African context have primarily been situated in South Africa. Scholars there have noted language barriers between English and Afrikaans-speaking doctors and patients who speak African vernacular languages [9,35,50], patient embarrassment with medical personnel whom they perceive to be highly educated and authoritative [10,11], and differences between patient magico-religious understanding of health and the biomedical approach of white physicians [12]. These observations parallel the first three mechanisms identified by Street.

South Africa is unique on the continent, however, and findings in that context are not necessarily relevant to the rest of sub-Saharan Africa. In other African nations, including Kenya where the

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present study was conducted, few doctors are white. African doctors are more likely to be aware of the worldview of their patients with respect to health and illness, and to operate with similar expectations regarding styles of communication in the medical encounter. They may still grapple with language difficulties; in Kenya, where the present study was conducted, over 40 languages are spoken; providers may not speak a particular client's vernacular even if they share fluency in one of the two national languages, Swahili and English. Furthermore, questions of inter-ethnic bias have recently come to the fore in nearly every aspect of Kenyan life. After irregularities in the December 2007 presidential election, Kenya found itself on the brink of civil war as the fabric of society ripped apart along tribal lines [29]. Peace-brokering efforts by former UN Secretary General Kofi Annan eventually succeeded in diffusing tensions enough for a coalition government to be built, but many Kenyans found in the process that ethnicity played a deeper role in their identities than they had suspected.

Given this history it is important to understanding the role of ethnicity in Kenyan patient–provider relationships. We therefore posed our first two research questions:

- RQ1: How important will Kenyan patients rate provider ethnicity in comparison with other factors in choosing a doctor?
 RQ2: Which communication-related issues will Kenyan patients report to be most strongly influenced by ethnic discordance?

Beyond these questions, it appeared to us that previous research on patient–provider ethnic discordance had not addressed an important characteristic of multi-ethnic societies. In many sub-Saharan nations, certain ethnic groups are associated with particular occupational geniuses. Among these, some groups are recognized for expertise in medicine, and even for treatment of specific types of conditions. In Kenya the Luo hold are known for excelling in medicine, as are Kenyans of Indian origin (commonly called *Asians*). It could be, therefore, that rather than seeking out physicians who share their own ethnic background, some patients might prefer that their doctors hail from another ethnic group, and that under those circumstances they might trust someone who did *not* speak their language more than someone who did. Although the particulars of this sort of preference would vary from country to country, the phenomenon is likely to be widespread. Therefore we posed two more research questions:

- RQ3: What preferences will participants express with respect to the ethnicity of their doctor when it comes to seeking treatment for various types of medical conditions?
 RQ4: To what extent will patient–provider ethnic concordance explain these preferences?

1. Method

Research questions were explored via a triangulation mixed methods design. In Creswell and Plano Clark's [32] typology, a triangulation design is a one-phase design in which both types of data are collected at the same time and given equal weight in the analysis. In the present study the quantitative component involved administration of a questionnaire and the qualitative portion was composed of focus group research. Ethical permission for the study was obtained from the University of Central Florida, Daystar University, and the Kenyan Ministry of Education, Science and Technology.

1.1. Questionnaire

Students from classes at a private university in Nairobi were asked to each collect questionnaire data from two individuals over

the age of 18 who had sought medical attention within the past year, only one of whom could be a family member. Students explained the purpose of the study and obtain informed consent from participants, and handed questionnaires to participants to fill out. Questionnaires were also distributed to classes of evening undergraduate and masters students at the same university. These classes were selected to represent a wider range of ages, professions, and income levels than traditional day classes. 237 questionnaires were returned, 16 of which indicated participants had not been to the doctor in the past 12 months and were therefore discarded.

