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Short report

Racial attitudes, physician–patient talk time ratio, and adherence in racially discordant medical interactions

Nao Hagiwara [a,*], Louis A. Penner [b], Richard Gonzalez [c], Susan Eggly [b], John F. Dovidio [d], Samuel L. Gaertner [e], Tessa West [f], Terrance L. Albrecht [b]

[a] Department of Psychology, Virginia Commonwealth University, 808 West Franklin Street, PO Box 842018, Richmond, VA 23284-2018, USA
[b] Department of Oncology, Karmanos Cancer Institute/Wayne State University, 4100 John R, MM03CB, Detroit, MI 48201, USA
[c] Department of Psychology, University of Michigan, 530 Church St., Ann Arbor, MI 48109, USA
[d] Department of Psychology, Yale University, 2 Hillhouse Rd., PO Box 208205, New Haven, CT 06520, USA
[e] Department of Psychology, University of Delaware, 108 Wolf Hall, Newark, DE 19716, USA
[f] Department of Psychology, New York University, 6 Washington Pl, New York, NY 10003, USA

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ABSTRACT

Physician racial bias and patient perceived discrimination have each been found to influence perceptions of and feelings about racially discordant medical interactions. However, to our knowledge, no studies have examined how they may simultaneously influence the dynamics of these interactions. This study examined how (a) non-Black primary care physicians' explicit and implicit racial bias and (b) Black patients' perceived past discrimination affected physician–patient talk time ratio (i.e., the ratio of physician to patient talk time) during medical interactions and the relationship between this ratio and patients' subsequent adherence. We conducted a secondary analysis of self-report and video-recorded data from a prior study of clinical interactions between 112 low-income, Black patients and their 14 non-Black physicians at a primary care clinic in the Midwestern United States between June, 2006 and February, 2008. Overall, physicians talked more than patients; however, both physician bias and patient perceived past discrimination affected physician–patient talk time ratio. Non-Black physicians with higher levels of implicit, but not explicit, racial bias had *larger* physician–patient talk time ratios than did physicians with lower levels of implicit bias, indicating that physicians with more negative implicit racial attitudes talked more than physicians with less negative racial attitudes. Additionally, Black patients with higher levels of perceived discrimination had *smaller* physician–patient talk time ratios, indicating that patients with more negative racial attitudes talked more than patients with less negative racial attitudes. Finally, *smaller* physician–patient talk time ratios were associated with *less* patient subsequent adherence, indicating that patients who talked *more* during the racially discordant medical interactions were *less* likely to adhere subsequently. Theoretical and practical implications of these findings are discussed in the context of factors that affect the dynamics of racially discordant medical interactions.

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Introduction

Even though Black patients generally prefer to see Black physicians (Garcia, Paterniti, Romano, & Kravitz, 2003; Saha, Taggart, Komaromy, & Bindman, 2000), approximately 75% of Black patients interact with non-Black physicians (Chen, Fryer, Phillips, Wilson, & Pathman, 2005), including White physicians from North America and physicians of various ethnicities trained outside North America (American Medical Association, 2007). The high incidence of Black patients who engage in racially discordant medical interactions has substantial implications for racial healthcare disparities because whether medical interactions are racially concordant or discordant has a direct impact on the quality of healthcare patients receive. There is strong evidence that communication in racially discordant medical interactions is usually less productive and positive in content and tone than in racially concordant interactions. For example, compared to racially concordant medical interactions, racially discordant ones are characterized by less: positive affect (Johnson, Roter, Powe, & Cooper, 2004), relationship building (Siminoff, Graham, & Gordon, 2006), treatment planning (Oliver, Goodwin, Gotler, Gregory, & Stange, 2001), and health

* Corresponding author. Tel.: +1 804 828 6822; fax: +1 804 828 2237.
E-mail address: nhagiwara@vcu.edu (N. Hagiwara).

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information exchange (Eggly et al., 2011; Gordon, Street, Sharf, Kelly, & Souchek, 2006).

The landmark volume of the Institute of Medicine, "Unequal Treatment" (Smedley, Stith, & Nelson, 2003), argued that both non-Black physicians' and Black patients' racial attitudes are major contributors to racial healthcare disparities. In health disparities literature, physicians' racial attitudes are typically operationalized as racial bias, whereas patients' racial attitudes are operationalized as perceptions of or reactions to the experience of racial prejudice and discrimination at both a societal and personal level. Prior research has shown that both physician racial bias and patient perceived past discrimination influence thoughts and feelings about racially discordant medical interactions (Benkert, Peters, Clark, & Keves-Foster, 2006; Penner et al., 2009). For instance, Penner, Dovidio, et al. (2010) reported that non-Black physicians' explicit racial bias affected their reports of how much they involved their Black patients in treatment decisions as well as their perceived communality with their Black patients. Cooper et al. (2012) found that greater physician implicit racial bias was negatively associated with patient ratings of interpersonal care. Similarly, Benkert et al. (2006) found that Black patients' perceptions of experience with racism was negatively associated with patients' satisfaction with their healthcare provider; this relationship was mediated by trust in that provider. That is, Black patients who perceived racism in their lives trusted their physicians less, which, in turn, led to lower satisfaction.

