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WHAT DO YOU SEE IN THIS PICTURE?

BIAS AND REFLEXIVITY IN PHYSICIAN NARRATIVES OF DISPARITIES

A Thesis Presented

by

MICHELLE DENISE LEVINE

Submitted to the Office of Graduate Studies,
University of Massachusetts Boston,
in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

June 2010

Clinical Psychology Program

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WHAT DO YOU SEE IN THIS PICTURE?

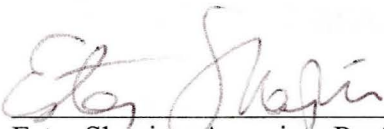
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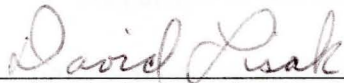
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MICHELLE D. LEVINE

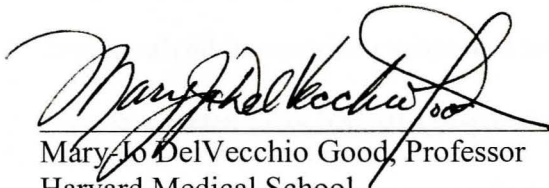
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Ester Shapiro, Associate Professor
Chairperson of Committee



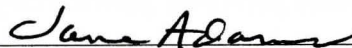
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ABSTRACT

WHAT DO YOU SEE IN THIS PICTURE?

BIAS AND REFLEXIVITY IN PHYSICIAN NARRATIVES OF DISPARITIES

June 2010

Michelle D. Levine, A.B., Harvard University
M.A., University of Massachusetts Boston

Directed by Associate Professor Ester Shapiro

Disparities in healthcare stem from historical, social, institutional, and interpersonal factors—all of which can manifest at the level of the clinical encounter. A growing body of research has addressed implicit bias and, more specifically, the implicit bias involved in aversive racism as a mediator of disparate care. While recent studies have suggested links between disparate treatment and implicit bias, little direct evidence exists for how implicit bias may effect disparate care. Qualitative research on physician understanding of processes by which implicit bias translates into disparate care can help fill this gap and identify areas for further research. This study conducted secondary analysis of physician narratives discussing health disparities using thematic analysis to focus on narratives addressing bias and striving for reflexivity. Thematic analysis yielded three distinct themes for bias: paternalism, involving assumptions about patient

lack of capacity and agency to engage in discussions around treatment and treatment itself; preferential connection, involving preferential attitudes toward members of one's identified group that come at a cost to others who are not treated so preferentially when physician time and focused attention are in effect rationed commodities; and social prototypes, involving the creation of medical prototypes contaminated by information from devaluing social stereotypes. Physician narratives of reflexivity revealed struggles to identify bias, and strategies for self-awareness and accountability to minimize distortion of patient care. Themes for reflexivity described processes that physicians identified to: encounter and counter bias by becoming aware, via attentiveness to one's own subjectivity, of the ways in which bias can operate and also the ways in which one can search for evidence within one's own experience to counter bias; and connect to and with difference by seeking better understanding of a patient's unique subjectivity, equalizing knowledge and power in the medical encounter, and seeking opportunities to serve diverse and marginalized patients as a positive source of knowledge and professional identity. This study substantiates both the presence of and the need to address physician bias, and suggests links to emerging research on social cognitive strategies for countering physician bias.

ACKNOWLEDGMENTS

This thesis is dedicated to my mother and my father, for their love and generosity in giving me educational opportunities, and to the memory of my beloved grandmother, Betty Levine, who worked for social justice all her life.

The physicians interviewed for this work, and the interviewer, deserve tremendous credit, and I wish I could thank each of them personally.

Ester Shapiro's guidance and support were vital throughout the process, and this thesis would not have been possible without her mentorship. I am deeply grateful to Ester for her generosity in sharing constructive feedback, resources, and time. What I have learned from Ester has transformed my ability to think critically about topics in psychology. David Lisak's feedback on methodology is much appreciated, as is his support. Mary-Jo DelVecchio Good's generosity in sharing her work, and her longtime support, encouragement, and interest in my development are greatly appreciated.

The clinical psychology program has my gratitude as well. The program's sincere focus on diversity, and its social justice mission, have been vital for my development and work. I thank the program's leadership: Joan Liem, for her support and for her wise suggestion during her Master's Research seminar that I narrow the focus of my initial work; Alice Carter, for her enthusiastic support and direction; and Linda Curreri, whose daily work and dedication to the program merit a doctorate several times over. I am grateful to everyone who has taught me, both formally and informally, in the program—

faculty, peers, and staff. Karen Suyemoto's teaching in Culture and Mental Health and in Qualitative Methods, and her constructive critiques, have educated me more than I could have imagined.

My family and friends deserve credit for their love and support, and for their good-faith examples that have inspired me. My mother's insistence on making her girl scout troupe an "open" and desegregated one for which she recruited, in the South in the 1970's and in the face of harassment, was before my time but speaks to her lifelong tenacity of spirit. My father, who was at the mercy of limiting educational quotas and job discrimination in his youth because of his religious background, spent years recruiting for government jobs at Historically Black Colleges and Universities, and his unpretentious and optimistic outlook is admirable. My husband, Jeff Blander, who was recently the only non-Tanzanian invited to Tanzanian government public health strategy sessions, embodies Martin Buber's I-thou perspective.

Asante sana to all.

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CHAPTER I

INTRODUCTION

In 2003, The Institute of Medicine published a report on healthcare disparities, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, calling national attention to healthcare disparities in the United States. The Institute of Medicine defines racial and ethnic disparities in healthcare as the lower quality of healthcare and poorer health outcomes received by marginalized racial and ethnic groups, despite controlling for income and insurance status (Smedley et al., 2003, p. 1). The Institute of Medicine's report was a landmark research synthesis because it was the first time a powerful medical institution acknowledged that racism plays a role in health disparities. Since the publication of the report, multiple initiatives have been designed to address the report's recommendations. Major among them are initiatives to address physician knowledge of best practices for the provision of culturally-sensitive care.

The existence of healthcare disparities in the United States has long been known. However, such disparities had been mostly attributed to barriers in access to care, such as health insurance status, or other factors outside of the relationships and institutional practices constituting care. More perniciously, providers and researchers have relied on

social racial stereotypes to assume that “lifestyles,” poor decision-making, and lack of compliance with medical advice are major factors in producing disparities, without systematic research to support these assumptions. Increasingly, disparities have been recognized as more pervasive in nature, and more complex in scope, acknowledging the role of multiple contexts in creating conditions for disparate health outcomes (WHO, 2008).

Healthcare may be only one of multiple contexts through which social inequality translates into higher burdens of illness and premature death. However, in the wake of the civil rights movement and the Reverend Martin Luther King’s often-repeated quote “Of all the forms of inequality, injustice in *healthcare* is the most shocking and inhumane,” researchers, policy makers, educators and providers have made a substantive commitment to recognizing and addressing the ways healthcare itself reflects and contributes to perpetuating social inequality. The Institute of Medicine’s report highlights that healthcare disparities “are rooted in historic and contemporary inequities” (Smedley et al., 2003, p.1). Much has been written about the long history of healthcare practices that have been glaringly racist at both institutional and individual levels. For example, regarding access, African-Americans were denied admission as patients to hospitals in the American South until the late 1960’s (Poussaint & Alexander, 2000), and were denied admission as future doctors to U.S. medical schools as a matter of policy until the 1970’s. Recently, Washington (2007) reviewed the tragic, deeply disturbing history of medical experimentation on African Americans. The ideal that equal access to health care alone, while vitally needed, can ameliorate these historical atrocities, not to

mention present-day provider and institutional attitudes, is something that requires thoughtful examination and critique. James Baldwin's reminder that "people are trapped in history and history is trapped in them" (1955, p. 163) is still salient.

Indeed, the third sentence of the abstract to the entire Institute of Medicine report notes that "the study committee focused part of its analysis on the clinical encounter itself, and found evidence that stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment" (Smedley et al., 2003, p. 1). A substantial body of research has provided empirical documentation for the existence of disparities in care (Good et al., 2003), yet, until recently, there has been little research on why such disparities persist. Numerous studies have demonstrated that whites are more likely than people of color to receive helpful and life-saving medical procedures, diagnostic tests, effective medication, and accurate diagnosis (Barr, 2008). Further, people of color are more likely than whites to receive amputations and other "undesirable interventions" (Becker & Newsom, 2003). There is some research suggesting that such documented disparities persist even when controlling for race and ethnicity of the clinician (Chen, Rathore, Radford, Wang, & Krumholz, 2001). An exponentially-growing body of literature on the contributions of provider behavior to disparities in care (see van Ryn & Fu, 2003; van Ryn & Burke, 2001; Green et al., 2007; Cooper, 2008; Barr, 2008; Sabin et al., 2009) supports a need for better elucidation of how social processes in the clinical encounter contribute to disparate care.