In total 237 questionnaires were returned, 16 of which indicated participants had not been to the doctor in the past 12 months and were therefore discarded. Thirty-six percent of the final sample were male and 60% females; three individuals did not indicate their gender. Regarding age, 64.6% were 21–30; 17.7% were 31–40; 12.4% were 41–50; 3.1% were 51–60; and .4% were over 61. Single persons comprised 62.8% of the sample, 31.4% were married, 1.8% were separated/divorced, and 1.8% widowed. With respect to highest level of education completed, 17.3% indicated secondary school; 15% technical college; 49.6% university; and 15% postgraduate. Eighteen different ethnic groups were represented with the largest being Kikuyu (32.7%), Kamba (15.0%), and Luo (14.2%). Five participants did not indicate their ethnicity.

After demographic questions at the beginning of the questionnaire, the remainder of the instrument was divided into three sections. Information on RQ1 was solicited by presenting participants with a list of 13 factors that might influence their choice of a doctor. Participants indicated the importance of each factor on a Likert-type scale ranging from 1 = “very unimportant” to 5 = “very important.”

Information on RQ2 was elicited through items developed in the light of Street's four communication factors in ethnically discordant patient–provider relationships and de Haes and Bensing's (2009) [47] six functions of patient–provider communication: fostering the relationship, gathering information, providing information, making decisions, enabling disease- and treatment-related behavior, and responding to emotions (see also [7]). Participants responded to a series of 38 statements on a five-point Likert-type scale, from “strongly disagree” to “strongly agree.” These questions were divided into two sections. The first was prefaced with the statement: “A doctor from my ethnic group would be more likely than other doctors to,” followed by a list of physician behaviors. The second was prefaced with the statement “If I was seeing a doctor from my own ethnic group as compared to others, I would be more likely to” and followed by a list of patient behaviors.

Information on RQ3 and RQ4 was elicited through a table listing 11 separate health issues. For each issue participants were asked to indicate which of four ethnicities they would prefer in a doctor who treated them for that condition: Kikuyu (the most numerous tribal group), Luo and Indian (the groups most known for being in the medical profession), and European (a term which in common usage encompasses Europeans, Americans, and Australians). They were also given options of writing in a different ethnic group or checking “no preference.”

Questionnaires were pretested with 17 undergraduate students who were not in participating classes. Several typographical errors were noted and corrected.

1.2. Focus group discussions

The following focus group discussions were conducted: two with urban low-income women in a Nairobi slum; two with urban middle-income urban women on faculty and staff at a Kenyan university; two with mixed income-level rural Kikuyu women

about an hour outside of Nairobi; and one with low- and another with middle-income rural Luo women in the western part of the country.¹ We chose to investigate women's responses for two reasons: (1) women in the Kenyan context have been shown to be more open to self disclosure on private health issues than are men (Miller and Rubin, 2007a,b; Ngula and Miller, in press; see also Stewart, 1984 as cited in [6]); and (2) the study was part of an anticipated larger research effort involving women's concerns about patient–provider communication. Participants were located through local opinion leaders like teachers and women's group leaders. Interview guidelines were translated from English into Swahili, Luo, and Kikuyu and back-translated to ensure accuracy.

Moderators first obtained informed consent and permission to audio-tape the discussions from participants. They then solicited participants' views on doctor–patient communication and criteria they used in choosing a doctor. After allowing participants to raise issues on their own, moderators specifically asked participants whether ethnicity was a factor in their selection of and satisfaction with their doctors. Following the discussion, participants were thanked, then presented with a small token of appreciation (approximately \$3.00) and/or given refreshments.

Audio-tapes were transcribed and those conducted in other languages translated into English. Because the transcripts were subjected only to broad analysis, we used minimal notational conventions, although we did edit to remove participant disfluencies. Thematic analysis was used to analyze data wherein patterns emerge via repeated content analytic passes through the data [46]. Focus groups were part of a larger project on patient–provider communication in Kenya; only findings having to do with ethnicity are related here.

2. Results

2.1. Questionnaire

RQ1 asked how participants would rate doctor ethnicity in comparison with other factors in choosing a doctor. Results are presented in Table 1. Higher means indicate more important criteria.

As indicated, demographic factors on the whole were rated relatively less important by participants than factors related to the doctor's qualifications, communication skills, and cost of service.

