Racism in healthcare: Its relationship to shared decision-making and health disparities: A response to Bradby

Monica E. Peek, Angela Odoms-Young, Michael T. Quinn, Rita Gorawara-Bhat, Shannon C. Wilson, Marshall H. Chin

The University of Chicago, Department of Medicine, 5841 S. Maryland Avenue, MC 2007, Chicago, IL 60637, United States

University of Illinois-Chicago, Department of Kinesiology and Nutrition, Chicago, IL, United States

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**Bradby’s (2010) critique of our paper ‘Race and Shared Decision-Making: Perspectives of African–Amercians with Diabetes’ (Peek, 2010) highlights important questions about racism, patient/provider communication and U.S. health disparities.** We address her concerns through the following questions: 1) How can we best conceptualize racism in healthcare? 2) Is there evidence for racism in the current U.S. healthcare system?, 3) How can we disentangle racial discrimination from discrimination based on other social factors?, 4) Is there evidence and/or theoretical model(s) that link institutional racism to population-level health disparities?, 5) Is there evidence and/or theoretical model(s) that link the patient/provider relationship and communication disparities to population-level health disparities?, and 6) Are there potentially effective solutions to address institutional racism, particularly unconscious provider bias?

**How can we best conceptualize racism in healthcare?**

The Institute of Medicine (IOM), in its landmark report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, identified two causes of healthcare disparities: healthcare systems and discrimination at the patient/provider level (defined as ‘biases, prejudices, stereotyping, and uncertainty in clinical communication and decision-making’) (Smedley, Stith, & Nelson, 2002, p. 4).

Within this context, one can consider theoretical models to further define racism and discrimination within healthcare. We used Camara Jones’ framework because of its widespread use and because it was developed to highlight how racism can lead to health disparities (Jones, 2000). Jones describes three levels of racism: institutionalized racism, personally-mediated racism and internalized racism. Institutionalized racism, defined as differential access to goods, services, and opportunities by race, includes differential access to health insurance, which study participants described as a contributing factor to communication disparities between African-Americans and their physicians. It is important to note that institutional racism does not require personal bias commonly associated with term ‘racism.’ This type of racism, termed personally-mediated racism, is defined as prejudice (differential assumptions about the abilities, motives, and intentions of others according to their race and discrimination (differential actions toward others according to their race) (Jones, 2000). Prejudice and discrimination may manifest as disrespect, poor service and failure to communicate options (Jones, 2000), all of which our study participants described in their experiences within the U.S. healthcare system. They attributed differential physician assumptions (e.g. “maybe they assumed that she would not understand”) and behaviors (e.g. “they just talk right at the patient because they are black”) specifically to being African–Americans, indicating participants’ perceived influence of race on patient/physician encounters.
There are two important points to underscore about personally mediated racism. First, it may occur subconsciously. Well-meaning individuals may harbor assumptions about people that reflect societal norms. According to social science theory, everyone uses the strategy of social categorization (e.g. by race or gender) in an attempt to understand, predict and control one’s environment and process new information (Hamilton, 1981; Klopf, 1991). Unfortunately, this process can lead to exaggeration of negative inter-group differences (stereotypes) and an over-generalization of them (bias/prejudice) (Klopf, 1991; Lalonde & Gardner, 1989). Second, although discrimination may be subconscious, its impact is powerful. Racism need not take overt forms of slavery or segregation to have a significant effect. In fact, the most potent forms of discrimination that African-Americans currently experience are subtle forms experienced chronically (Banks, Kohn-Wood, & Spencer, 2006).

Finally, Jones defines internalized racism as the acceptance by members of stigmatized races of negative messages about their abilities and intrinsic worth (Jones, 2000). Internalized racism can have many manifestations, including helplessness, self-devaluation, and limiting one’s right to self-determination and self-expression (Jones, 2000). Our participants reported a decreased ability of African-Americans to question their treatment and speak up to their physicians, and also described devaluing characteristics (e.g. poor physical presentation, not “speaking well”) as potential causes of communication disparities.