Researchers in the field of health disparities argue that historical reluctance to recognize racism as a factor in health outcomes has interfered with systematic study of its

processes and impacts (Krieger, 2003; American Public Health Association, 2001; Lopez, 1989). Reluctance to recognize racism involves both reluctance to acknowledge the existence of racism, and also reluctance to recognize how racism operates and the multifaceted natures of racisms (cf Appiah, 1990). Jones (2000), theorizing about race-associated differences in health outcomes, differentiates between institutionalized racism, defined as differential access based on systemic factors, and personally-mediated racism, “defined as prejudice and discrimination” (p. 1212), suggesting that both types of racism contribute to health disparities. She defines prejudice as “differential assumptions about the abilities, motives, and intentions of others according to their race,” and discrimination as “differential actions toward others according to their race” (pp. 1212-13). She notes that the impacts and consequences of personally-mediated racism operate irrespective of intent, and that it can result in both action and inaction. Snowden (2003), writing about health disparities, echoes Jones on levels of racism, but uses the term “bias,” a term that encompasses both judgment (prejudice) and action (discrimination) based on social category (p. 239). The term bias overlaps with the term racism, and both words have been used to describe similar presumed attitudes and actions, whether at the level of an institution or individual.

Since the civil rights movement in the United States, explicit and readily blatant forms of racism, both institutional and personally-mediated, have become socially and personally abhorrent to people who seek to honor and enact egalitarian ideals. Yet, disparities at the level of the clinical encounter persist. One way to understand how racism continues to operate despite explicit endorsement of egalitarian ideals is the theory

of aversive racism that Dovidio and colleagues developed to explain multiple research findings in social psychology that suggest the presence and operation of implicit bias. Dovidio and colleagues (1986; 2008), following the work of Kovel (1970), made a distinction between “dominative” and “aversive” racism. Dovidio distinguishes between overt expressions of racism that are rooted in explicit and unapologetic racist attitudes, versus more subtle and hypothetically implicit expressions of racism that enact themselves despite the well-meaning, explicit intentions of an institution or individual. This more implicit form of racism is labeled aversive racism, because of its aversive effects and also because such racism is considered aversive to the people who nevertheless inadvertently participate in its expression and impacts (Dovidio et al., 2008). Aversive racism is theorized to involve feelings of discomfort, anxiety, disgust, and fear that can translate to non-verbal behavior, yet remains unacknowledged as racism at an explicit level by the person experiencing these feelings and acting on these aversions (Dovidio et al., 2008). Dovidio and colleagues (2008) propose that aversive racism not only affects the outcomes of interactions, but fundamentally shapes the content of interactions themselves.

Theoretical work on topics of implicit bias has been substantiated through the use of several relatively new measures, major among them the Implicit Association Test (IAT) (Greenwald, McGhee, & Schwartz, 1998). Research using the IAT has generated a great deal of excitement as a methodological innovation that can address the impasse between explicit recognition of bias and its more subtle workings due to implicit attitudes guiding behavior in social settings. The procedure presents participants with computer-

generated pairings of positive and negative words with black and white faces, and measures reaction times for associations of words and faces. The power of this method has been its ability to demonstrate how reaction times are linked to social prejudice, as participants display statistically significant faster reaction times for recognition of computer-generated pairings of positive words with white faces and negative words with black faces, while displaying statistically significant slower reaction times for recognizing white faces with negative words and black faces with positive words. This paradigm for measuring implicit bias has become widely used in social-cognitive psychology research, and has drawn significant attention to the implicit aspects of bias, on a level of basic positive/negative valence. Recent physiological studies have supported the validity of the IAT paradigm by correlating higher IAT scores with greater race-related differential amygdala activation as evidenced by scalp-recorded neural activity (He, Johnson, Dovidio, & McCarthy, 2009) and functional magnetic resonance imaging (Cunningham et al., 2004).

The IAT has only recently been used to explore and substantiate physician implicit bias. Sabin and colleagues (2009) explored a sub-sample of 2,535 physicians in an IAT database of 404,277 test-takers and found that physicians, similar to the larger sample, showed an implicit preference for white faces. However, these findings did not apply to African-American physicians, who, on average, showed no implicit racial bias, and applied less-so to women, who on average, showed weaker implicit and explicit bias than men. Sabin and colleagues (2008) administered the IAT to a sample of pediatricians, and found that while their IAT scores were significantly weaker than others

in society, when the IAT was used in a novel way to assess perceived patient compliance with patient race, a moderate effect was found. Preliminary but compelling research in preparation, involving physicians in real-world settings, suggests that physicians rated on videos as less open to listening to patients of color score lower on the IAT (Cooper, 2008). While it is unclear to what extent such implicit attitudes effect clinical interactions, bias has been seen as “a little studied but viable explanation” for disparate care (Snowden, 2003, p. 239)—and the impacts of physician implicit bias on treatment are becoming increasingly more-studied. Dovidio and colleagues (2008) emphasize that despite suggestive research, “there is minimal *direct evidence*” that physician bias effects professional interactions (p. 483, italics his). They hypothesize that studies have “rarely sought” such direct evidence perhaps secondary to physician reluctance to potentially display socially-aborrent behavior, and emphasize that “understanding the nature of the problem is essential for formulating effective solutions” (p. 483).

A focus on how physicians carry their personal and social subjectivity and bias into the clinical encounter has become a focus of attention in the movement to address health disparities. While bias has been hypothesized to play significant roles in unequal treatment, it is unclear exactly how, and why, such biases and stereotypes seem to play out in clinical realities. As it has been suggested that the mechanisms and processes that contribute to institutional and individual racism in medicine are both “multidimensional and subtle” (Good et al., 2003, p. 595), complexities of what bias is, and how it may play out, deserve consideration. A better understanding of these multidimensional and subtle

processes and how they are reflected in physician assessment and treatment may play an important role in developing ways to ameliorate their harmful effects.

In working toward this goal, researchers and educators have focused on medical education and the need to incorporate training that will increase physician sensitivity to the workings of their own biases within the clinical encounter. Most medical schools and practice settings require some form of cultural sensitivity training. There are two major approaches to this training: one approach focuses on an expanded knowledge of cultures different from one's own, or "cultural competence" training; the second approach focuses more on physician subjectivity and capacity for reflection on personal bias due to social location, and bias due to medical training itself. A focus on reflexivity recognizes that physician bias is "multidimensional and subtle," evoked not just by race and ethnicity but by complexities in the encounter between a particular physician's personal experiences, social location, and a particular patient, their personal characteristics, and the demands of their care. Due to the urgency of concerns about physician contribution to ethnic and racial disparities in health, well-intentioned educational programs have proceeded in the absence of theoretically guided research on their effectiveness. In order to better develop meaningful training addressing mechanisms at work in physician encounters with diverse patients, and better measure effective outcomes of training addressing these mechanisms, a better understanding is needed of how physicians think about diversity in the patients they treat, and how they narrate their capacity to reflect on personal and social bias evoked by encounters with particular patients.

Recent research by Cooper (2008) examines physician bias as a contributor to disparate care, and suggests that patient-centeredness, as coded in video recordings of medical encounters, may be associated with more culturally sensitive care. Patient-centered care, defined by the Institute of Medicine as “providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions,” (2001, p. 3) would seem, indeed, to dovetail nicely with conceptualizations of cultural sensitivity. However, it is questionable whether and to what extent efforts toward patient-centeredness can counter social and internalized bias. Patient-centeredness may be necessary, but not sufficient, for culturally sensitive care in the presence of institutional and personally-mediated racism.

Baarts, Tulinius, & Reventlow (2000) write about reflexivity as a strategy for a patient-centered approach. They define reflexivity as “a self-conscious account of the production of knowledge as it is being produced,” noting the importance of an awareness of one’s positioning in the particular context” (pp. 430-31). The authors highlight the importance of how the interaction influences “information that is exchanged in the interaction,” and emphasizes the importance of close listening as a way to better ferret out important clinical information.