RQ2 asked which factors of patient–provider communication participants would report to be most strongly influenced by doctor–patient ethnic discordance. To examine this question we compared means and confidence intervals on an item-by-item basis. Results are presented in Table 2. In the interests of saving space only items the difference of whose means was statistically significant at the .05 level are presented. No clear pattern emerged with respect to doctor behavior items; means on patient behaviors were higher on communication-related items. No significant differences emerged regarding different preferred styles of communicating in medical encounters, different explanatory models of health and illness, or racist or perceptual biases.

RQ3 asked what preferences Kenyan patients would express with respect to the ethnicity of their doctor when it came to seeking treatment for various medical conditions. Across categories between 46% and 65% of participants stated they had no preference. Chi square tests of significance were conducted on cases in which participants expressed a preference. Because a

¹ Although a large proportion of doctors in Kenya are of Indian ethnic origin, less than 1% of the population is Indian [30]. Therefore, although it was important to specifically ask participants about their preferences with respect to "Asian" doctors, we did not consider it necessary to assess attitudes of Asian patients.

Table 1

Criteria for choosing a doctor.

Criterion	M	SD
Doctor had lots of experience	4.46 _a	.86
Doctor has a good educational background	4.46 _a	.83
Doctor is responsive and caring	4.42 _a	.85
Doctor's staff is professional	4.39 _a	.76
Cost of service is reasonable	4.26 _a	.90
Doctor has a good reputation	4.35 _a	.88
Doctor is a good communicator	4.31 _a	.76
Location of doctor's office	3.72 _b	1.11
Doctor was recommended by a friend	3.38 _c	1.08
My family always goes to this doctor	3.26 _d	1.29
Doctor's age	2.97 _e	1.35
Doctor's appearance	2.72 _e	1.33
Doctor's gender	2.67 _e	1.25
Doctor's religious faith	2.53 _e	1.32
Doctor's ethnic group	1.96 _f	1.06
Doctor's marital status	1.83 _f	.97

Differing subscripts indicate statistically significant differences between means at the $p < .05$ level.

Table 2

Patient report of the influence of doctor–patient ethnic discordance on aspects of the doctor–patient relationship.

Doctor behavior	M	SD
<i>A doctor from MY ethnic group would be more likely than other doctors to</i>		
Be friendly	3.42 _a	1.27
Give me clear directions on what I need to do next	3.31 _a	1.21
Provide useful information beyond my specific problem of the day	2.96 _b	1.23
Take plenty of time attending to me	2.95 _b	1.29
Put me at ease	2.94 _b	1.28
Suggest more than one alternative for treatment	2.93 _b	1.22
Make me feel that I am in control of my illness	2.92 _b	1.21
Negotiate the cost of my visit	2.71 _b	1.32
Patient behavior	M	SD
<i>If I was seeing a doctor from MY ethnic group as compared to others I would be more likely to</i>		
Ask the doctor to explain terms I did not understand	3.51 _a	1.30
Be able to explain my problem to the doctor clearly	3.40 _a	1.29
Feel comfortable having the doctor ask about my emotional state	2.92 _b	1.32
Honestly answer the doctor about my health habits	3.03 _b	1.32
Follow the doctor's advice to the letter	2.92 _b	1.25
Negotiate payment	2.81 _b	1.34
Give my own opinion about different treatment options	2.81 _b	1.24

Differing subscripts indicate statistically significant differences between means at the $p < .05$ level.

number of participants wrote in a fifth doctor ethnic group – Kamba – we included that category in the analysis (Table 3).²

As indicated, participants who had a preference for ethnicity of their doctor were significantly more likely to prefer Indian doctors for dental and eye problems, and European doctors for major surgery, cancer, and heart problems. Kikuyus were preferred for pregnancy and general ailments. In the remaining categories more than one group was about equally preferred.

