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Disparities and distrust: The implications of psychological processes for understanding racial disparities in health and health care

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ABSTRACT

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Review

This paper explores the role of racial bias toward Blacks in interracial relations, and in racial disparities in health care in the United States. Our analyses of these issues focuses primarily on studies of prejudice published in the past 10 years and on health disparity research published since the report of the US Institute of Medicine (IOM) Panel on Racial and Ethnic Disparities in Health Care in 2003. Recent social psychological research reveals that racial biases occur implicitly, without intention or awareness, as well as explicitly, and these implicit biases have implications for understanding how interracial interactions frequently produce mistrust. We further illustrate how this perspective can illuminate and integrate findings from research on disparities and biases in health care, addressing the orientations of both providers and patients. We conclude by considering future directions for research and intervention.

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In the last two decades, racial and ethnic disparities in the United States have attracted the attention of scholars in a range of professions and academic areas. Despite large differences in focus and methodology, their studies yield a common conclusion: people who self-identify as White are healthier than members of all other racial/ethnic groups (with the exception of people who self-identify as Asian or Pacific Islander; National Center for Health Statistics, 2004). The largest disparities in health status, however, are between Whites and Blacks (U.S. Department of Health and Human Services, 2000).

Several different explanations for these disparities have been proposed. In particular, racial disparities in health may be explained by differences between genetic populations' susceptibility to different diseases (Pettaway, 1999); socioeconomic differences, which may directly affect access to health care (IOM, 2003) and indirectly influence health status through the impact of education on health literacy and health practices (Sentell & Halpin, 2006); differential exposure to environmental hazards or stressors (Stuber, Galea, Ahern, Blaney, & Fuller, 2003); or differences in health-related attitudes and behaviors (Harris, 2004). Beyond these effects, psychological factors of prejudice and stereotyping have also been implicated (IOM, 2003; Williams, 2005). Prejudice reflects a general negative evaluation or orientation to a group or a member of a group, whereas stereotyping involves the association or attribution of specific characteristics to a group and its members. Both prejudice and stereotyping can produce discrimination, an unfair or unjustified group-based difference in

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behavior that systematically disadvantages members of another group.

In this paper, we explore bias toward Blacks in interracial relations and the implications it has for racial disparities in health care. We focus our attention specifically on White–Black relations because these racial disparities are particularly pronounced and these relations have received the most attention in the psychological literature. We propose that it is important to recognize that (a) racial biases (i.e., prejudice and stereotyping) occur implicitly, without intention or awareness, as well as explicitly; and (b) the implications need to be understood as an outcome of interactions involving both majority and minority group members. This paper is divided into three sections that (a) describe the psychology of contemporary racial bias, (b) review studies relating to the implications of these processes for medical encounters, and (c) consider future directions in research and intervention.

The processes and consequences of racial bias

In the United States, Whites' obvious and blatant expressions of prejudice toward traditionally underrepresented groups, and toward Blacks in particular, have declined substantially over the past 50 years. As Bobo (2001) concluded in his review of racial attitudes, "The single clearest trend in studies of racial attitudes has involved a steady and sweeping movement toward general endorsement of the principles of racial equality and integration" (p. 269). Although more obvious acts of bias certainly exist in society (e.g., Bertrand & Mullainathan, 2004; van Ryn & Burke, 2000; Virtanen & Huddy, 1998), a recent public opinion poll reported that only 13% of Whites self-identified as being racially biased (Shabazz, 2007). Furthermore, limited evidence exists of self-reported racial prejudice specifically among well-educated and high socioeconomic status Whites (Schuman, Steeh, Bobo, & Krysan, 1997). At the same time, however, racial disparities in economic (Blank, 2001), physical (IOM, 2003), and psychological/mental health (Surgeon General, 2001) remain. In addition, and despite Whites' reported decrease in prejudice, racism is still unmistakably apparent: 84% of Blacks (compared to 66% of Whites) recently reported that racism is a serious problem, and 51% claim to have been "a victim of discrimination" (Shabazz, 2007).