While the construct of reflexivity is useful in encouraging patient-centeredness, it can also contribute to better understanding of processes by which relational learning can itself help transform bias. What might a focus on reflexivity have to contribute to better understanding how bias shapes knowledge production in medical encounters, how bias effects disparate care, and how bias might be transformed through reflexive thought and

action? Several literatures contribute to expanding the concept of reflexivity in ways useful to health disparities research.

In the psychology research methods literature, Finlay (2002) defines reflexivity as “thoughtful, conscious self-awareness,” and conceptualizes a continuum between somewhat distanced reflection on an object, and a “more immediate, continuing, dynamic subjective self-awareness” (pp. 532-33). Finlay (2006) expands her concept of reflexivity to a “reflexive embodied empathy” that takes account of how knowledge becomes embodied in our physical reactions, and how a fine attunement to and reflexive awareness of such embodied reactions is important to creating possibilities for empathy within dialogue. Finlay emphasizes that empathy within dialogue then serves to enable better self-understanding. In her writings, Finlay focuses on the intersubjective relationship between researcher and participant. However, her theoretical contributions have implications for examining reflexivity in multiple arenas. A focus on reflexive-embodied empathy seems particularly relevant to medical settings, where fine attunement to the body of another is vital.

The medical anthropology literature has a foundational stake in contributing to understandings of reflexivity in medical encounters. Much has been written about how experience and meaning is co-constructed by doctors and patients in medical encounters, and how overarching narrative plots inform both illness and healing (cf Good, 1995; Good & Good, 2000; Kleinman, 1988; Mattingly & Garro, 2000; Mattingly, 1998). Medical narratives, in fact, may become transformed via a highly reflexive approach on the part of doctors (Katz & Shotter, 1996) to narratives of increasing agency on the part

of patients, and increasing sensitivity to the social-embeddedness of dialogue on the part of doctors. Katz & Shotter (1996) write about the “social poetics” of medical encounters and how such encounters can become “dialogically iterative”: as doctors learn to put reflexive approaches to medical encounters into practice, they “begin to articulate what has previously been tacit” and are then empowered to become “better able to articulate, i.e., provide a commentary on, what they are doing in it and why” (p. 930).

The relatively newly-named field of narrative medicine works within medical humanities to help physicians reflect on experience in ways not encrypted by high-technology medicine, and defines itself as medicine practiced with narrative competence (Charon, 2005). Narrative competence entails effectively bearing witness (cf Farmer, 2005. p. 26) to people’s stories and experience, which has become a challenge to physicians in a context of systematized highly sophisticated technological interventions which can be fragmenting and even dehumanizing or traumatizing; such technological interventions might be considered necessary to acute care, but can interfere with effective clinical partnerships. Narrative competence facilitates effective adherence and disclosure on the part of the patient, and facilitates empathy, within the context of a medical encounter, on the part of the doctor. A close-reading of a medical dialogue recognizes multiple levels of subjectivity, positionality, and performance, and training in sensitivity to these levels of dialogue aims to better equip doctors to develop capacities for self-understanding, facilitating empathy for diverse patients. Following Katz & Shotter’s “social poetics,” narrative medicine attempts to explore physician reflexivity as a way to

empathically re-educate doctors, and to create a positive “medical transference” (Charon, 2005, p. 265) for patients.

In addition to a focus on reflexivity, the social psychology literature has just recently emphasized the potential contributions of bias reduction and counter-stereotype models for targeting physician bias. Burgess and colleagues (2007) emphasize the overarching social psychological process of individuation, and its associated affective and cognitive features, as a promising starting-point for future research. Others have suggested that models to reduce the uncontrolled activation of stereotypes, involving both exposure and expanded conceptualizations of in-group membership (Dovidio et al., 2008; Kawakami, Dovidio, & van Kamp, 2007; Kawakami, Dovidio, & van Kamp, 2005), may hold promise in countering bias.

It seems plausible that physicians can be better-trained to listen to and bear witness to their patients’ stories in ways that monitor personal, socially-located subjectivity evoked in the dialogue with that particular patient. Bias can be considered one important and destructive factor operating within a medical encounter, and might be seen as creating barriers to processes of learning through reflexivity, particularly if such bias remains outside of a physician’s awareness. The IAT, as it was developed, can only access positive or negative valence, although new and exciting methods are being developed to access more complex aspects of implicit cognition and affect. Perhaps physicians, via narratives of disparities, may have something to tell us about the complexities of bias, how bias effects medical decision-making and action, and how physicians, when encouraged to reflect on these processes, demonstrate both narrative

competence and its limits. Because narratives can be complex and dialogic, a focus on physician narratives of disparities and the processes by which physicians explore responses to patient differences can help to: better formulate and operationalize conceptualizations of bias and processes of reflexivity; better understand how bias can carry socially-constructed barriers to learning through differences into the clinical encounter; and better understand how and when reflexivity offers pathways for awareness to counter bias.

Main Areas of Inquiry

This research focuses on physician narratives of disparities, exploring the following questions:

- How do physicians appear to understand bias as a contributor to health disparities, especially focused on the clinical encounter and its contexts?
- How can processes of bias be better elucidated by a focus on qualitative data?
- What processes and themes are associated with physician capacity for reflexivity or barriers to reflexivity?
- How can processes of reflexivity be better elucidated by reflections on sources of or challenges presented by personal bias?

Specific Aims

This study aims to help advance thinking about how bias operates in clinical encounters, and about the development of physician capacity for reflexivity within a context of medical care that effects documented health disparities. Bias is a construct that encompasses both prejudiced thought and action based on social category. Reflexivity is a construct that is often used to describe processes of how conscious awareness and reflection impact action. Operationalizing conceptualizations of bias and reflexivity, based on actual qualitative data, may offer pathways to counter disparities in care at the level of the clinical encounter. Cooper (2008) notes the challenge inherent in asking clinicians directly about their own biases, arguing for the use of methods illuminating more implicit processes. She notes that her quantitative work using the IAT garnered results when direct questions did not. Dovidio and colleagues (2008) note the lack of research seeking direct evidence for physician bias. Qualitative work has a potential to reveal complexities of bias that may complement and further elucidate quantitative data from measures such as the IAT. In focusing on physician narratives of disparities, this study suggests that physicians' capacity to speak about their own experiences in caring for and learning from diverse patients is itself facilitated by a context of exploratory mutual learning, whether and to what extent such capacity is context-dependent.

This study involves secondary analysis of a dataset of in-depth interviews gathered originally for a study on how the culture of medicine impacts disparities at multiple levels of care (Good, 2002). Since physicians spoke in-depth about their

experience during the course of these original interviews, this researcher saw a good opportunity to take a closer look specifically at bias and reflexivity in these physician narratives of disparities.

Aim 1: Explore formulations of bias based on qualitative data.

Aim 2: Explore formulations of reflexivity based on qualitative data.

CHAPTER II

METHODS

This study is a secondary analysis of in-depth interviews originally conducted for a grant-funded study by Professor Mary-Jo DelVecchio Good, Ph.D. (Good, 2002).

Participants and Sample Size

Participants were all employees of teaching hospitals or teaching-hospital-affiliated community health centers in a Northeastern city. The original sample consisted of 56 MDs, 6 nurses, 1 security guard, 1 psychologist, 5 administrative assistants, and 6 policy-makers. Of the 75 participants, 31 identified as people of color, and 44 identified as white. The study recruited participants through nomination by colleagues who identified them as especially willing to discuss disparities in health care and how their own ethnic background and training in cultural diversity influenced their patient care.

Selection of Participants

Participants were selected by contacting clinicians who peers identified as exemplar and as interested in talking about healthcare disparities. Participants were also

selected with a goal of including a multi-ethnic and gender mix reflective of the medical community in this academic locale.

IRB

IRB-approval from Harvard University was obtained by Mary-Jo DelVecchio Good, Ph.D., and has been renewed yearly. This author has confirmed she is on that IRB. Professor Good's IRB-approval includes terms listed here. Consent forms were obtained from all participants. Clinicians' identities remained confidential unless they specified otherwise. Institutional affiliation will be masked in publications unless participants wish otherwise. Public figures were interviewed "on" and "off" the record. When public figures were "on record," they agreed that their names could be used; when off record, they are not identified and their institutions are not named.