The above literature defining racism in healthcare provides a strong theoretical framework for understanding its contribution to health disparities, and corroborates the findings of our study.

Is there evidence for racism in the current U.S. healthcare system?

Indeed, there is evidence that racism exists within the U.S. healthcare system (institutional racism) and among healthcare providers (personally-mediated racism). The IOM report Unequal Treatment reviewed the disparities literature and concluded that an important contributor to racial disparities in health status is the difference in the quality of medical care given to racial/ethnic minorities (Smedley et al., 2002). For example, among diabetes patients, African-Americans are less likely to receive influenza vaccinations, have glycosylated hemoglobin (HbA1c) testing or cholesterol testing (Peek, Cargill, & Huang, 2007). Healthcare providers may harbor racial biases (personally-mediated racism), and may be at increased risk of using stereotypes as cognitive short-cuts because of clinical encounter characteristics (time pressure, high cognitive demand, limited resources and uncertainty) (Hamilton, 1991). There is evidence that physicians hold stereotypes based on patient characteristics (e.g. race), which may influence their interpretation of patient behaviors and symptoms, and consequently their clinical decisions (Burgess, van Ryn, Dovidio, & Saha, 2007; Finucane & Carrese, 1990). For example, one study found that physicians were more likely, after controlling for confounding variables, to rate their African-Americans patients as less educated, less intelligent, more likely to abuse drugs and alcohol, and less likely to adhere to treatment regimens (van Ryn & Burke, 2000). Green et al. (2007) documented the association between implicit physician bias and racial disparities in treatment recommendations for acute myocardial infarctions.

While there is no consensus on how to best measure healthcare discrimination (Kressin, Raymond, & Manze, 2008), most researchers rely upon patient reports of perceived discrimination — a strategy with inherent advantages and disadvantages. While perceptions may be misinterpreted, they do reflect patients’ personal experiences and how they are internalized, which may be important to how discrimination affects health (see discussion below). This may be particularly true for patients who lived through U.S. segregation, as their historical healthcare experiences undoubtedly shaped how they currently experience healthcare encounters. In our study, all but three participants were born before the 1964 Civil Rights Act outlawing U.S. segregation.

There is growing evidence that minorities perceive healthcare discrimination and that such perceptions are associated with important outcomes, such as less preventive healthcare (e.g. cancer screening, dyslipidemia screening, and influenza vaccinations) (Hausmann, Jeong, Bost, & Ibrahim, 2008; Trivedi & Ayanian, 2006), prescription medication utilization and medical testing/treatment (Van Houtven et al., 2005). Among diabetes patients, perceived healthcare discrimination is associated with lower quality physician interactions, and worse diabetes care and outcomes (Piette, Bibbins-Domingo, & Schillinger, 2006; Ryan, Gee, & Griffith, 2008; Trivedi & Ayanian, 2006).

The above evidence compels us to conclude that racism is embedded within the U.S. healthcare system, at both institutional and personally mediated levels.

How do we disentangle racial discrimination from discrimination based on other social factors?

Racial disparities in healthcare (institutional racism) persist after adjusting for other sociodemographic variables such as gender and class (Smedley et al., 2002). There has been less research separating personally-mediated racism from other forms of discrimination. However, in several studies, healthcare discrimination attributed to race (vs. other social factors) was reported most commonly among minorities and associated with worse care and outcomes (Ren, Amick, & Williams, 1999; Ryan et al., 2008; Trivedi & Ayanian, 2006). For example, in a study of discrimination and diabetes management, perceived racial discrimination was associated with a 50% lower probability of three aspects of diabetes care, while perceived gender discrimination was associated with a 22% lower probability of one aspect of care (Ryan et al., 2008).

In our study, we explored the relationship between race and shared decision-making (SDM), while recognizing that other social factors affect such communication and may interact with race. As we note in our paper, an important next step will be to explore how perceptions of race interact with other social variables to influence SDM.