What can account for the discrepancy between the reported reductions in expressed prejudice, the persistent disparity in economic, residential, and health status between Blacks and Whites, and the widespread perceptions of discrimination by Blacks? One answer is that explicit prejudice still exists but that Whites have become more aware of social norms against it, and are therefore more guarded about public expressions of bias. Another answer is that explicit prejudice is being replaced by aversive racism (Dovidio & Gaertner, 2004; Gaertner & Dovidio, 1986), a contemporary form of prejudice that is less conscious and more indirect. Both perspectives suggest that racial biases are now less blatant than in the past, and that new perspectives and techniques are needed to understand the depth and scope of contemporary racism.

Aversive racism

In contrast to traditional "old-fashioned" racism which is expressed overtly, aversive racism is a subtle form of bias. Aversive racists consciously endorse the principle of racial equality and regard themselves as nonprejudiced. However, at the same time, aversive racists possess unconscious negative feelings and beliefs about particular minority groups. Thus, aversive racists demonstrate a fundamental discrepancy between their *explicit* egalitarian attitudes, which they consciously endorse, and their *implicit* negative racial attitudes, which they do not recognize. Explicit attitudes are reflected in traditional self-report measures; implicit attitudes are assessed with new techniques (e.g., response time measures; see Dovidio, Kawakami, & Beach, 2001; Nosek, 2005), which assess spontaneous and uncensored reactions.

Because of their explicit egalitarian orientation, the feelings that aversive racists experience toward other groups are not of hatred or open contempt, which motivate direct harm, but are rather of anxiety and discomfort, which lead to avoidance. Moreover, the negative feelings and implicit attitudes of aversive racists produce systematic discrimination, but in subtle and indirect ways that do not threaten an aversive racist's nonprejudiced image. This contemporary form of racism is termed "aversive" because these "well-intentioned" people would find any suggestion that they are racially biased to be aversive (Dovidio & Gaertner, 2004).

The negative orientations toward groups and their members that aversive racists develop from widespread and generally functional cognitive (e.g., social categorization), motivational (e.g., need for status), and sociocultural (e.g., social transmission of stereotypes) processes (Dovidio & Gaertner, 2004). For instance, people automatically distinguish others on the basis of race, and this social categorization spontaneously activates more positive feelings and beliefs about ingroup members ("we's") than outgroup members ("they's") (Gaertner & Dovidio, 2000). In addition, Whites automatically activate stereotypes of Whites as intelligent, successful, and educated and of Blacks as aggressive, impulsive, and lazy (Blair, 2001; Wittenbrink, Judd, & Park, 1997). Although the activation of stereotypes and negative attitudes does not necessarily lead to discrimination, it can predispose Whites to be biased. Automatically activated attitudes and stereotypes are particularly likely to produce discriminatory actions when people lack the motivation or cognitive resources to monitor and control their actions, such as when they have time pressure or substantial cognitive demands.

Subtle discrimination

Whereas traditional, old-fashioned racists exhibit a direct and overt pattern of discrimination, aversive racists' responses are more contextually sensitive. Because aversive racists consciously recognize and endorse egalitarian values and truly aspire to be nonprejudiced, they will *not* discriminate in situations in which discrimination would be obvious to others and to themselves. However, because they still possess feelings of uneasiness toward the outgroup, these feelings will often be expressed in indirect ways.

Evidence in support of the aversive racism framework comes from a range of paradigms (Dovidio & Gaertner, 2004). For instance, aversive racists do not discriminate when job applicants are clearly qualified or unqualified for a position. However, they do discriminate on the basis of race when applicants have moderate qualifications—that is, when it is unclear what the appropriate decision should be and when latitude exists to discriminate without appearing so. In these circumstances, aversive racists weigh the positive qualities of White applicants and the negative qualities of Black applicants more heavily in their evaluations, providing justification for their decisions (Hodson, Dovidio, & Gaertner, 2002).

We propose that prejudice not only systematically influences intergroup *outcomes*, but also intergroup *interactions*. In particular, aversive racists' dissociation between negative implicit attitudes and egalitarian explicit attitudes can significantly affect how Whites and Blacks interact in ways that contribute substantially to misunderstandings in intergroup interactions.