Although previous studies have demonstrated that both physicians' and patients' racial attitudes affect each participant's perceptions of racially discordant medical interactions, little work has examined how their racial attitudes simultaneously affect their behaviors during such interactions. The present study addresses this issue by examining the impact of racial attitudes on the dynamics and outcomes of racially discordant medical interactions. The dynamics of medical interactions can be assessed in many different ways, but we focus on one specific aspect of physicians' and patients' behavior—the amount of talk time during medical interactions—because it has been shown to affect patient health-related attitudes and behaviors (e.g., Epstein & Street, 2007; Hahn, 2009; Roter & Hall, 1993) and health (Kaplan, Greenfield, & Ware, 1989).

As far as we are aware, only one prior study (Cooper et al., 2012) has examined how racial attitudes affect the relative amount physicians and patients talk during medical interactions. In that study, Cooper et al. found that higher physician implicit bias was associated with greater physician verbal dominance, which they defined as a greater *number* of physician utterances relative to patient utterances. The present study, which was a secondary analysis of self-report data and video-recordings from a larger study of clinical interactions between low-income Black patients and their non-Black primary care physicians (see Penner et al., 2009), builds on this prior research. Like Cooper et al., we examined verbal dominance during racially discordant medical interactions. In our study, however, we operationalized verbal dominance as the ratio of *time* the physician talked relative to time the patient talked (i.e., physician–patient talk time ratio). In research on social interactions, relative and/or absolute talk time is considered a valid measure of participants' motivation to dominate an interaction (Dovidio, Brown, Heltman, Ellyson, & Keating, 1988; Mast, 2002). We extended Cooper and colleagues' work in three ways. First, we examined the simultaneous effects of physicians' implicit and explicit racial bias on physician–patient talk time ratio. Second, we examined the impact of patients' perceived past discrimination on physician–patient talk time ratio. Third, we examined the association between physician–patient talk time ratio and patients' subsequent adherence to physician treatment recommendations. The rationale for the study hypotheses follows.

Racial attitudes, interaction goals, and behaviors

Non-Black physician perspective

Racial attitudes can operate at both an explicit and implicit level (see Wilson, Lindesy, & Schooler, 2000). At the explicit, or conscious, level, non-Black physicians are more likely to perceive Black patients as less trustworthy, more contentious, and less likely to adhere to their recommendations than White patients (Moskowitz et al., 2011; van Ryn & Burke, 2000). At the implicit, often non-conscious, level, physicians display a preference for White over Black patients and are more likely to associate White, rather than Black, patients with being compliant and cooperative (Sabin, Rivara, & Greenwald, 2008). Thus, biased physicians might be inclined to assume an authoritative role and exert more control during interactions with Black patients.

However, behaviors that might represent bias in healthcare are widely and vigorously condemned within the medical profession (Green et al., 2007). As a result, physicians are likely to attempt to self-regulate these potentially negative behaviors (Shelton, Richeson, & Salvatore, 2005; Shelton, Richeson, Salvatore, Trawalter, 2005; Vorauer & Turpie, 2004). Yet, there is substantial evidence showing that people's ability to self-regulate the expression of bias in their behaviors depends on how aware they are of their racial bias and how easy or hard the behaviors are to self-regulate (Ferguson, 2007). Specifically, people are better at self-regulating explicit racial bias manifested in more planned behaviors, such as verbal behaviors, than they are at regulating implicit racial bias manifested in more spontaneous behaviors, such as nonverbal and paraverbal behaviors (Dovidio & Gaertner, 2004). Thus, even if non-Black physicians are able to successfully self-regulate negative explicit racial bias manifested in more planned behaviors, their implicit racial bias may still be manifested in spontaneous behaviors that are more difficult to self-regulate (Cooper et al., 2012; Penner, Dovidio, et al., 2010).

Black patient perspective

One widely held belief among Blacks is that when they interact with non-Blacks, they will be the target of prejudice and/or discrimination (Shelton, 2003; Shelton & Richeson, 2006). As a consequence, Blacks often avoid interracial interactions (Mendoza-Denton, Downey, Purdie, Davis, & Pietrzak, 2002; Shelton & Richeson, 2005, 2006). However, some interracial interactions are unavoidable, such as medical interactions. In these situations, Blacks are likely to become more active with the aim of limiting their vulnerability associated with being the target of prejudice (Shelton, Richeson, & Salvatore, 2005; Shelton, Richeson, Salvatore, et al., 2005). Moreover, prior research has shown that Black patients with higher levels of perceived past discrimination are less likely to trust physicians (Benkert et al., 2006; Schuster et al., 2005) and that less trusting patients, regardless of their racial background, tend to play a more active role during medical interactions and are less willing to give physicians treatment decisional control (Trachtenberg, Dugan, & Hall, 2005). This research thus suggests that Black patients who report higher perceived past discrimination may be more verbally active in their medical interactions with non-Black physicians and perhaps less likely to follow the physicians' recommendations (see Penner et al., 2009).

Hypotheses

In the present study, we examined the simultaneous effects of physicians' explicit and implicit racial bias and patients' perceived past discrimination on the amount of time the physician talked relative to the patient (i.e., physician–patient talk time ratio). We also examined the association between physician–patient talk time

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