RQ4 asked to what extent patient–provider concordance would explain these preferences. To explore this we ran crosstabs with chi square tests between participant ethnicity and each medical condition. Participant ethnicity was collapsed to include the three most numerous groups in the sample – Kikuyu, Luo, and Kamba –

² Because figures on the proportion of Kenyan doctors from each ethnic group were unavailable, expected values for the five ethnic groups were set as equal. This is likely to produce conservative results in cases where Asian or European doctors are preferred in the sample, as those groups are very small within the larger Kenyan population, and liberal results when Kikuyu doctors are preferred in the sample, as the Kikuyu number twice as many in the general Kenyan population as any other group.

Table 3
Preference for doctor ethnicity by medical condition.

Medical condition	Preferred doctor ethnicity						χ^2 ^a (d.f. = 4)	p
	No preference	Kikuyu	Indian	Luo	European	Kamba		
Dental issues	122	14	42	13	18	4	35.51	.000
Eye problems	113	5	60	4	26	2	125.73	.000
Cancer	112	1	18	9	67	2	155.53	.000
General ailments	147	25	6	15	7	9	19.94	.001
STIs	134	16	10	13	25	6	14.71	.005
Minor surgery	114	10	21	27	33	4	30.00	.000
Major surgery	98	6	23	19	61	4	93.33	.000
Heart problems	97	10	28	14	59	3	86.44	.000
Skin problems	134	17	24	9	22	4	19.13	.001
Pregnancy	128	28	8	17	16	9	16.48	.002
Children's health	133	21	8	11	25	12	13.58	.009

^a (d.f. = 4) values report a comparison between those who indicated a preference for ethnicity of physician.

Table 4
Effect of participant ethnicity on preference for doctor ethnicity, by medical condition.

Medical condition	χ^2	d.f.	p
Dental	39.28	18	.003
Eye problems	33.25	21	.043
Cancer	22.57	15	.094
General ailments	39.56	15	.001
STIs	35.44	15	.002
Minor surgery	33.85	18	.013
Major surgery	12.00	15	.680
Heart problems	15.09	15	.445
Skin problems	20.04	18	.330
Pregnancy	58.44	21	.000
Children's health	66.07	21	.000

with the rest categorized under "other." Results are presented in Table 4.

As indicated, participants of all ethnic groups had similar preferences for ethnicity of their doctors when it came to serious medical conditions. However, for less severe conditions, ethnicity of participant was significantly related to preference for ethnicity of doctor. Examination of cross-tabulations revealed that with respect to general ailments, children's illnesses, and sexually transmitted infections, participants from each ethnic groups were more inclined to indicate a preference for a doctor of their own ethnicity. Regarding dental issues, only Kikuyu participants preferred ethnically concordant providers.

Post hoc analyses were run on all dependent variables in the form of *t*-tests and chi square tests to determine whether any effects for gender emerged. No statistically significant differences were found between men and women on any variable.

2.2. Focus groups

The topic of doctor ethnicity did not spontaneously arise in any groups. When moderators introduced the issue, participants as a whole said that the ethnicity of doctors was not important. As a member of one of the Luo focus groups explained,

I never feel disturbed by the doctor's tribe provided he can attend to what I want... You may go to a Luo and be treated well; you may also go to another tribe and be treated well. Just as I said earlier about the Luhya doctor who was here and used to treat us well, so we loved him and would ask whether he was there.

Participants were more likely to indicate that doctor gender as opposed to ethnicity was important to them, with most preferring

the communication style of male as opposed to female physicians. Most discussants insisted that they were most concerned about the competence and empathy of their physicians above any demographic factors. Another Luo participant related:

On choosing doctors, I can say that I do not discriminate. One time my baby was sick and I was attended to by an Indian doctor. That was also in Taita where there was no Luo or Kikuyu doctor. I was helped by a doctor of Chagga tribe to deliver a baby. A Kikuyu doctor has also removed my teeth. So I do not discriminate against doctors as long as they are competent.

