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

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A B S T R A C T

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 interra-
cial relations and the implications it has for racial dispar-
ities 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 pro-
pose 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 im-
plications need to be understood as an outcome of interac-
tions 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 ex-
pressions of prejudice toward traditionally underrepre-
sented 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 sin-
gle clearest trend in studies of racial attitudes has involved
a steady and sweeping movement toward general endorse-
ment 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 opin-
on 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 de-
spite 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 be-
tween Blacks and Whites, and the widespread percep-
tions 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 sugg-
est 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 contempo-
rary 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 racism possess unconscious neg-
ative feelings and beliefs about particular minority groups.
Thus, aversive racists demonstrate a fundamental disagree-
ment 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 feel-
ings 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 discrimina-
 tion, 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 categoriza-
tion), motivational (e.g., need for status), and sociocultural
(e.g., social transmission of stereotypes) processes (Dovidio
& Gaertner, 2004). For instance, people automatically dis-
istinguish others on the basis of race, and this social catego-
rization spontaneously activates more positive feelings and
beliefs about ingroup members (“we’s”) than outgroup
members (“they’s”) (Gaertner & Dovidio, 2000). In addi-
tion, Whites automatically activate stereotypes of Whites
as intelligent, successful, and educated and of Blacks as ag-
gressive, impulsive, and lazy (Blair, 2001; Wittenbrink,
Judd, & Park, 1997). Although the activation of stereotypes
and negative attitudes does not necessarily lead to discrimi-
nation, it can predispose Whites to be biased. Automati-
cally activated attitudes and stereotypes are particularly
likely to produce discriminatory actions when people lack
the motivation or cognitive resources to monitor and con-
tral their actions, as such as when they have time pressure
or substantial cognitive demands.

Subtle discrimination

Whereas traditional, old-fashioned racists exhibit a di-
rect and overt pattern of discrimination, aversive racists’ re-
sponses are more contextually sensitive. Because aversive
racists consciously recognize and endorse egalitarian values
and truly aspire to be nonprejudiced, they will not discrim-
inate in situations in which discrimination would be obvi-
ous 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) related the research's perception 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, & Souchek, 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 Souchek (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, Dahanaty, & 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...
as factors in treatment bias only to the extent that they are specifically measured.

This point may appear obvious, but it is important to note that although there is evidence that health care professionals do react differently to Black and White patients, there is minimal direct evidence that physician's attitudes and beliefs about minority group members affect professional interactions with them. One likely reason for this absence of direct evidence is that studies have rarely sought it. Patients may be reluctant to have their clinical interactions recorded for analysis, and providers may feel personally and legally threatened by research that may uncover their racial biases. Despite these objections, the potential long-term benefits to the profession and to society are significant. Understanding the nature of the problem is essential for formulating effective solutions.

Seeking solutions

The social psychological literature can also help to guide the development of practical interventions designed to attenuate and reduce bias in the clinical encounter. To the extent that overt racism is relatively rare among people who choose a career in health care (Epstein, 2005) and that the potential role of bias in racial disparities in health care is largely unrecognized among providers (Lurie et al., 2005), interventions may be more productive if they consider the subtle, perhaps unintentional nature of contemporary racial bias. The distinction between prejudice-reduction techniques in traditional and aversive racism may represent a useful starting point. Traditional prejudice-reduction techniques have been concerned with eliminating overt expressions of bias. They aim to change conscious attitudes—old-fashioned racism—with direct educational programs and persuasion (Stephan & Stephan, 2001). However, because of the nature and complexity of contemporary racism, traditional techniques for eliminating racial bias are ineffective for combating subtle bias. Aversive racists already recognize prejudice as detrimental, but do not recognize that they are prejudiced.

Addressing unconscious attitudes and beliefs

As described earlier, aversive racism is characterized by conscious (explicit) egalitarian attitudes and negative unconscious (implicit) attitudes and beliefs. Simply because implicit attitudes are unconscious and automatically activated, however, does not mean that they cannot be changed. To the extent that unconscious attitudes and stereotypes are associations learned through socialization, they can also be unlearned or inhibited by equally well-learned countervailing influences. We have found that with extensive practice, it is possible to change implicit beliefs. For example, extended practice in associating counter-stereotypic characteristics with a group can inhibit or suppress the “automatic” activation of cultural stereotypes (Kawakami, Dovidio, Moll, Hersmien, & Russin, 2000).

The practical problem, though, is that Whites are typically motivated to avoid seeing themselves as racially biased. For instance, Whites often adopt a colorblind orientation, particularly when they anticipate racial tension; if they deny that they notice race, they cannot be accused of racism. Nevertheless, efforts to be colorblind and suppress acknowledgement of race can produce a “rebound effect,” where implicit attitudes become activated even more. Moreover, because minorities seek acknowledgement of their racial identity, Whites' efforts to be colorblind may alienate minority group members and further contribute to racial distrust (Dovidio et al., 2002).