Bias and interracial interaction

Implicit and explicit attitudes can influence behavior in different ways and under diverse conditions (Dovidio, Kawakami, Johnson, Johnson, & Howard, 1997; Fazio, Jackson, Dunton, & Williams, 1995). Explicit attitudes shape deliberative, well-considered responses for which people have the motivation and opportunity to weigh the costs and benefits of various courses of action. Implicit attitudes influence responses that are more difficult to monitor and control. For example, whereas self-reported prejudice predicts overt expressions of bias, measures of implicit attitudes predict biases in nonverbal behaviors, such as measures of interest (e.g., eye contact), anxiety (e.g., rate of eye blinking), and other cues of friendliness (Dovidio et al., 1997). Thus, the relative impact of implicit and explicit attitudes is a function of the situational context, individuals' motivation and opportunity to engage in deliberative processes, and the nature of the behavioral response (Fazio et al., 1995).

Because it creates situations of conflicting cues, the nature of contemporary racial prejudice in the United States is particularly problematic with respect to producing and perpetuating misunderstandings in interracial interactions (Dovidio, Kawakami, & Gaertner, 2002). People rely heavily on their conscious intentions in assessing whether they are discriminating (Swim, Scott, Sechrist, Campbell, & Stangor, 2003), and as a consequence Whites tend not to recognize when their actions are racially biased (see Devine & Plant, 2003). In general, Whites' perceptions about how they are behaving or perceived by others are based more on their explicit attitudes and overt behaviors (e.g., verbal contents of their interaction with Blacks), which are positively managed, than on their implicit attitudes or less deliberative behaviors (e.g., nonverbal behavior).

In contrast, the perspective of Blacks in these interracial interactions allows them to attend to both the spontaneous (e.g., nonverbal) and deliberative (e.g., verbal) behaviors of Whites. Blacks tend to show heightened attentiveness and sensitivity to nonverbal cues of prejudice (Richeson &

Shelton, 2005). To the extent that Black partners attend to Whites' nonverbal behaviors, which may signal more negativity than their verbal behaviors, Blacks are likely to form more negative impressions of the encounter and to be less satisfied with the interaction compared to Whites (Dovidio et al., 2002).

One fundamental implication of these processes is that Whites and Blacks are likely to develop very different perceptions of race relations. In general, Whites tend to adopt a colorblind orientation, avoid acting in ways that can readily be attributed to racial bias, and are unaware of subtle cues of bias that Blacks perceive; thus, they are much less likely to perceive the existence of racial bias than are Blacks. Blacks, who are more aware of different racial identities and are more sensitive to subtle cues of bias (even when accompanied by contradictory overt behaviors) may tend to show a general distrust and suspicion of Whites (Dovidio, Gaertner, Kawakami, & Hodson, 2002).

Given the different perspectives of Whites and Blacks, in addition to Blacks' experiences with explicit prejudice and discrimination, it is not surprising that current race relations in the United States are characterized by racial distrust. Blacks commonly believe that conspiracies inhibit the progress of Blacks (Crocker, Luhtanen, Broadnax, & Blaine, 1999), and about a third of Blacks are overtly distrustful of Whites in general (Gallup, 2002). With regard to health care, national surveys find that Blacks are significantly more likely than Whites to believe that their race negatively affects their health care (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004), and Blacks are less trusting of their physicians than are Whites (Doescher, Saver, Franks, & Fiscella, 2000). In a national survey, 57% of Blacks said that discrimination occurs "often" or "very often" in Blacks' interactions with White physicians (Malat & Hamilton, 2006). Such feelings almost certainly affect interactions between Black patients and White health care providers: estimates from a national sample reported that approximately 75% of Black patients' medical interactions were with a race-discordant provider (versus about 25% for White patients) (Chen, Fryer, Phillips, Wilson, & Pathman, 2005).

We propose that aversive racism, the contemporary form of prejudice found among liberal and well-educated Whites, thus has important implications for understanding racial disparities in health care in the United States.