When participants were probed, two major themes emerged with respect to their attitudes toward the ethnicity of their physicians: (a) preference for seeing doctors of their own ethnic group, and (b) preference for seeing doctors *not* from their ethnic group. A third minor theme addressed preference for doctors from specific other ethnic groups.

Comments about preferring ethnically concordant doctors mostly centered around the idea that sometimes it was easier to explain one's symptoms to someone who spoke one's language. "You may go to the hospital and call for a Luo doctor because you probably cannot express some details in Swahili," one Luo participant said. "So you need a Luo doctor who will understand you well. You may tell a Kikuyu doctor that you have a headache when you probably have a stomachache. He will therefore prescribe the wrong medicine. A Luo is better for me." Members of the middle-income urban groups were not so concerned for themselves as for their elderly relatives: "If you are taking let's say your grannie, your mama, probably who are not conversant with English and Swahili, you'd prefer a doctor who speaks the language they best understand. Because they'll be comfortable and you're assured they also feel very confident." Others took pains to make it clear that concerns about language were not the same as concerns about ethnicity. A Kikuyu participant stated, "Yes, I would prefer to wait for a doctor from my tribe; I'll trust easier and express myself better. But even if he is not from my tribe but can still understand me, I will trust him."

In addition to language, participants in both middle-income urban groups mentioned the possibility that during the post-election violence in Kenya in 2008, doctors might not have treated patients from opposing ethnic groups well. One recalled taking her sick child to a clinic at that time: "And when I went in the doctor I found was of the clashing ethnic group. And I was like, 'God in heaven I just pray that this guy has strong values in professional ethics.' So he did the tests and he prescribed but I was still under a lot of fear." Participants stated that this sort of thought had been unknown prior to the civil unrest of the previous year. A few participants in the urban low- and middle-income, and Luo groups

mentioned having heard of incidents in which although doctors showed no preferential treatment along ethnic lines, nurses, receptionists, and other personnel occasionally did. Shortcomings of nurses' communication was a spontaneous topic of discussion in most groups.

The opposite preference, for doctors not from their own ethnic group, arose mostly in the Luo focus groups. Several members of these groups said that they would not want a doctor from near their hometown. "A Luo doctor is good but the way he treats you will depend on where you come from. If you come from near him he will be less likely to treat you better than he would have done if you came from far," one stated. A participant from an urban low-income group spoke of avoiding doctors from her ethnic group who knew her family for fear that the doctor might reveal her illness to her relatives. Other Luo participants complained that Luo doctors might speak to one in the vernacular language in the village, but in their offices in town they would insist on speaking one of the national languages, thus the communication advantage would be lost. One Luo participant told a moderator outside of the group setting that even Luo greetings involve introducing oneself as the child of so-and-so from such-and-such village, and with such information in hand a doctor could easily be tempted to spread one's private information to persons within one's social circles. Somewhat differently, an urban low-income participant explained it could be uncomfortable seeing doctors from one's own ethnic group because they might think one wanted favors from them such as lower cost for services. One would rather avoid such a situation entirely.

Several participants qualified that ethnicity could be a factor depending on the medical condition. One participant proclaimed, to general laughter of other participants, she would prefer not to see doctors from her tribal group because they were not the best doctors. She preferred Luo doctors because they were the majority ethnicity in the medical school at the university she had attended and she respected their diligence in their studies. Other urban middle-income participants expressed preferences for Indian doctors in certain circumstances: "Well for me, for the ear thing. Unfortunately I've just had a better experience with Asian doctors. So I think for the ear, my sensitive issues, my ears, it would have to be an Asian doctor. Anybody else can treat me for anything else." One participant claimed that Indian doctors did not treat Africans well unless the patient was rich.

