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Disaggregating ethnoracial disparities in physician trust

Abigail A. Sewell *

Emory University, United States
University of Pennsylvania, United States

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ABSTRACT

Past research yields mixed evidence regarding whether ethnoracial minorities trust physicians less than Whites. Using the 2002 and 2006 General Social Surveys, variegated ethnoracial differences in trust in physicians are identified by disaggregating a multidimensional physician trust scale. Compared to Whites, Blacks are less likely to trust the technical judgment and interpersonal competence of doctors. Latinos are less likely than Whites to trust the fiduciary ethic, technical judgment, and interpersonal competence of doctors. Black–Latino differences in physician trust are a function of ethnoracial differences in parental nativity. The ways ethnoracial hierarchies are inscribed into power-imbalanced clinical exchanges are discussed.

0. Introduction

The patient–physician relationship is inherently unequal given the status differences between clinicians and help-seekers (Gilson, 2003; Kramer and Cook, 2004; Mechanic, 1998; Parsons, 1951). The absence of physician trust on behalf of ethnoracial (i.e., racial/ethnic) minorities is considered to be a key mechanism underlying health care disparities (LaVeist et al., 2000; Smedley et al., 2003). In fact, ample evidence shows that Blacks and Latinos hold less trust toward medical research, pharmaceuticals, health care facilities, and health care providers than Whites (Armstrong et al., 2006; Boulware et al., 2003; Corbie-Smith et al., 2002; Freimuth et al., 2001; Hughes-Halbert et al., 2006; Stepanikova et al., 2006). Lack of trust in physicians and health care matters in a broader sense because trust in medical actors is considered a contributing factor to help-seeking behavior when one becomes ill and to compliance behavior as one navigates the medical institution (Mechanic, 1998; Whetten et al., 2006). High levels of trust, moreover, have been linked to better self-rated health and more positive functional health across the life course (Barefoot et al., 1998). Inequalities in trusting medical actors by race and ethnicity, then, may partly contribute to ethnoracial inequalities in morbidity, mortality, *and* health care service use (Smedley et al., 2003).

Yet, research evaluating ethnoracial differences in trusting *personal physicians* provides mixed evidence regarding both the magnitude and substantive nature of ethnoracial differences in physician trust. For instance, on one hand, unidimensional studies examining the perceived willingness of doctors to put their patients' needs above all other considerations show Blacks are substantially less likely than Whites to trust personal physicians (Ahern and Hendryx, 2003; Doescher et al., 2000; Levinson et al., 2005; Patel and Chernew, 2007; Schnittker, 2004; Stepanikova et al., 2006). On the other hand, studies employing multi-dimensional scales of trusting personal physicians do not show evidence of less trusting affect

* Address: Emory University, Department of Sociology, 204 Tarbutton Hall, 1555 Dickey Drive, Atlanta, GA 30322, United States.
E-mail address: abigail.a.sewell@emory.edu

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toward medical doctors among Blacks compared to Whites (Benjamins, 2006; Guffey and Yang, 2012; Musick and Worthen, 2008; Tai-Seale and Pescosolido, 2003). Meanwhile, Latino–White differences in physician trust have been found in unidimensional studies (Stepanikova et al., 2006) but have not been evaluated in multidimensional studies. These divergent sets of findings prompt an important question: Why do multidimensional studies of physician trust not detect ethnoracial differences in physician trust? If ethnoracial minorities are so overwhelmingly distrustful of medicine and, arguably by extension, physicians, then ethnoracial gaps should be evident regardless of the instrument employed.

This ethnoracial physician trust paradox is the concern of this study. Recent studies argue that (dis)trust in the health care system cannot be translated to (dis)trust in physicians (Shoff and Yang, 2012). I argue that ethnoracial differences in medical system trust do not necessarily translate to ethnoracial differences in physician trust. The perspective that ethnoracial minorities are culturally *predisposed* to distrust must be questioned. Rather, as stated by Benjamin (2013) in a study of stem cell research, "distrust is socially produced in the everyday experiences of patient families in and outside of the clinic" (115). The approach taken to elucidating this paradox is primarily methodological, with substantive and theoretical implications, as it highlights the utility of disaggregating multidimensional physician trust scales.