Contemporary bias and health care

In this section, we attempt to connect research on the social effects of implicit and explicit attitudes with the literature on racial disparities in health care, drawing primarily on studies published since the *Institute of Medicine Report* (2003). We first focus on research that illustrates the role of subtle biases in treatment delivery and medical interactions. Then, we consider how racial distrust affects the behavior of Blacks within the context of health care.

Racial disparities in medical treatment

The question of interest here is the extent to which disparities in health care between Black and White patients in

the United States are due to race-based prejudice and discrimination. The Institute of Medicine Panel (2003) identified race-based prejudice as a major cause of health disparities, but the case was largely circumstantial. The difficulty in making this case is in demonstrating an unambiguous pattern of racial discrimination by health care professionals that have adverse effects over and above what the Institute of Medicine Committee (2003) called “system level factors”. System level factors refer to the manner in which health care is provided; examples of system level factors include health insurance coverage and unequal geographic distribution of medical services. These factors disproportionately and negatively affect the health care of Blacks, but they are not the result of discriminatory practices motivated by health care providers’ explicit or implicit racial bias. We believe, however, that sufficient data do exist to conclude that subtle racism is a significant contributor to health care disparities.

As we discussed earlier, discriminatory actions at the individual level are more likely to occur when situational demands are unclear or when norms for appropriate actions are weak or ambiguous (Dovidio & Gaertner, 2004). This pattern has also been found in the health care literature. Treatment disparities appear to be greater when physicians engage in “high-discretion” procedures, such as recommending a test or making a referral for a procedure or drug, than when they engage in “low-discretion” procedures, such as emergency surgery (Geiger, 2003). For example, Black women are less likely than White women to receive testing for osteoporosis (Mudano et al., 2003) and, when women of both races have been diagnosed with osteoporosis, Black women are less likely to receive the appropriate medication than are White women (Mikuls, Saag, George, Mudano, & Banerjee, 2005).

Similar results have been found in the study of racial disparities in prostate cancer, a disease that can be difficult to diagnose definitively, and for which there is considerable disagreement in the profession on the most desirable treatment once the cancer is diagnosed (Underwood et al., 2004). When presented with patients suspected of having prostate cancer, physicians are more likely to delay active treatment of prostate cancer for Blacks than for Whites. Among patients for whom active treatment is delayed, Blacks have a longer time frame before their first medical monitoring visit and are monitored much less frequently than are Whites (Shavers, Brown, Klabunde, et al., 2004; Shavers, Brown, Potosky, et al., 2004). Taken together, these findings implicate the role of racial bias in treatment. Nevertheless, we note that these findings come from analyses of archival data, and it is difficult with such data to exclude alternative explanations of the treatment differences. Therefore, we now turn to studies that have individual physicians, patients, or patient/physician dyads as their unit of analysis.

One notable example of experimental research on treatment disparities is a study by Schulman et al. (1999). Primary care physicians at a national conference viewed video tapes of actors playing the role of patients complaining about chest pain. The gender and ethnicity of the patients (Black or White) were systematically manipulated. Of interest to racial interaction, Schulman et al. (1999) found that Blacks were significantly less likely to be

referred for further testing than were Whites. Although the validity of this experimental study has been questioned (e.g., Arber et al., 2006), the results are quite consistent with findings from archival studies of differences in the treatment of Black and White cardiology patients (see, for example, Vaccarino et al., 2005).

Recently, Green et al. (submitted for publication) extended this line of research to explore the role of physicians’ explicit and implicit racial attitudes and stereotypes in their treatment decisions. Physicians’ explicit and implicit attitudes toward Blacks and Whites were assessed. They were then presented with descriptions of hypothetical cardiology patients, in which the race of the patients was systematically varied. Physicians reported no explicit biases toward Blacks relative to Whites. However, physicians had more negative implicit attitudes toward Blacks and had stronger stereotypes of Blacks as uncooperative patients. Moreover, the more negative these implicit attitudes were, the less likely respondents were to recommend thrombolytic drugs for Black patients.