IRB-approval for secondary data analysis has been granted by the University of Massachusetts Boston.

Procedure

Professor Good's original proposal documents the research procedure as follows (Good, 2002). Interviews were conducted by two medical anthropologists: a physician/anthropologist just completing a four-year medical residency; and a soon-to-be Ph.D. with a specialty in medical education and training. Policy interviews were conducted by the primary investigator, Mary-Jo DelVecchio Good. Interviews were semi-structured, conversational, and generative. Interviewees were asked about their training background, basic demographics, and a brief career history. Interviewees were

asked to speak about their own experiences, to illustrate with case examples, and to freely express concerns about their own practice and that of colleagues. The interviewers tended to encourage expression and disclosure of personal subjectivity. A formal list of questions was developed by the original research team, and included the following main areas of inquiry:

1. What are the patient and staff population demographics of your current work site?
2. Can you describe clinical experiences, possibly even something going on recently or currently, where culture and ethnicity really made a difference?
3. Whether and to what extent did your training cover anything related to culture, and how helpful has that been?
4. How would you describe your ethnicity and race, social class, and background?
5. Have you thought about how your ethnic and social background, even gender, has had an impact on your interactions with different types of patients?
6. What kinds of patients are most challenging, for you personally?
7. What kinds of patients are most enjoyable to treat?

All interviews were recorded and transcribed.

Interview Selection and Data Analysis

For the purposes of this project, criteria were established for selection of participant narratives that would support the study's focus on narratives of bias and reflexivity. After reviewing all 75 narratives, two selection criteria were used: including physicians only, and within this dataset, including interviews conducted by only one of the two interviewers. The interviewer selected had an interactive style, probed more consistently for participant personal background, and she included comments about her own subjectivity. In marked contrast, the second interviewer's interviewing style was more structured and non-disclosing. Because acknowledgement of personal bias had become so aversive to most physicians, it was thought that interviewer reflexive self-

disclosure would encourage reflexivity in physician narratives. Limiting analysis to the one interview style held constant the influence of the interviewer style on the narratives. These selection criteria resulted in thirty-three interviews of physicians that were conducted by one of the two interviewers included in this study (please see Table 2).

This qualitative study used thematic analysis as the tool for exploring the narratives for discussions of bias and reflexivity. Thematic analysis involves the creation and application of codes to qualitative data, and was used to identify main themes and sub-themes in the data. Thirty-three main codes were originally developed by this author, via open coding in Atlas-ti. Atlas-ti is a widely-used qualitative data management program. Within Atlas-ti, open coding supports the researcher identifying and tracking themes and sub-themes. Initial open coding served to identify and describe narrative themes as an initial step in identifying areas of potential follow-up (please see Table 1).

In a second step, informed by the theoretical and empirical review of the literature, the conceptually meaningful areas of inquiry focusing on bias and reflexivity were identified and operationalized in the narratives. The entire dataset was re-coded in Atlas-ti for themes of bias and reflexivity. This second re-coding in Atlas-ti was itself fully reviewed a second time as sub-themes were identified and refined, using the refinement of themes to pick up pieces of narrative that may have been missed the first time, and to include more narrative context for many coded selections. Due to the nature of the narratives and the context required for each code, some selections contained themes of, and were coded for, both physician identification of bias and physician discussion of reflexivity operationalized as discussion of social location and its impact on

knowledge. This coding generated output of 192 single-spaced pages in font size 10 for the code of bias, and 188 single-spaced pages in font size 10 for the code of reflexivity. This output was then read and re-read several times, and further coded, using analytic coding, a form of coding “used to make, celebrate, illustrate, and develop categories theoretically” (Richards & Morse, 2007, p. 141) to reflect more specific themes that emerged associated with bias and reflexivity. All of the interview transcripts were categorized using the themes of bias and reflexivity, to account for as many distinct aspects of bias and reflexivity as could be found in the narratives.

Inevitably, qualitative research exploring physician bias and reflexivity requires meticulous monitoring of potential bias on the part of the researcher through methods for review of evolving responses to the data analysis on the part of the researcher. This researcher kept a journal to record and process reflections and associations. Meetings with research mentors and peers, ongoing clinical work in a marginalized community, and attendance at relevant talks and seminars allowed further opportunities for reflexivity on the part of the researcher. After the development of themes for bias and reflexivity, the Health Promotion Research Group at the University of Massachusetts Boston reviewed these themes and gave feedback on the utility of making them more “inside” the physician narrative experience of struggle with bias and striving for understanding, rather than “outside” the physician narrative as evidence of collusion with socially supported racism.

Table 1***Original Themes and Codes: Open Coding***

| | |
|----------------------------|------------------------------------|
| 1. Appreciate diversity | 18. Patient education level |
| 2. Building | 19. Patient personality |
| 3. Classism | 20. Race of clinicians |
| 4. Community | 21. Race of patients—stats |
| 5. Compliance | 22. Race—talking about |
| 6. Culture of medicine | 23. Racism talk—bias |
| 7. Difficult patients | 24. Racism talk—no bias |
| 8. Experienced racism | 25. Secretaries help connect |
| 9. Explanatory models | 26. Systems issues |
| 10. Good patients | 27. Talk about cultural competence |
| 11. “Lifestyle” | 28. Talk about disparities |
| 12. Personal background | 29. Translation |
| 13. Physician bad behavior | 30. Trust—general |
| 14. Physician personality | 31. Trust—individual |
| 15. Privileged patients | 32. Trust—institutional |
| 16. Process talk | 33. What patient values |
| 17. Process talk—self | |

Table 2***Demographics***

| Interview # | Training | Self-identified as | Gender |
|-------------|---------------|-----------------------|--------|
| 001 | MD | White | Female |
| 002 | MD | White | Female |
| 003 | MD | White | Female |
| 004 | MD | White | Female |
| 005 | MD | White | Male |
| 006 | MD | White | Male |
| 007 | MD | Black | Male |
| 008 | MD | White | Female |
| 009 | MD | Asian | Male |
| 010 | MD | Black | Female |
| 011 | MD | White | Male |
| 012 | MD | South Asian | Female |
| 013 | MD | White | Male |
| 014 | Nurse | White | Female |
| 015 | Nurse | White | Female |
| 016 | MD | Latino | Male |
| 017 | MD | Black | Male |
| 018 | MD | White | Female |
| 019 | MD | Black | Female |
| 020 | MD | White | Female |
| 021 | MD | Black | Male |
| 022 | MD | Asian | Female |
| 023 | Nurse | Latina | Female |
| 024 | med secretary | Latina | Female |
| 025 | MD | White | Female |
| 026 | MD | White | Male |
| 027 | Nurse | White | Female |
| 028 | MD | White | Female |
| 029 | MD | White | Male |
| 030 | MD | Black | Female |
| 031 | MD | Latino | Male |
| 032 | MD | South Asian | Female |
| 033 | MD | White | Male |
| 034 | MD | Black | Male |
| 035 | MD | White | Male |
| 036 | MD | Black | Male |
| 041 | MD | Black | Female |
| 051 | MD | Asian | Male |

*Interviews #14, 15, 23, 24, and 27 were not included in data analysis for this project.

CHAPTER III

RESULTS

Table 3

Overview of Themes in Physician Narratives

| | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><i>Bias:</i> Judgment (prejudice) and action (discrimination) based on social category. (Also see: Jones, 2000; Snowden, 2003).</p> | <p><u>Paternalism:</u> Assumptions and judgments about lack of patient agency to engage in decision-making and determine or comply with a course of treatment.</p> <p><u>Preferential connection:</u> Preferential attitudes on the part of doctors toward members of their own identified group based on a felt connection or sense of likeness to themselves, their family, or their community. Such attitudes come at a cost to those who are not so preferenced, in situations where physician time and attention are, in effect, rationed commodities.</p> <p><u>Social prototypes:</u> Creation of medical prototypes based on stereotypes about social categories.</p> |
| <p><i>Reflexivity:</i> Conscious awareness of and engagement with positionality and subjectivity regarding bias. (Also see: Baarts et al. 2000; Finlay, 2002, 2006).</p> | <p><u>Encountering/Countering bias:</u> Looking within oneself to monitor personal cognitions and how they are distorted by bias.</p> <ul style="list-style-type: none"> a. Awareness b. Questioning assumptions <p><u>Connecting to/with difference:</u> Meeting a patient where they are, and surmounting barriers to patient-centered knowledge.</p> <ul style="list-style-type: none"> a. “Understanding”—entering a patient’s unique relational world. b. Equity in knowledge, value, power, and personhood. c. Seeking out, learning from, and serving marginalized patients as a positive source of knowledge and professional identity. |

Bias

I: Yeah. The last question I like to ask people is what I forgot to ask. What questions should I have asked? Or what should we have discussed that we haven't discussed?