Is there evidence/theoretical model(s) that link institutional racism to population-level health disparities?

Several well-known models broaden our understanding of how institutional racism may lead to population-level health disparities. The chronic stress induced by personal experiences with discrimination is one mechanism by which institutional racism may affect health (Jones, 2000; Williams, 1996). For example, McEwen’s model (1998) of allostatic load emphasizes interactions between cognitive processes (i.e. responses to perceived stress) and physiological responses (e.g. cardiovascular, immunological effects) to explain how environmental stressors, major life events and trauma (e.g. racism) result in physiological changes. In Massey’s biosocial model of racial stratification (2004), concentrations of poverty and violence (due to socioeconomic inequalities and residential segregation) result in high allostatic loads that have downstream health effects such as coronary artery disease, inflammatory disorders and cognitive impairment. Among African-Americans, perceptions of discrimination are independently associated with C-reactive protein, a marker of systemic inflammation that correlates to cardiovascular disease and other health outcomes, and precursors to cardiovascular disease (e.g. coronary artery calcification).
Institutional racism may also affect health through negative health behaviors such as delays in healthcare utilization and treatment non-adherence (Casagrande, Gary, LaVeist, Gaskin, & Cooper, 2007), and cigarette and alcohol use (Borrell et al., 2007). Institutional racism, as perceived discrimination within society, is associated with poor health measures, including depression, high blood pressure, cardiovascular disease, and pulmonary disease (Gee, Spencer, Chen, & Takeuchi, 2007; Williams et al., 1997).

In the above, we have highlighted some of the evidence linking institutional racism to health outcomes and illustrated models proposing pathways between racism and population-level health disparities.

Is there evidence and/or theoretical model(s) that link the patient/provider relationship and communication disparities to population-level health disparities?

Evidence-based models have shown how health providers may contribute to racial/ethnic disparities in health (Ashton et al., 2003; van Ryn, 2002). These models focus on patient/provider relationships and how bias, health and interpersonal behaviors, cognitive and affective factors, perceptions, and professional decision-making influence healthcare delivery and health outcomes.

Based on our research, we have developed a conceptual model for exploring relationships between race, shared decision-making and health outcome (Fig. 1). It is important to note that our model is nested within the broader context of the healthcare system and macro-level factors which also affect health outcomes and health disparities.

The model demonstrates how shared decision-making is a joint endeavor, and its successful execution depends on the preference of both patients and providers to engage in this process, and on the patient/provider relationship, which creates the situational context for SDM. Race may potentially affect SDM through several mechanisms. First, racial differences may exist in patient preferences for SDM or in how SDM is conceptualized. A study of a multi-ethnic population found no differences between white and African-Americans patients in preferences for SDM (Peek, Tang, Cargill, & Chin, 2007), suggesting that patient preference is unlikely to drive SDM disparities. In a prior analysis, we found that African-Americans with diabetes defined SDM in ways that are different than how it is conceptualized in the literature (Peek et al., 2008), which may influence SDM behaviors and contribute to differential experiences of SDM among African-Americans.

In the above, we have highlighted some of the evidence linking institutional racism to health outcomes and illustrated models proposing pathways between racism and population-level health disparities.

Physician mistrust is associated with lower preferences for shared decision-making (Kraetschmer, Sharpe, Urowitz, & Deber, 2004), and in our conceptual model, trust and normative beliefs (e.g. biases) are two mechanisms by which race may influence SDM, either directly or through the patient/provider relationship (Blanchard & Lurie, 2004). For example, providers may have preconceived ideas about who is more likely to prefer an active role, which may influence how engaging they are of different racial/ethnic groups in decision-making. In general, African-Americans have less participatory physician visits with more physician verbal dominance, less information delivery, and less patient-centered communication than whites (Epstein, Taylor, & Seage, 1985; Johnson, Roter, Powe, & Cooper, 2004).