Other research has focused more directly on physicians’ perceptions. van Ryn et al. (van Ryn & Burke, 2000; van Ryn, Burgess, Malat, & Griffin, 2006) researched the relationship between perceptions of health care providers and health disparities, examining the possibility that implicit and explicit racial stereotypes affect physicians’ perceptions of Black patients and their treatment decisions. van Ryn and Burke (2000) surveyed physicians after they interacted with Black and White patients about the patients’ likelihood of drug abuse, compliance with medical advice, intelligence, educational level, and rationality. Physicians described Black patients as more likely to abuse drugs, less likely to comply with medical recommendations, less intelligent, and less educated. These effects were found even after controlling for patient age, gender, socioeconomic status, and degree of illness.

van Ryn et al. (2006) reported similar findings regarding physicians’ perceptions of the personal attributes of Black and White candidates for coronary bypass surgery. Physicians’ stereotypes about Blacks affected their treatment decisions: perceptions of patients’ education and physical activity levels were primarily responsible for Blacks being recommended for bypass surgery less often than Whites (van Ryn et al., 2006). In a summary review of the literature, van Ryn and Williams (2003) concluded that patient race “can influence providers’ beliefs about and expectations of patients, independent of other factors” (p. 497).

Research has also examined whether interactions between White physicians and White patients differ from interactions between White physicians and Black patients in ways that have implications for understanding racial disparities in health care. In a literature review of observational and retrospective studies of medical interactions involving minority group patients, Ferguson and Candib (2002) concluded that, relative to members of majority groups, minority patients are less likely to “engender empathic response from physicians” and to “receive sufficient information,” and are encouraged less “to participate in medical decision making” (p. 353).

Studies that have audio-recorded race-concordant and race-discordant medical visits of Black and White patients

yield convergent evidence. Cooper et al. (2003) demonstrated that race-concordant visits were significantly longer and were characterized by greater patient positive affect compared to race-discordant interactions. Johnson, Roter, Powe, and Cooper (2004) also found more positive affect in White physician–White patient dyads compared to White physician–Black patient dyads, and showed that White physicians were more verbally dominant and less patient-centered with Black than with White patients. In addition, when White physicians interact with Black patients, they provide less information and engage in less joint decision-making than when they interact with White patients (Gordon, Street, Sharf, & Soucek, 2006). Similarly, Siminoff, Graham, and Gordon (2006) found that, among breast cancer patients, White physicians spent significantly less time engaging in relationship-building activities with Black than White patients. These findings are consistent with earlier work by Cooper-Patrick et al. (1999), who reported that Black patients rated participatory decision-making in interactions with White doctors significantly lower than did White patients.

As the more general literature on interracial interactions would suggest, Blacks have less trust in the health care system and in their health care providers than do Whites (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003), which can further adversely affect medical interactions and outcomes. Although national surveys report that the majority of Blacks do not openly express a preference for a race-concordant physician, there is evidence that, if given a choice, Blacks prefer a race-concordant physician (LaVeist & Nuru-Jeter, 2002). Moreover, Black patients tend to be more satisfied with their medical encounter (LaVeist & Nuru-Jeter, 2002; Robins, White, Alexander, Gruppen, & Grum, 2001) and with their medical care (LaVeist & Carroll, 2002; Saha, Komaromy, Koepsell, & Bindman, 1999) when their physician is Black than when their physician is White. LaVeist, Nuru-Jeter, and Jones (2004) further reported that Black patients were more likely to schedule appointments with their physicians and were less likely to postpone or delay these appointments when they had a Black physician rather than a White physician, even after controlling for health status.

It is also important to consider how the potential racial biases of providers, which may be subtle and unintentional, and the sensitivity of Black patients to possible cues of bias jointly influence the nature and outcomes of the medical encounter. Gordon, Street, Kelly, and Soucek (2006) demonstrated that Black and White patients expressed similar levels of trust in their physician before their initial visit for lung cancer evaluation. However, after the visit Black patients reported significantly lower levels of trust in providers than did White patients. Difference in trust was predicted by Black patients' perceptions of less supportiveness, less partnership, and less information during the clinical interaction. Thus, understanding the dynamics of interracial interaction can provide valuable insight into how the potential biases of both providers and patients can combine to contribute to racial disparities in health care and health status.