[white female]

008: ...One thing I think is interesting is, why there isn't - I think why are [our] acknowledgement within the daily functioning of medicine of how much our reactions to patients and their reactions to us do affect what happens from the purely medical perspective. 'Cause, I think about it, it just seems kind of obvious to me, um, I don't know. It seems like, I think you and I have talked about this, how any conversation that comes up about healthcare disparities for different racial groups, you spend more than half the time getting people to buy into the fact that they exist. But it's interesting - I think sometimes it's harder, maybe part of it is, you know, the studies where they look at something that's so - that's easily measurable, like (cardiac catheterization). Sometimes that's, I don't know whether - it seems harder to see there, but if you have a conversation like this, where you talk about who comes into your office and what happens with those different people depending on whatever they bring to the table versus what you bring to the table. It's just clear that, you know-

I: What some of the factors are?

008: Yeah.

The physician in the above narrative suggests how even studies that show “easily measurable” disparities such as rates of cardiac catheterization may not lend themselves to better physician understanding of how they contribute to such disparate care. Even when an outcome is so easily measurable, it may still seem “harder to see” and to translate into the measure of one’s day-in and day-out experiential reality. Yet, as the physician above suggests, conversations about clinical encounters may lend visibility and greater clarity to some of the “factors” involved in physician contribution to disparities. In exploring how well-meaning physicians provide unequal care, as the narrative above acknowledges,

human interaction is central to the “daily functioning of medicine.” People—doctors and patients—bring different life experiences, sources of knowledge, authority and responsibility, fears and hopes, to this human encounter. The physicians who participated in this study were selected for their willingness to speak about healthcare disparities. They also demonstrated awareness, in various ways, of how their own attitudes and behaviors impacted care, and their ability to speak about these biases was a testament to their efforts toward such awarenesses. Aspects of physician bias tended to be best elucidated in the narratives when more extended sections of transcript were considered. These narratives could be somewhat halting and prone to interruption when focused on topics that were more troublesome. One important context for these discussions of racial health care disparities is provided by the significant societal changes catalyzed by the civil rights movement, which made it socially unacceptable to betray overtly racist attitudes. To consider the workings of racial bias in their health care encounters, physicians have to look more deeply at the subtle ways personal and professional dimensions affect their treatment relationships and decision-making, and admit to attitudes and actions considered socially abhorrent and medically irresponsible. These narratives suggest how physicians appreciated the importance of this exploration, and struggled to understand the complexities of their clinical encounters.

Efforts to elucidate themes associated with physician bias are useful in not only better understanding how bias operates, but in showing that physician bias does clearly exist. As the [black female] physician narrates below, “you can’t test the hypothesis if you can’t even write it to test.”

041: One of the things I find very frustrating about this racial disparity issue is what you mentioned from the very get-go at the interview, that people really toss aside the whole issue of attitude, and the care we give that's different, even though we can't really pin it down. I think that everyone doesn't really embrace that that's true. People are even afraid to start with the hypothesis that it's potentially true. I think that has to do more with the larger social context of the whole issue of race in the society that's so charged. Because really people are even unwilling to start with the hypothesis, and I think that's where the problem is. Part of the problem is. Because you can't test the hypothesis if you can't even write it to test.

In the following sections, physicians do “write it to test,” looking beyond overt attitudes of racial bias to seek the more subtle ways their personal and professional relationships with patients are influenced by social bias.

Paternalism

The theme of paternalism was characterized by assumptions and judgments about the lack of competence or agency of a patient to engage in decision-making and determine or comply with a course of treatment. Physician narratives suggested that judgments about patient capacity could result in less-aggressive treatment and undertreatment. This theme in the narratives was related to physician evaluation of differential treatment options, particularly when those options involved a multiplicity of norms--the existence of several parallel and unequal, yet acceptable, treatment pathways--consistent with conceptualizations of biomedicalization (Clarke, Mamo, Fishman, Shim, & Fosket, 2003). A paternalistic approach to treatment planning was contrasted to a more interactive approach involving shared knowledge and shared understanding of illness and treatment. The narratives suggested that judgments about patient capacity to

participate in treatment decision-making were linked to educational level, race, ethnicity, and age of patients.

In the following narrative, a [white male] doctor describes how he tends to be more paternalistic with patients he sees as less well-educated, and contrasts paternalistic decision-making with a more interactive kind of decision-making that includes offering options to patients.

033: Yeah, I find that in my own practice, I feel much more, I feel that when somebody - I feel that I make more decisions for people who are undereducated, or who are less sophisticated in terms of their understanding of things than I do for people who are...not. If I'm talking to you about your options for therapy, I will often - I am much more likely to give you options, explain to you what the risks and benefits are, and why you can make your own decision, with my guidance of course, then I feel like somebody is less able to understand and process some of those things, you know.

I think you always try to explain things to people as much as you're able to, but I think that by default you end up being more paternalistic with patients who are less educated, and that I find that to be bothersome and I feel uncomfortable about that often, that I'm not entirely sure how to make it better. You know, when patients say, well, what do you think doc, or you know, I trust you with, you make the decision, that - I find that those things occur more often in my patients who are less educated, and by, you know - and it happens more often in the patients who are referred to me from [name of clinic] or from, who are black, who are Hispanic, who are older as opposed to younger. That those are patients who are more likely to make a decision for them, than to press (unclear) information. And make the decision in an interactive way.

Paternalistic approaches can significantly impact which treatments are offered or seen as viable for a particular patient. Risks associated with noncompliance intersect with assumptions about who is a “risky” patient, that is, a patient who runs the greater risk of complications due to noncompliance, and who is not. Less-aggressive treatment is justified by concerns about doing no harm, as the bias underlying paternalism assumes these risky patients cannot participate in a dialogue or be educated to use a more effective

treatment safely. In the following example, a [white male] doctor discusses which patients are more likely to get insulin pumps, devices associated with better outcomes because they deliver insulin as needed.

I: Do people who get pumps tend to be young or older, male or female?

029: They tend to be younger, although they don't have to be. There's no exclusion for anybody, as long as they have the dexterity to work the pump and don't have such bad neuropathy or vision that they can't see stuff. And they have to be compliant.

I: Do you have lots of patients on pumps yourself?

029: Yes, plenty. A good few. Maybe 20, 25.

I: They're black, Latino, Asian, Caucasian -

029: Very over-represented Caucasians.

I: Do you think that reflects their interest in high tech or structural barriers?

029: It probably reflects their interest in technology, it reflects their interest in progressive technologies, I suppose, but also reflects their compliance and interest in managing the diabetes.

I: The pumps require a higher level of involvement?

029: For a diabetologist to feel comfortable giving a patient a pump, because their risk of severe consequences from not taking care of the pump is more obvious than those who are on multi-dosing regimen, so if your pump stops working and you're not compliant checking your blood sugars you can go into decay very quickly, because don't have any insulin at all, in Type I. But you have to have a certain degree of trust with the patient in order to say, I know you well enough and I know your style, and I think we can start talking about insulin pump therapy now. That tends to be patients who are Caucasian and who are involved in their diabetes team and have engaged everybody and have shown an ability to make an effort and be compliant.

I: Do patients raise the issue of the pump themselves, or is that something that almost always the endocrinologist will suggest?

029: It's always been my experience that I've raised that question. Although once patients start on pumps they never seem to come off. They love them.

In the above narrative, the doctor notes that the only exclusions for pumps are poor vision or dexterity, and potential noncompliance. Significantly, a patient's potential for compliance is, in the end, a judgment call on the part of the doctor. In the above example, how well the doctor feels he knows the patient, and how he judges the patient to have effectively "engaged" everyone on the team, is linked to whether a patient is judged potentially compliant, and becomes a main precondition for a pump being offered as a treatment option. The physician also used the word "trust" to describe this sense that the patient can comply with a complex treatment protocol. So, access to the most effective course of treatment is linked to a subjective risk management decision based primarily on qualities of the treatment relationships. Consistent with the bias found in paternalism, these treatment relationships are evaluated based on social structural variables that imply judgments about patient capacity to participate in a more complex protocol.