Instead, efforts to reduce prejudice can potentially capitalize on aversive racists' good intentions and induce self-motivated efforts to reduce unconscious biases by increasing awareness. Monteith and Voils (1998) found that when low prejudiced people recognize discrepancies between their behavior (i.e., what they would do) and their personal standards (i.e., what they should do) toward minorities, they feel guilt and compunction, which subsequently produces motivations to respond without prejudice in the future. With practice over time, these individuals learn to reduce prejudicial responses and to respond in ways that are consistent with their nonprejudiced personal standards. This process of self-regulation may produce changes in even unconscious negative responses when extended over time (Dovidio, Kawakami, & Gaertner, 2000).

Redirecting ingroup bias

A basic argument we have made in our analysis of social biases is that the negative feelings that develop toward other groups may be rooted in, in part, fundamental, normal psychological processes. One such process is the categorization of people into ingroups and outgroups. As we noted earlier, social categorization contributes to aversive racism. Because categorization is a basic process fundamental to intergroup bias, we have targeted this process as an avenue through which we may attempt to attenuate and reduce the negative repercussions of aversive racism. To do this we have proposed the Common Ingroup Identity Model (Gaertner & Dovidio, 2000).

The Common Ingroup Identity Model is rooted in the social categorization perspective of intergroup behavior and recognizes the central role of social categorization in intergroup bias. Specifically, if members of different groups are induced to think of themselves as a single superordinate group rather than as two separate groups, attitudes toward former outgroup members will become more positive through ingroup bias. Thus, by changing the basis of categorization from race to an alternative dimension, one can alter who “we” is and who “they” are, thereby undermining a contributing force to contemporary racism. Formation of a common identity, however, does not necessarily require groups to forsake their other identities. It is possible for members to conceive of themselves as holding a “dual identity” in which other identities and the superordinate group identity are salient simultaneously.

One additional advantage of this approach in clinical settings is that an intervention emphasizing the common bond between provider and patient could have a positive impact on both of them, producing a more harmonious interaction and enhancing rapport—even while maintaining recognition of different racial identities (i.e., a dual identity). Indeed, Stewart et al. (2000) argued that physicians oftentimes view themselves as members of one group (health care providers) charged with the responsibility of helping members of another group (patients) solve their
medical problems, and that such perceptions are not beneficial to physicians or patients.

We propose that existing attitudes, beliefs, and expectations among physicians and patients and the social role that each party occupies can lead to social categorization of one another in medical interactions. Social categorization makes existing negative attitudes and stereotypes about the situation and different group identities even more salient in the interaction. As a result, the climate of communication in medical interactions will affect the health care and health status of minority group patients. If this argument is valid, then some procedure is needed to moderate the effects of preexisting attitudes, beliefs, and social categorization processes in the medical interaction. For example, it may be possible to give both patients and providers a sense that they are collaborators in the decision-making process of identifying and treating the patient’s problem (Cooper-Patrick et al., 1999). This intervention would not be intended to eliminate the participants’ respective role or social identity, or even to change existing attitudes. Rather, it would be intended to make both parties in an interaction aware of the overriding need to work together as a team to solve a common problem.

This approach appears to be conceptually similar to the “common ground” component of Stewart et al.’s (2000) patient-centered clinical method. Particularly in primary care clinical settings, finding common ground requires that the physician and the patient reach agreement with regard to: the nature of the medical problem, goals of treatment, and the roles of the doctor and patient. A nonexperimental investigation of the efficacy of the patient-centered method produced some promising results. Specifically, Stewart et al. (2000) reported that medical interactions characterized by the common ground approach were associated with “better [patient] recovery from their discomfort and concern, better emotional health... and (appropriately) fewer diagnostic tests and referrals” (p. 796). As already discussed, other studies have also found significant positive associations between patient involvement in medical interactions and patient satisfaction (Stewart et al., 2000) and medical outcomes from these interactions (Hall et al., 1988). The authors of this article are currently conducting pilot studies on the efficacy of such an intervention.

Conclusion

The literature reviewed in this paper provides direct experimental evidence of the impact of racial attitudes and stereotypes on White–Black relations in the United States. In general, although explicit prejudice and stereotypes have declined over time, many Whites still harbor implicit, negative racial attitudes and stereotypes toward Blacks. These implicit biases are manifested in subtle, often unintentional forms of discrimination that produce less favorable outcomes for Blacks than for Whites, contribute to error and miscommunication, and create racial distrust. Although there is limited direct evidence of these processes operating in the medical encounter, there is significant circumstantial evidence from archival research showing disparities consistent with these processes. Moreover, the limited experimental evidence yields convergent conclusions that racial biases in patient–provider interactions contribute directly to racial disparities in health care and thus health status.

Understanding the implications of general processes of racial bias and distrust for medical interactions does not impugn the integrity of medical professionals. Indeed, the social psychological evidence reveals that contemporary racial biases operate unconsciously and unintentionally among well-intentioned people. Instead, we see this analysis as an opportunity to develop collaborations among motivated medical providers to better understand the complexity of interracial interactions in medical settings. Such knowledge would be the foundation for the development of specific interventions to combat contemporary racism in a cooperative effort to reduce racial disparities in health care and status.

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