These disparate findings in race-concordant and race-discordant patient–provider interactions bear directly on

health disparities. There is a significant positive relationship between patient involvement in the interactions and patient recall of medical information (Stewart, 1995), treatment adherence (Roter et al., 1997), patient satisfaction (Stewart et al., 2000; Thompson & Parrott, 2002), and health outcomes (Hall, Roter, & Katz, 1988).

In addition, pervasive racial distrust, which inhibits Blacks from seeking care, can at the same time create a greater need for these services. Perception of being discriminated against personally is directly related to psychological distress (Williams, Neighbors, & Jackson, 2003) and poorer physical health, as measured by self-reports (Williams et al., 2003). Moreover, patients with more negative stereotypes about physicians seek medical care less often when they are sick, are less likely to be satisfied with their medical care, and are less likely to adhere to physician's treatment recommendations (Bogart, Bird, Walt, Delahanty, & Figler, 2004).

We acknowledge that health care disparities may be caused by a variety of factors, including system level factors, outside of medical interactions. Nevertheless, we contend that efforts to reduce the impact of prejudice and stereotyping in patient–provider interactions can help to reduce racial disparities in health by improving the quality of care for racial and ethnic minority groups. Indeed, studies have shown that when treatment disparities are eliminated, disparities in health outcomes are substantially attenuated or absent (Bach et al., 2002). In the next section, we identify future directions in research to address the negative impact of contemporary racism on racial disparities in health care and health.

Planning for the future

Despite the long-term interest of social psychology in prejudice and stereotyping and the widespread attention to racial disparities in health and health care, only recently have serious attempts been made to integrate these two literatures. Traditionally, social psychologists have focused primarily on processes and mechanisms that underlie prejudice and stereotyping; practical consequences have generally been secondary. In contrast, health disparity researchers have focused primarily on the practical problem—racial disparities in health and health care (Williams, 2005). Although these perspectives and goals are quite different, the approaches of social psychologists and many health care researchers interested in disparities are largely complementary. Thus, an integration of these perspectives is likely to produce a more accurate and comprehensive understanding of the issue, which may ultimately yield viable solutions to the problem.

Understanding the problem

The social psychological perspective emphasizes the importance of directly studying patient–provider interaction to understand the processes that underlie racial disparities in health care. In addition, person-level variables (e.g., individual differences in distrust and implicit and explicit prejudice) need to be incorporated into research design and methodology. Prejudice and stereotyping can be identified

588 as factors in treatment bias only to the extent that they are
589 specifically measured.

590 This point may appear obvious, but it is important to
591 note that although there is evidence that health care profes-
592 sionals do react differently to Black and White patients,
593 there is minimal *direct evidence* that physician's attitudes
594 and beliefs about minority group members affect profes-
595 sional interactions with them. One likely reason for this ab-
596 sence of direct evidence is that studies have rarely sought it.
597 Patients may be reluctant to have their clinical interactions
598 recorded for analysis, and providers may feel personally
599 and legally threatened by research that may uncover their
600 racial biases. Despite these objections, the potential long-
601 term benefits to the profession and to society are signifi-
602 cant. Understanding the nature of the problem is essential
603 for formulating effective solutions.

604 *Seeking solutions*

605
606
607 The social psychological literature can also help to guide
608 the development of practical interventions designed to at-
609 tenuate and reduce bias in the clinical encounter. To the ex-
610 tent that overt racism is relatively rare among people who
611 choose a career in health care (Epstein, 2005) and that the po-
612 tential role of bias in racial disparities in health care is largely
613 unrecognized among providers (Lurie et al., 2005), interven-
614 tions may be more productive if they consider the subtle, per-
615 haps unintentional nature of contemporary racial bias. The
616 distinction between prejudice-reduction techniques in tradi-
617 tional and aversive racism may represent a useful starting
618 point. Traditional prejudice-reduction techniques have
619 been concerned with eliminating overt expressions of bias.
620 They aim to change conscious attitudes—old-fashioned rac-
621 ism—with direct educational programs and persuasion (Ste-
622 phan & Stephan, 2001). However, because of the nature and
623 complexity of contemporary racism, traditional techniques
624 for eliminating racial bias are ineffective for combating subtle
625 bias. Aversive racists already recognize prejudice as detri-
626 mental, but do not recognize that *they* are prejudiced.