In the following narrative, a [white male] doctor's judgment of a patient's capacity to engage in dialogue can significantly impact whether a potentially life-saving intervention that also carries some risk, such as bypass surgery, is offered.

033: So I think that, that people who are less, who have sort of less of the, who are less savvy, are more likely to be treated with an inaction, than action, because of that, maybe that's - I don't think there are a lot of people who err on the side of (unclear) and this old woman to surgery, I think there are more people who say that, so let's not, let's hang tight here, because they don't want to send the person who dies, and have to be their decision, you know, but if there's a, you know - I have no problem with a patient saying, you know, I understand that I might die, and you know, my quality of life currently is not what I would like, and I'm willing to have the bypass surgery to see if I can make things better. You know, it's not that you want, that you're happy when that patient dies, but if the patient dies, and they and their family and everybody was in on that decision making

process, then they've had a sort of self determination, and they, and they, and I don't lose a lot sleep with that.

Here, physician judgment about recommending a potentially-risky yet life-saving intervention appears to hinge on a sense of whether patients are more or “less savvy.” In this narrative, whether a patient is seen as “savvy” seems linked to physician judgment about whether a patient can, in this doctor’s words, “understand” and be “willing” to accept a potentially adverse outcome of an aggressive treatment that should, if things go well, improve quality of life and in fact significantly prolong life and serve as a prophylactic against future cardiac morbidity. This is an especially important judgment in cases where the potentially adverse immediate outcome could be death. Although reluctance to put into play potential risks associated with treatment seems evident, here, risk is acceptable if the doctor feels the patient can take the responsibility for the treatment decision and understand the potential consequences. Ultimately, the doctor appears to make a judgment about whether and to what extent a patient is capable of “self-determination”—a decision based on a subjective judgment of how well a patient and her family are “in on that decision-making process.” However, this decision-making process seems to involve a medical “catch-22,” in which the assessment itself precludes patient participation that might prove the patient capable of participating. If the doctor judges a patient capable of being savvy and “in on” the decision-making process, the patient will be seen as having agency in the form of self-determination, and the patient will be offered options. Yet if the patient is seen as “less savvy,” she will be seen as less capable of being “in on” the decision-making process, and not offered the option for

intervention. What makes this example of bias paternalism is the physician judging that the patient is not capable of engaging in a full discussion of risk and benefit, and on that basis failing to offer a higher standard of care.

Even when a procedure carries little risk, assumptions about patient capacity to understand and comply with treatment, which form the basis for paternalistic bias, can come into play. In the following narrative, a [white female] doctor explains how she determines whether and to what extent she will recommend a colonoscopy, an unpleasant but low-risk diagnostic procedure.

002: Definitely trying to talk people into things like screening colonoscopies and Pap smears and mammograms. There's a cultural precedent for mammograms, people sort of get that, that's not usually hard. But colonoscopies, that's a hard sell. I think that probably I have been conscious that I make assumptions about whether or not people are going to go for a colonoscopy, and then I probably sell it less - I'm very conscious of this, so I try not to change my pitch. I try to believe that all of my patients are going to go for colonoscopies. I know that the way that I describe the colonoscopy is affected by my assumptions about whether or not they're actually going to go. I try to believe that everybody's going to go. It makes a big difference if I try to believe that everybody's going to go. But it's not always - I'm not always great about that.

I: That's really a very perceptive insight. And in your experience this would come up a lot with patients from the Dominican Republic or from Puerto Rico? Does it include the African American patients also?

002: Yeah, probably - I am inclined to believe that when people have chaotic lives they prioritize preventive health care at a low level because they have other things going on. So I have to be very careful not to shortchange people's ability to care about their own preventive health care.

I: People might surprise you and say yes, I want that screening colonoscopy.

002: People have definitely surprised me.

In the narrative above, the doctor realizes that the way she describes a low-risk but unpleasant procedure is “affected by my assumptions” about patient capacity to prioritize preventive care. Further, she assumes that people who have “chaotic lives” are less able to prioritize preventive care. It is unclear exactly what connotes a sense of “chaotic lives” and how, here, it seems that people of color appear to be seen as having more chaotic lives than anyone else. Perhaps a testament to the strength of the doctor’s assumptions is her feeling of being “surprised” when people she assumes will not opt for care do in fact want care. Also perhaps a testament to the strength and endurance of her assumptions is her sense she must be “very careful” to guard against enacting these assumptions in dialogue with patients. In this example, paternalistic bias appears based on a physician’s pre-emptive decision-making about a patient’s life circumstances and how those circumstances might impinge on “ability” to value preventive care.

Paternalistic bias appears related specifically to feelings of difference and the uncertainty those feelings can engender. In the narrative below, a [white female] doctor describes how feelings of uncertainty impact her ability to offer treatment options.

008: Okay, wait, before I launch into another thing - the other thing I wonder about too, is um, and I've wondered about this bias in myself, is whether there are sometimes - because my bias is to a certain extent toward nihilism - is that if I'm likely to identify someone who's different from me, as someone in whom I even have less faith that (gets) aggressive intervention - should be used. Because I feel less certain that I understand whether that's gonna be helpful for them, and I might expect that there are other factors. And so, I wonder if in my, in my own - what I think of as my own sensitivity to difference, there may be different outcomes.

I: And so you don't offer that intervention to the patient that seems different?

008: I think I probably do. I don't think that, that, that the disparity is gross, I think it's more subtle than that.

I: It sounds-

008: But that's the point I'm getting at. That I might not offer it. Not because I devalue that person, but because I somehow value them differently or are aware of potential differences for them. In my urge not to-

I: Do them a disservice?

008: Yeah. I might do them a disservice. Or might do something different - service. I don't know if it's disservice or, I'm not sure.

Here, the doctor's feelings of uncertainty appear linked specifically to feelings of greater potential risk when making decisions about whether to offer treatment options. Physician statements concerning sensitivity to difference would ideally result in questions that would increase knowledge and understanding. With the bias of paternalism, as in the narrative above, the lack of knowledge associated with perceived differences between doctors and their patients instead translated into uncertainty about risks involved, and was reported as culminating in another reason to forgo recommending a more aggressive intervention. This same doctor elaborates below on how such felt lack of understanding about a patient inhibits a more positive form of physician authority which is not in and of itself paternalism—pushing the treatments that doctors believe are, in their own right, considered best options.

008: Well, yeah, yeah. Like for example, with my patient who - and I don't know if this is a terrific example - but my patient who um, I described earlier - in her seventies with bad OA [osteoarthritis], from Haiti.

I: Mhmm.

008: Like I just wonder if-

I: A joint replacement?

008: Yeah. Should I have pushed more for that? Should I have recognized, this is a woman who is limited by pain everyday. Should I be calling her daughter? Should I be, you know, should I be urging her in a way that I might urge another patient. But am I holding back some (unclear) because of this vague sense that I - of - I guess on what hand could be called humility and I don't really understand what goes on in her life. That I might to be too aggressive. But does that in some ways actually make me more likely to be hands off and not be as appropriately assertive about an intervention that could help her.

I: No, I mean, that's a great example, um-

008: Right, so it's not like, do people like her get fewer joint replacements?

I: Because there are more doctors who are skittish about pushing the patient to get them?

008: Right. Or just, or even just having a general sense, you know, there's enough I don't know about you that my general sort of helpful doctor arrogance will not come to play. My life - trust me, you need this, you're gonna have to take it 'cause your life is gonna be better afterward.

In the narrative above, the doctor realizes she holds back in the absolutely vital process of engaging the patient—here, in the form of “urging her” and calling her daughter. When judgments about patient ability to engage in a decision-making process become key factors in whether a treatment is offered, the extent a doctor holds back engaging the patient in this decision-making process seems key as well. This doctor describes her “helpful doctor arrogance” as an asset when she is dealing with patients whom she feels she does understand fundamentally, and contrasts that to “humility” that she doesn’t understand what goes on in the patient’s life. In narratives demonstrating a bias of paternalism, physicians seem to be making a judgment that this is a social or contextual domain where engaging a patient or gaining additional knowledge is not warranted or possible but withholding information concerning treatment options is warranted.