Our study explored patient perceptions about the influence of race on patient/provider communication and specific domains of shared decision-making, an area that has received little attention to date. Consistent with our conceptual model, participants described patient trust, bias/stereotypes and the patient/provider relationship as mediating factors between race and SDM. We also found that race has the potential to negatively influence SDM within each of its domains—information-sharing, deliberation/physician

![Fig. 1. Conceptual framework.](image-url)
recommendation and decision-making—through cultural discordance, patient beliefs arising from internalized racism, and unconscious provider bias (personally-mediated racism). While SDM and patient-centered care are associated with health outcomes, the mechanisms are not fully understood. However, we do know that information-sharing and joint goal-setting (important SDM components) are associated with self-efficacy and diabetes self-management, and research suggests that patient understanding, self-efficacy, patient satisfaction and trust predict adherence and self-management, and may be the mechanisms through which shared decision-making impacts health (Heisler, Bouknight, Hayward, Smith, & Kerr, 2002; Heisler et al., 2003; Piette, Schillinger, Potter, & Heisler, 2003).

Are there potentially effective solutions to address institutional racism, particularly unconscious provider bias?

The question of how to effectively address U.S. racial/ethnic health disparities is an important one, and for which there is no simple or single solution. Rather, the answers must address the range of causes of disparities (e.g. inequalities in education, housing, and health insurance) and empower multiple levers of change (e.g. patients, providers, health systems, policymakers, communities). For example, researchers at the University of Chicago are working to reduce diabetes disparities on the city’s South Side, a predominantly working class African–American community, through a multi-site intervention that combines patient education/activation, provider training, health systems redesign and community engagement (Alliance to Reduce Disparities in Diabetes, 2010).

Our paper focuses on patient/provider communication, and as such, our proposed solutions target patients and physicians. The issue that Bradby (2010) raises about how to address unconscious provider bias is an important one. The training of health providers involved in the Tuskegee syphilis experiment in racial eugenics showed that medical education can create racial bias and exacerbate health disparities (Lombardo & Dorr, 2006). To date, however, no research has shown that physician education through cultural competency training can reduce disparities in health outcomes (Beach et al., 2005; Sequist et al., 2010). However, such training can improve provider knowledge, attitudes and skills, which may be an important precursor to addressing unconscious provider bias.

There is evidence that with sufficient motivation, cognitive resources and effort, people can inhibit stereotypes and focus on individuals rather than the sociodemographic groups they represent (Blair, 2002; Fiske, Lin, & Neuberg, 1999). Drawing upon evidence in social cognitive psychology, Burgess et al. (2007) have outlined strategies and skills for healthcare providers to prevent unconscious racial biases from influencing the clinical encounter. Their framework includes: 1) Enhancing internal motivation and avoiding external pressure to reduce bias, 2) Enhancing understanding of the psychosocial basis of bias, 3) Enhancing providers’ confidence in their ability to successfully interact with socially dissimilar patients, 4) Enhancing emotional regulation skills specific to promoting positive emotions, 5) Increasing perspective taking and affective empathy, and 6) Improving the ability to build partnerships with patients. Teal et al. (2010) developed a medical student elective designed to help manage patient bias that incorporates many of Burgess’ principles; they reported significant improvements in students’ strategies to identify and address their racial biases.

Thus, medical science is currently on the cutting edge of identifying and implementing strategies to reduce unconscious provider bias in healthcare, but much work remains to be done. Addressing such bias is only one of many strategies needed to make strides in eliminating racial/ethnic health disparities.

In summary, Bradby (2010) raises important issues about racism within healthcare and its potential effects on patient/provider communication and health disparities. Yet the evidence is clear: race and racism affect the U.S. healthcare system and the patients and providers that interact within it. Our current study builds upon a large body of evidence and gives voice to the perceptions and experiences of African–Americans with diabetes. Only through continued work to understand racism can we make strides in addressing its effects on healthcare delivery and health disparities.

References