3. Discussion and conclusion

3.1. Discussion

Previous research on ethnic concordance between patients and physicians has viewed ethnic similarity as a generally positive thing [13–15]. Kenyan patients in our study, in contrast, expressed a range of attitudes toward patient–provider ethnic concordance: from positive to neutral to distinctly negative. On the one hand, nearly all of our participants stated that when choosing a doctor, ethnicity was among the least of their concerns; it was a non-issue. On the other hand, when asked about their preferences for treatment of specific medical conditions, a substantial majority did express partiality. For less serious medical conditions the inclination of these participants was in congruence with previous research: they preferred an ethnically concordant doctor. Our findings suggest that this may be due in part to patients' higher degree of confidence in their ability to express themselves plainly to doctors from their own ethnic group [16]. Among the ways that ethnic discordance has been found to negatively affect the patient–provider relationship in other populations, this was the only one was mentioned with any regularity among our participants [16–19]. A few participants in the qualitative component of the study

did mention fears of ethnic bias [1], but said they were not conscious of such possibilities except around the post-election violence in 2008. Thus the salience of their ethnic identity in the patient–provider relationship was to some extent situational [20,48].

Interpersonal factors were apparently trumped for a substantial proportion of our participants, however, in cases of serious illness. In such situations, those participants who stated a preference were most likely to favor either European or Indian doctors depending upon the illness. This inevitably raises the question of whether this significant minority of our participants – black Africans themselves – harbored notions of ethnic inferiority with respect to the capabilities of black Kenyan physicians to provide certain types of medical care. If so, doctors in these medical specialties who hail from other Kenyan ethnic groups may need to be especially cognizant of communicating professional expertise to patients and the community at large. Even less expectedly, our results also suggest negative attitudes toward doctor–patient ethnic concordance. Some participants in the qualitative portion of the research, particularly those of Luo ethnicity, simply did not want to interact with doctors from their own ethnic group no matter what the medical condition. In hindsight we could see the sense of this. The intertwined network of relationships and obligations in collectivistic African societies [21–23] inevitably entails negative corollaries. As Kenyan writer Mbiti [24] stated, "The corporate type of life makes every member of the community dangerously naked in the sight of the other members" (p. 209). For patients, the risk to privacy inherent in being treated by someone who might know one's relatives and could possibly make an off-hand comment about one's condition either accidentally, maliciously, or out of a collectivistic concern for the welfare of the group, might outweigh any advantage of speaking a common mother tongue.

3.2. Conclusion

For the most part our findings did not echo those of research on this topic in other cultural contexts. Among the ways that ethnic discordance has been found to affect the patient–provider relationship in other populations, only one appeared to have any degree of importance to our participants [16–19]. Conversely, ethnicity influenced doctor–patient communication in our sample in ways that been little explored in other contexts. Our findings thus highlight the need for additional research that troubles the application of Western concepts in health communication to the sub-Saharan context [51,52].

3.3. Practice implications

Our findings have implications for the staffing of clinics, particularly HIV voluntary counseling and testing centers, where the diagnostic issues involved are extremely private. It has long been recognized that simply walking into one of these clinics carries the risk of stigmatization [25]. In ethnically Luo regions (which are also high in HIV prevalence), doctors may be well advised to take extra care to convey sensitivity and professionalism in the area of confidentiality in order to get the trust of local folk despite the collectiveness of the society. Alternatively, medical clinics may need to consider purposefully employing staff from outside the communities – even outside the ethnic group – of the location in which they are located.

Several limitations of this research should be mentioned. First, our sample was highly educated. It is possible that in a less educated sample more ethnic bias would have been evident. Furthermore, as an initial exploratory study, this research measured only general patient attitudes, not patient outcomes from actual doctor–patient interactions. Further, all focus groups

conducted were composed of women. Although our quantitative data revealed no evidence of an effect of gender on the dependent variables we assessed, it is possible that some gender differences would have arisen in the open forum of focus group discussion. Finally, the questionnaire was structured so as to tap into patient perceptions regarding specific communicative benefits of a concordant patient–provider relationship. This was in accordance with previous research in other cultural contexts. In hindsight we realize there was not a corresponding section of the study that inquired into costs of concordant relationships. Thus the preference expressed by some Luo focus group participants for ethnically discordant patient–provider relationships could not be picked up in the quantitative data.

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