627 *Addressing unconscious attitudes and beliefs*

628
629 As described earlier, aversive racism is characterized by
630 conscious (explicit) egalitarian attitudes and negative un-
631 conscious (implicit) attitudes and beliefs. Simply because
632 implicit attitudes are unconscious and automatically acti-
633 vated, however, does not mean that they cannot be
634 changed. To the extent that unconscious attitudes and ste-
635 reotypes are associations learned through socialization,
636 they can also be unlearned or inhibited by equally well-
637 learned countervailing influences. We have found that
638 with extensive practice, it is possible to change implicit
639 beliefs. For example, extended practice in associating
640 counter-stereotypic characteristics with a group can inhibit
641 or suppress the “automatic” activation of cultural stereo-
642 types (Kawakami, Dovidio, Moll, Hermsen, & Russin, 2000).

643 **06** The practical problem, though, is that Whites are typi-
644 cally motivated to avoid seeing themselves as racially bi-
645 ased. For instance, Whites often adopt a colorblind
646 orientation, particularly when they anticipate racial ten-
647 sion; if they deny that they notice race, they cannot be
648 accused of racism. Nevertheless, efforts to be colorblind

649 and suppress acknowledgement of race can produce a “re-
650 bound effect,” where implicit attitudes become activated
651 even more. Moreover, because minorities seek acknowl-
652 edgement of their racial identity, Whites' efforts to be col-
653 orblind may alienate minority group members and further
654 contribute to racial distrust (Dovidio et al., 2002).

655 Instead, efforts to reduce prejudice can potentially
656 capitalize on aversive racists' good intentions and induce
657 self-motivated efforts to reduce unconscious biases by in-
658 creasing awareness. Monteith and Voils (1998) found that
659 when low prejudiced people recognize discrepancies be-
660 tween their behavior (i.e., what they *would* do) and their
661 personal standards (i.e., what they *should* do) toward minor-
662 ities, they feel guilt and compunction, which subsequently
663 produces motivations to respond without prejudice in the
664 future. With practice over time, these individuals learn to
665 reduce prejudicial responses and to respond in ways that
666 are consistent with their nonprejudiced personal standards.
667 This process of self-regulation may produce changes in even
668 unconscious negative responses when extended over time
669 (Dovidio, Kawakami, & Gaertner, 2000).

670 *Redirecting ingroup bias*

671
672 A basic argument we have made in our analysis of social
673 biases is that the negative feelings that develop toward
674 other groups may be rooted, in part, in fundamental, nor-
675 mal psychological processes. One such process is the cate-
676 gorization of people into ingroups and outgroups. As we
677 noted earlier, social categorization contributes to aversive
678 racism. Because categorization is a basic process funda-
679 mental to intergroup bias, we have targeted this process
680 as an avenue through which we may attempt to attenuate
681 and reduce the negative repercussions of aversive racism.
682 To do this we have proposed the Common Ingroup Identity
683 Model (Gaertner & Dovidio, 2000).

684 The Common Ingroup Identity Model is rooted in the so-
685 cial categorization perspective of intergroup behavior and
686 recognizes the central role of social categorization in inter-
687 group bias. Specifically, if members of different groups are
688 induced to think of themselves as a single superordinate
689 group rather than as two separate groups, attitudes toward
690 former outgroup members will become more positive
691 through ingroup bias. Thus, by changing the basis of cate-
692 gorization from race to an alternative dimension, one can
693 alter who “we” is and who “they” are, thereby undermin-
694 ing a contributing force to contemporary racism. Formation
695 of a common identity, however, does not necessarily re-
696 quire groups to forsake their other identities. It is possible
697 for members to conceive of themselves as holding a “dual
698 identity” in which other identities and the superordinate
699 group identity are salient simultaneously.