Using data from English-speaking respondents of the 2002 and 2006 General Social Surveys, this study adjudicates among the disparate findings of physician trust studies by evaluating measurement variance in a shortened form of a standard multi-dimensional "Trust in Physician" scale and its constituent disaggregated items (Anderson and Dedrick, 1990). Five dimensions of the patient–physician relationship are considered: honesty, fiduciary ethics (i.e., commitment to uphold the Hippocratic Oath), technical expertise, cultural authority, and interpersonal competence (Mechanic, 1998; Pescosolido et al., 2001). A commonly-used measure of confidence in medicine is employed as a comparison measure to capture social attitudes toward the larger health care system. Ethnoracial differences in the various forms of physician trust are evaluated both naïvely and holding constant sociodemographic factors. The ways ethnoracial hierarchies are inscribed into power-imbalanced clinical exchanges are discussed.

1. Literature review

1.1. Trust in the health care system

Trust is an essential ingredient of social interactions characterized by high levels of uncertainty and vulnerability (Smith, 2010), such as those within the medical institution (Cook et al., 2004; Hall et al., 2001; Mechanic, 1998; Pearson and Raeke, 2000). Social conditions, such as race and ethnicity, constrain and shape the contour of interactions within and across ethnoracial groups (Ross et al., 2001). Race, in particular, influences the relationships people form with others (Link and Phelan, 1995). Racism creates dissimilarities in the life opportunities, lived experiences, and collective interests of individuals marked indelibly by phenotype (Bonilla-Silva, 1997; Omi and Winant, 1994). Moreover, racial stratification intensifies power imbalances already present in the interactions between patients and physicians (King, 1996). Racial stratification fosters racially distinct attitudinal profiles toward institutional gatekeepers of the goods and services of society (Bonilla-Silva, 1997), including toward the medical and scientific enterprises (Benjamin, 2013).

Processes of inequality within and tangential to the medical system have placed racial and ethnic minorities in a position of high vulnerability to medical actors (Smedley et al., 2003; Whaley, 1998). For instance, the misuse and abuse of Black bodies in medical science is considered to have incited general mistrust and anxiety among Blacks toward medicine (Gamble, 1997; Thomas and Curran, 1999; White, 2005). Such mistrust and anxiety reflects a history of exploitation and benign neglect that Blacks have experienced at the hands of actors across the medical hierarchy (Beardsley, 1987; Jones, 1981; Nelson, 2011; Washington, 2006. In characterizing the medical attitudes of Blacks, Gamble (1997) suggests there is a spillover effect from Black's general beliefs that their lives are devalued: "They perceive, at times correctly, that they are treated differently in the health care system solely because of their race, and such perceptions fuel mistrust of the medical profession" (1775–6).

Social processes of inequality also place Latinos at a disadvantage in medical encounters. Recent studies indicate that experiments such as Tuskegee also occurred among Guatemaleans during the 1940s (Reverby, 2011), suggesting that Latinos may also have a collective memory of medical abuse and benign neglect. Moreover, Latinos have more limited English proficiency than non-Latinos – a factor that undermines trust via compromising the quality of patient–physician communication (Betancourt et al., 2003; McGorry, 1999). One study found that 82% of Latinas who participated in a focus group study cited language problems as a reason to withhold information from their physicians (Julliard et al., 2008). Because the presence of a third party heightens feelings of discomfort, fear, and vulnerability in a relationship that is already power-imbalanced, interpreters may also create more barriers to establishing trust between Latino patients in their doctors. In fact, Latinos may experience cultural dissonance with Western medical practices that mandate patients disclose confidential information and personal problems with clinicians (Echeverry, 1997).

Still, researchers have not provided a systematic examination of how pan-ethnic inequalities influence the extension of trust to physicians within the medical encounters. For instance, research often lumps Latinos into the "Other" category or omits them from analysis altogether. Furthermore, among demographically-similar adults, no ethnoracial differences have been found in prior studies examining ethnoracial differences in confidence in leaders of medicine or general confidence in physicians (e.g., Alesina and La Ferrara, 2002; Benjamins, 2006). These findings call into question the assumption that ethnoracial inequalities in physician trust are ubiquitous and/or are a ready reflection of ethnoracial inequalities in medical distrust.