Addressing Racial Healthcare Disparities: How Can We Shift the Focus from Patients to Providers?

Diana J. Burgess, PhD^{1,2}

¹Center for Chronic Disease Outcomes Research, One Veterans Drive; Minneapolis VA Medical Center (a VA HSR&D Center of Excellence), Minneapolis, MN, USA; ²Department of Medicine University of Minnesota, Minneapolis, MN, USA.

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“In contrast to patients’ trust in clinicians, clinicians’ trust in patients has not been investigated.” So wrote Moskowitz et al., whose study, published in this issue of JGIM¹ is the first to show that primary care providers’ trust in their patients (indigent patients with HIV who were part of a longitudinal study of pain) was lower for non-whites than whites, despite the fact that there were no actual racial differences in patient characteristics that might be expected to affect trust, such as patients’ self-reported illicit drug use and misuse of opioids. Trust in this study was assessed using a scale that asked providers to indicate how confident they were that the patient would engage in various behaviors indicating that the patient could be trusted (e.g., “will not manipulate the office visit for secondary gain” such as “inappropriate disability certification or prescription of controlled substances”; “will follow the treatment plan you recommend.”) Notably, in multivariate analyses, non-white race was the largest predictor of provider mistrust, followed by providers’ number of years in practice and patients’ current drug use, while patients’ reports of opioid analgesic misuse and lifetime alcohol abuse/dependence were not significant predictors.

These results are troubling because lower levels of provider trust in their non-white patients with pain may contribute to racial disparities in pain treatment,^{2–4} particularly where opioid analgesics are concerned,^{5–7} since opioids require a certain amount of trust by physicians that the patient will not divert or abuse the prescription. Such racial disparities in pain treatment, in turn, may contribute to the greater prevalence of pain and greater functional impairments due to pain experienced by racial minorities, compared to whites.^{2–4}

Although disturbing, the finding that non-white race was associated with lower levels of provider trust is not surprising, as it is consistent with numerous studies showing that many individuals in the United States, including healthcare providers, manifest a pro-white bias, at the conscious and unconscious level.^{8–10} In fact, the existence of racial bias among healthcare providers and its role as a potential contributor to racial healthcare disparities were discussed in the seminal Institute of Medicine report, *Unequal Treatment*, published in 2003.¹¹ What is surprising, though, is that the Moskowitz et al. study, published in 2011, is the first to examine the effect of patient race on clinicians’ trust, in

contrast to the many published studies examining patient trust.¹² This imbalance underscores what is arguably the dominant way in which the problem of racial healthcare disparities is framed, in which the focus is on identifying and addressing the characteristics of racial minority patients, rather than the characteristics of providers, that contribute to disparities.

The prevailing tendency to frame racial healthcare disparities in terms of patient race rather than providers’ racial stereotypes and biases¹³ is reflected in the prevailing training approaches aimed at improving the care of racial minority patients. Although it was almost a decade ago that *Unequal Treatment* recommended that providers receive training to understand and address ways in which they may unintentionally contribute to racial healthcare disparities,¹¹ there are few programs aimed at helping providers overcome their own race-related beliefs and stereotypes (such as the belief that white patients are more trustworthy than nonwhite patients), that contribute to racially disparate care. By contrast, the most popular training approach for reducing racial healthcare disparities focuses on improving providers’ “cultural competency,” defined as “the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences by recognizing the importance of social and cultural influences on patients.”¹⁴ Although some cultural competency programs do address issues of provider bias, the primary focus is on characteristics of the patient.^{15,16} It is noteworthy that the number of cultural competency training programs is growing,¹⁵ despite the fact that there is a lack of evidence that cultural competency training reduces racial/ethnic healthcare disparities.¹⁷

This dominant framing of disparities is also consistent with the views of many providers, who believe that disparities are due mainly to patient factors rather than provider factors.^{18–20} For example, in a study of primary care clinicians by Sequist et al. published in JGIM in 2008, among the 52% who reported that racial disparities in the quality of diabetes care existed in their own health care system, less than 10% attributed these disparities to provider differences in prescribing medications and differences in referral to specialists and about 20% attributed disparities to providers’ miscommunication with patients. By contrast, about 40% attributed disparities to patient preferences; 45% to patient attitudes and beliefs about the provider; and over 70% to patient health behaviors.