“Helpful doctor arrogance” may be an aspect of physician decision-making that is necessary to medical care yet can intersect with social differences in ways that result in lower standards of care for some patients.

Contained in each of these examples are explicit assumptions about a patient’s ability to understand or comply with treatment. Also explicit are physician assumptions about what some of their patients can in fact understand, or even want to understand (“it reflects their interest in progressive technologies”), and to what extent patients value less-progressive technologies involving even preventive care. Assumptions about what a patient can understand or value appear to impact a doctor’s subjective judgment about whether and to what extent a patient can engage in a decision-making process, resulting in a medical catch-22; doctors appear to judge patients as better able to engage in medical decision-making based on a subjective sense of how “savvy” the patient is. Feelings of uncertainty engendered by felt difference and feelings of not “knowing” the patient can become rate-limiting factors for engaging a patient in a decision-making process, and can therefore become a significant barrier to treatment being offered. These assumptions and feelings seem to constrain or preclude, on the part of the doctor, potential efforts toward dialogue that might serve to bridge difference, suggesting how destructive bias about patient ability to understand or comply with treatment can be and how this bias operates in the context of physician decision-making. Indeed, difference, along with a felt lack of knowledge about patients, seems to take on a static, unchangeable, unbridgeable quality, a quality seemingly not amenable to mutual learning through dialogue, and becomes a significant barrier to providing equal treatment.

Preferential Connection

The theme of preferential connection was characterized by preferential attitudes on the part of doctors toward members of their own identified group based on a felt connection or sense of likeness to themselves, their family, or their community. Unlike paternalism, which was associated with complex decision-making concerning more aggressive care or care requiring consideration of risk including life-threatening consequences, the theme of preferential connection was apparent in narratives related to all levels of care. A bias for preferential connection appeared to result in quicker care, “more care” in the form of amount of time spent with a patient, and better access to care by way of, in one example, differential distribution of a doctor’s e-mail address. The theme of preferential connection seemed to operate independently of social prejudice, while adding to the costs of bias associated with social prejudice. While people sometimes do more for people they feel more connected to, such an attitude has significant consequences for physician decision-making concerning quality of care. A bias for preferential connection on the part of the doctor is seen as contributing to barriers in bridging difference, since a bias for preferential connection with some becomes a disadvantage for others.

[white female]

002: Sure, I think it's racism. But I also think it's all of those intangibles that affect a caregiving relationship. You feel some people's pain more immediately when you feel more like them in some way. Everybody has a series of emotional experiences with their patients where they just - for whatever reason, somebody reminds you of your grandmother or yourself or something that just connects you to that patient. It's possible

to feel that sense of connection across a barrier of age or race or class or whatever, but whatever it is that separates the doctor from the patient makes that sense of connection less likely. So people respond in an intuitive emotional way that's rooted in the degree of connection they feel for their patients.

When a doctor likes a patient, this can impact factors such as how much time a doctor spends interacting with a patient in a more informal way. In the narrative below, a distinction is drawn between feeling a friend-like quality with a patient and letting this quality of the treatment relationship impact professional judgment.

[South Asian female]

032: But it's the same thing as being friends. You're not friends with everybody that you meet, you're only friends with people who you like (unclear) and why should it be any different with patients. You know.

I: Yeah.

032: It's a different thing that you don't let it affect your professional judgment or your treatment of them, but I'm sure in a sense with how much time you linger by the bedside, or you know how much you shoot the breeze or, whatever, it does vary - based on whether you like them.

Whether or not professional judgment is impacted, in example above, the amount of time spent with certain patients varies according to whether the doctor likes the patient.

In the narrative below, a bias for preferential connection results in preferential treatment, in the form of a [white female] doctor differentially providing her e-mail address to patients based on an implicit sense of likeness to herself.

I: Where it's not just the difficulty in language, but it's the difficulty sort of the unspoken language. The fluency in the unspoken language that we all communicate with.

020: Right, like if you were my patient, I could assume, for example, your upbringing was similar enough to my upbringing, that there would be things that we would

understand in an unspoken way. You know, code if you will. And you don't have that. Well - two things; one is sometimes you have it and you assume you don't, so that's educational too - that you have a connection that you assume you don't because the person looks different from you. So, it can happen both ways, I think. And sometimes you just don't have it.

I: Can you think of an example that illustrates that, a time when you felt like you probably were really different from a patient, that it turned out that in fact you weren't.

020: I went through this thing recently, where I realized I was - I like to email with patients, I find it's a good speed. And I found that I was offering my email address to white people from the suburbs, and wasn't offering my email address to like black from the inner city. And once I kinda caught myself, and I started asking some of my patients from the inner city, "do you email." They do. They're on line, whether they're on line at work or they're on line from home, or they're on line from the neighbor's house, you know, they're connected as well. And that really opened my eyes to, okay, that was a real blatant example of prejudice that I wasn't very happy about. And so what I've discovered lately is the people who don't email, are usually the elderly, regardless of whether they're black, or white or green. But young people often have some connection to a computer, and are happy enough to email me. Um, and that's been really, that was like one of those times, or just sometimes when I've been sitting with a patient, and we'll have a connection over something that I wouldn't have expected.

A bias for preferential connection cannot only impact access to care in the form of options-to-access offered, but, as a continuation of the same narrative suggests below, can impact speed of medical decision-making, and can break down barriers of distance or intimidation that make a patient feel a doctor is more accessible.

020: I think, I mean I'd like to say no, that it doesn't affect the standard of care. And I think that's probably true. What I think it probably it does affect is one, if I completely speak the same code language with somebody, I might understand their symptoms, and therefore be able to make a diagnosis more quickly. I think also they may feel more comfortable with me. So, they would feel that I'm more accessible or feel less like they were bothering me if they had a problem, so it might translate into sort of call, whatever. It's a-

I: So that people, patients you feel like they're of the same, speaking the same code with you might just be more comfortable paging you or calling you 'cause they sort of feel like there's an understanding. So, then their access is more smooth.

020: Right, or if they call and (name) answers the phone and says I'm busy, they feel more entitled to say, please ask her to call me. And if they don't they should wait for three [period of time?] for an appointment, they will make that clear. And sometimes other patients don't.

In the above narrative, while a bias for preferential connection seems to advantage some patients, a lack of comfort resulting from not necessarily speaking the same unspoken “code language” as the doctor appears to disadvantage others, when this apparent lack of comfort translates into less felt entitlement in accessing care. A bias for preferential connection appears to therefore disadvantage some patients, in the absence of corrective measures that might make patients whose backgrounds differ from the doctor’s background feel more comfortable.

When preference is felt for one’s own identified group, other groups are further “somewhat unintentionally disadvantaged” when a medical decision involves rationed treatment such as transplants. In the narrative below, a [black male] physician describes how a bias for preferential connection with some ends up disadvantaging others.

007: They assign them a rating of severity based on, like I know for a heart transplant it's if you're hospitalized, if you're hospitalized in intensive care unit on pressors, if you're, yeah, all those things. And assign them, I think it was severity, and I think they try to take those social indexes out of it. So that they wouldn't determine. But very clearly, again, this is a perfect example of where a group of people is somewhat unintentionally disadvantaged, and this is what happens a million small times a day in probably the average hospital. An individual or a group is disadvantaged, but not intentionally, they'd say, you know, people would express their preference for their own group, or for a group which is perceived to be better. I'm sure black people and white people do this. And Asian people and Hispanic people express their preference for a group, which is perceived to be better, and not for, less so for another group. Or they make negative assumptions or predispositions about another group.

Above, groups of people are disadvantaged, in a more constant way, “a million small times a day in probably the average hospital.” In the above narrative, even the decision-making involved in severity ratings is described as potentially influenced by “social indexes” because they operate implicitly. The physician in the above narrative, who self-describes as black, notes that preferential connection is a social process observed in many groups of people, who in addition to enhancing connection by “like” might make “negative assumptions or predispositions” about individuals from different backgrounds. Here, a bias for preferential connection is seen as both operating independently of social prejudice when people “express their preference for their own group,” and as compounded by the effects of social prejudice when people express preference “for a group which is perceived to be better” or when “they make negative assumptions or predispositions about another group.”

Social prejudice is seen as compounding a bias for preferential connection, in the following continuation of the above narrative.