700 One additional advantage of this approach in clinical
701 settings is that an intervention emphasizing the common
702 bond between provider and patient could have a positive
703 impact on both of them, producing a more harmonious in-
704 teraction and enhancing rapport—even while maintaining
705 recognition of different racial identities (i.e., a dual iden-
706 tity). Indeed, Stewart et al. (2000) argued that physicians
707 oftentimes view themselves as members of one group
708 (health care providers) charged with the responsibility of
709 helping members of another group (patients) solve their

710 medical problems, and that such perceptions are not bene-
711 ficial to physicians or patients.

712 We propose that existing attitudes, beliefs, and expecta-
713 tions among physicians and patients *and* the social role that
714 each party occupies can lead to social categorization of one
715 another in medical interactions. Social categorization
716 makes existing negative attitudes and stereotypes about
717 the situation and different group identities even more sa-
718 lient in the interaction. As a result, the climate of commu-
719 nication in medical interactions will affect the health care
720 and health status of minority group patients. If this argu-
721 ment is valid, then some procedure is needed to moderate
722 the effects of preexisting attitudes, beliefs, and social cate-
723 gorization processes in the medical interaction. For exam-
724 ple, it may be possible to give both patients and providers
725 a sense that they are collaborators in the decision-making
726 process of identifying and treating the patient's problem
727 (Cooper-Patrick et al., 1999). This intervention would not
728 be intended to eliminate the participants' respective role
729 or social identity, or even to change existing attitudes.
730 Rather, it would be intended to make both parties in an
731 interaction aware of the overriding need to *work together*
732 *as a team* to solve a common problem.

733 This approach appears to be conceptually similar to the
734 "common ground" component of Stewart et al.'s (2000) pa-
735 tient-centered clinical method. Particularly in primary care
736 clinical settings, finding common ground requires that the
737 physician and the patient reach agreement with regard to:
738 the nature of the medical problem, goals of treatment, and
739 roles of the doctor and patient. A nonexperimental investi-
740 gation of the efficacy of the patient-centered method pro-
741 duced some promising results. Specifically, Stewart et al.
742 (2000) reported that medical interactions characterized
743 by the common ground approach were associated with
744 "better [patient] recovery from their discomfort and con-
745 cern, better emotional health... and (appropriately) fewer
746 diagnostic tests and referrals" (p. 796). As already dis-
747 cussed, other studies have also found significant positive
748 associations between patient involvement in medical inter-
749 actions and patient satisfaction (Stewart et al., 2000) and
750 medical outcomes from these interactions (Hall et al.,
751 1988). The authors of this article are currently conducting
752 pilot studies on the efficacy of such an intervention.

753 Conclusion

754
755
756 The literature reviewed in this paper provides direct
757 experimental evidence of the impact of racial attitudes
758 and stereotypes on White–Black relations in the United
759 States. In general, although explicit prejudice and stereo-
760 types have declined over time, many Whites still harbor
761 implicit, negative racial attitudes and stereotypes toward
762 Blacks. These implicit biases are manifested in subtle, of-
763 ten unintentional forms of discrimination that produce
764 less favorable outcomes for Blacks than for Whites, con-
765 tribute to error and miscommunication, and create racial
766 distrust. Although there is limited direct evidence of these
767 processes operating in the medical encounter, there is sig-
768 nificant circumstantial evidence from archival research
769 showing disparities consistent with these processes.
770 Moreover, the limited experimental evidence yields

771 convergent conclusions that racial biases in patient–pro-
772 vider interactions contribute directly to racial disparities
773 in health care and thus health status.

774 Understanding the implications of general processes of ra-
775 cial bias and distrust for medical interactions does not
776 impugn the integrity of medical professionals. Indeed, the so-
777 cial psychological evidence reveals that contemporary racial
778 biases operate unconsciously and unintentionally among
779 well-intentioned people. Instead, we see this analysis as an
780 opportunity to develop collaborations among motivated
781 medical providers to better understand the complexity of in-
782 terracial interactions in medical settings. Such knowledge
783 would be the foundation for the development of specific in-
784 terventions to combat contemporary racism in a cooperative
785 effort to reduce racial disparities in health care and status.

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