Presently there is a commitment by a number of researchers and educators to shift the focus away from patient race, as a cause of racial healthcare disparities, to provider-level and system-level factors. The National Institutes of Health and the National Cancer Institute, for instance, recently sponsored a

conference, "The Science of Research on Discrimination and Health," in which the NIH/NCI program officers were vocal in their commitment to shifting the lens from patient race, to societal racism. Along those lines, the Society of General Internal Medicine's Health Disparities Task Force developed a curriculum that includes content related to provider racial bias as a contributor to disparities.²¹

However, in attempting to address provider bias as a source of disparities, it is critical that we explore the potential risks involved in doing so, and that we develop strategies to mitigate those risks. The dominant framing of disparities in terms of "patient race" may be partially rooted in broader societal attitudes about race and racism held by majority group members in the United States. These attitudes, which include the belief in a just world, and the minimization or denial of racism, help members of majority groups maintain a positive view of themselves, their group and the larger culture.²² Indeed, studies have shown that many whites and majority group members in the general U.S. population feel threatened by evidence of racial inequality and "white privilege."^{13,14} Indications that providers may be threatened by the existence of racial inequality are findings that, while a sizable percentage of providers do not believe that disparities exist, even fewer acknowledge the existence of disparities in their own practice.^{18–20,23,24} For example, in a survey of cardiologists, 33% thought that disparities existed in cardiovascular care, but only 12% thought disparities existed in their own hospital setting and only 5% thought disparities existed among their own patients.²³

Several recent studies have shown that the threat of being perceived as racist can result in behaviors that, ironically, have negative consequences for interracial interactions, including "distancing" behaviors in the presence of African Americans (e.g., fidgeting, avoiding eye contact) and increases in unconscious racial bias.^{15,16} Also troubling is a study of undergraduates who completed a required course on racial diversity in which the course achieved its objectives of increasing students' awareness of racism and white privilege but also led to an increase in fear of other races as well as an increase in prejudice.²⁵ Along those lines, white undergraduates who were asked to think about "white privilege" expressed higher levels of "modern racism" compared to those who were asked to think about experiences that had nothing to do with race.²⁶ There is also evidence to suggest that some existing approaches to teaching about unintentional provider bias might have unintended consequences. For instance, a number of educators are now using the Implicit Association Test (or IAT), which measures unconscious bias, as a tool for making medical students and physicians aware of their own unconscious racial biases.²⁷ However, a series of studies has shown that the very act of taking the race IAT led to increased levels of unconscious racial bias and that this effect was particularly strong among individuals who were threatened by the possibility of appearing racist and who were highly motivated to control their prejudiced responses.²⁸

Given the potential resistance and "backlash" to shifting the focus of disparities-reduction away from patient factors (like patient culture and patient trust) to potentially threatening provider factors (like provider bias), it is critical that research be conducted to determine the most effective ways of communicating these messages. One body of literature that can inform the development of such communication is self-affirmation

theory. Numerous studies have found that the act of self-affirmation—in which individuals focus on and affirm their important values and sources of personal pride—can reduce the negative consequences that typically occur when individuals feel threatened, by allowing them to maintain a positive self concept.²² In the aforementioned series of studies in which the act of taking the race IAT increased unconscious racial bias,²⁸ individuals who affirmed their commitment to behave in a non-prejudiced manner, before taking the IAT, showed lower levels of unconscious racial bias compared to individuals who were not given the opportunity to self-affirm, even in a condition designed to enhance threat. Other studies have demonstrated that self-affirmation can increase Whites' willingness to perceive the existence of racism across a variety of scenarios,²⁹ to acknowledge the existence of institutional racism,³⁰ and to acknowledge "white privilege."³¹ This suggests that giving providers the opportunity to affirm their worth prior to or as part of communication about unintentional provider bias might help reduce defensiveness to potentially threatening messages.

Findings such those of Moskowitz et al., underscore the importance of addressing providers bias, in order to reduce racial healthcare disparities. As we attempt to switch to this potentially more threatening frame, however, it is critical that the ways in which we communicate this message are carefully considered and based upon sound theory and research.

Disclaimers: The views expressed in this article are those of the authors and do not necessarily represent the position or policy of the Department of Veterans Affairs.

Corresponding Author: Diana J. Burgess, PhD; Center for Chronic Disease Outcomes Research, One Veterans Drive; Minneapolis VA Medical Center (a VA HSRD Center of Excellence), Minneapolis, MN 55417 USA (e-mail: diana.burgess@va.gov).

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