007: You know, and, I think, most, the majority of doctors think about these things, and weigh these decisions heavily, and try to exclude things, like race and ethnicity and other things, and sex from the equation. But, obviously on some level it's hard to escape those things if, you know, in the back of your mind, you sort of feel like I never met you know, somebody, you know, whatever. But I think, even, uh, in general care with people, when you hear people talk about a patient, if they say, he was a nice, you know, like if this is a really nice guy, blah, blah, blah, people will justify giving him more care, versus, he wasn't a nice guy. And then again, if you bring your predispositions to the table, and say, this group of people are probably not nice people, or are criminals, or uneducated or whatever, they're less likely to receive your attention and care because you don't feel close to them.

I: Right. You don't invested personally in some way.

007: Somebody reminds you of you grandparents or son, you're a little more excited to know them. (both laugh) You know, and if they don't, or if you assume they don't-

I: So, if they remind you of your grandmother, or they remind you of most of the criminals you've seen on TV.

007: Right, exactly, exactly, exactly, exactly.

Above, the doctor describes how “more care” is justified for people who are considered liked, and for whom doctors feel more “excited to know,” and how this bias for preferential connection does not seem to operate for people “you don’t feel close to” based on negative social stereotypes.

In a continuation of this narrative, the doctor explains how when a bias for preferential connection appears to operate in the absence of social prejudice, the result is still, in effect, racist action.

007: Hmm. I never, I very seldom ever worked in the emergency room, (laughs) it's hard for me to say, but I, you know, I think many of these things, I think, you know, just sort of this feeling that we were talking about before. A lot of things with, I think racism in the country, and in the hospital and in the individual are things that are not intentional, it's not that people are bad people, and they say I don't like Black people or I don't like Hispanic people, or I don't like people who, you know, are Persian, you know, they say, people say, I prefer this person who looks like my grandson.

In the following narrative, a(n) [Asian female] doctor describes how she feels closer to and thus more likely to offer preferential treatment for people she sees as more connected to the “culture” of medicine.

022: And we haven't even talked about culture bias. It's not just a culture of race and, it's not just the difference between race, it's really - it's the difference between medicine and the rest of the world.

I: What do you mean by that?

022: Don't you feel, like - when you have a family member - I got my mom in for (unclear) at an island. And I have to admit, when I treated someone, and they have a family member as a doctor or nurse, or (unclear) therapist, you treat them a little bit differently.

A sense of almost filial piety can involve a bias for preferential connection with those in the "medical family," and results in not-so-subtle preferential, and apparently, exemplary treatment.

022: She shows up, you're right, and it's like - and I felt like stress debriefing, when you - you're right, that whole other bias just is like, oh my God, she's f-ing - and uh, she got an MRI, Cat Scan, and LP, consult from the Chief of service of neurology ID, all within two hours.

I: Wow.

022: Yeah, you know.

I: And it's a very different feeling than like the quarterback from the [sports team], where, it's a VIP, but it's like an outsider. They're a VIP because they have power. They have money, they have fame. But you bring your intern in, who's sick, who doesn't have power, money, or fame, but she's like our little sister or whatever.

022: Yeah.

I: And that everyone, at least within-

022: It's a different culture.

...

022: In the ED, and you're just like shitting bricks, and you actually - you literally drop everything with the other person, you run over, to take care of them, because they're medical family.

I: Especially in the ED.

022: Yeah.

I: Huge. And fireman, and the policemen, ENT, any of those.

022: Yeah.

Above, if a doctor will “literally drop everything” in an emergency room for certain patients with whom she feels close, it stands to reason that other patients, who may have just as severe emergencies and with whom she may not feel as close, will not receive the care that, as in the above example, is the epitome of the best-organized, most timely, and most complete care possible. Thus, especially in the context of an emergency room, a bias for preferential connection with some necessarily results in a lower standard of care for others. Here, while treatments themselves are not necessarily a rationed commodity, time and focused attention are in effect limited commodities, and when some patients receive more time and attention, others necessarily receive less.

At the level of the community and institution, economic decisions that are based on a bias for preferential connection are described by a [black male] physician as advantaging some, and, in the process, necessarily disadvantaging others, in a context of rationed resources.

007: Yeah. And I think we spend a lot of time trying to figure out whether it's the economics or race, and I think on some level, the easiest thing is just to say realistically, it's both, and both are wrong. You know, spending hours and years and trying to establish that it's both, or what percentage of each it is, it's you know, probably is, uh, but I'm not sure all these things at [hospital name] and these other things are intentional things to, I think most of these, many of these are economic decisions, which are geared towards advantaged populations, you know, so, they end up disadvantaging minorities clearly, but as opposed to someone thinking, you know, yeah, exactly, suppose there's someone thinking I hate these people, they're really, sort of, trying to help out an advantaged group, or trying to help out themselves.

Above, a bias for preferential connection at the level of the institution is seen as operating independently of social prejudice. However unintentional and however independent of

social prejudice this bias for preferential connection is, the result is a lower standard of care for disadvantaged groups when economic decisions are made to benefit advantaged groups.

In the following narrative, an ethic of medical service involving doing good for others is linked by a black male physician to a bias for preferential connection at the level of the institution and community.

021: Right. And so there's a lot to learn there. They're not interested in that. That's not their area of interest. They don't care about their patient population. That's really what it is to me, that I don't think they care about their patient population, even whites who train in inner city communities. I was at [place] as an attending for four years, and the majority of the residents were white, in the Hispanic community. Most of them didn't care about their patient population. They cared about learning off of their patient population but they were not concerned about the issues and the problems that affected that community. They didn't understand the problems that affected the community. They didn't understand gangs, and they had no interest in understanding gangs. These were just crazy, stupid, inner-city urban children. That's not what gangsterism and street gangs are all about. They had no understanding of that. They didn't understand that when you get to be 20 or 21, for example, you migrate out of the gang because you realize that gang life is about nothing, it's not taking you anywhere. Plus, a lot of people would leave the gang if they themselves were injured by violent street gang activity or they had a friend that was injured or killed in violent street gang activity. They were more so likely to walk away from gang life. But imagine if you had programs in the ER that were effective, dealing with gang members when they presented to the ED, when they were injured, to help them move out of the gang. They have no real interest in that patient population. They're only concerned about certain patient populations, and they're really only concerned about certain races of people, and so I think race is a big issue. But I also think conservatism is another big problem, because I think it mostly - medicine leans more to the right than it does toward the middle. Clearly very little of it is to the left, but it leans more to the right. Very, very conservative. When you have that level of conservatism, you're not really overly concerned about the poor and the issues related to the poor. For example, to me, with all the physicians that you have now in the United States, not that you have an oversupply, because there are a lot of areas in the country that are underrepresented, not necessarily just by race, but just by the sheer number of physicians in [city] versus the number of physicians in rural areas of [state in which city is located] or in [nearby state] that really need physicians. They're not in those areas, because that's not where they want to be. There are certain populations that people don't want to serve. You don't mind training off of that patient population, but you don't want

to serve that patient population. So the question is, why do you want to train off of that patient population but you don't see yourself serving that patient population? You've spent four years learning off of those people.

Above, a black physician comments on bias for preferential connection, which he views as operating in conjunction with social prejudice for physicians who feel no empathic connection with underserved communities: "There are certain populations people don't want to serve." Medical learning, here, is seen as quite distinct from service. In this example, he suggests that personal caring and interest may operate akin to a rationed commodity, available for some but not others, and therefore disadvantaging those for whom it is not available. Such personal caring and interest is seen as linked to a motivation to understand and work with a community. Noteworthy in this narrative, as in other narratives by physicians who are themselves from racially or culturally diverse backgrounds, the starting point for identifying bias differs for physicians who have themselves been targets of social bias. In the above narrative, the physician identifies a bias for preferential connection involving caring more about "certain populations"--in effect "certain races"--and associated with a politics of individualism, as compared to a politics concerned with the social conditions impacting poor or disadvantaged communities. He further links physician individualism to a lack of commitment to serving the disadvantaged patient populations on whom physicians train. In the end, when there is a preference for working with advantaged populations, disadvantaged and marginalized communities receive lower standards of care, and care is not improved in areas where it could be changed.

Contained in each of these narratives are explicit preferences that play themselves out in medical decisions, both at the level of the patient and the institution. Preferences appear based on a doctor's felt sense of closeness, identification, and connection that varies with patient group and is linked to social indexes. A bias for preferential connection seems to emerge and operate both independently of and also in conjunction with social prejudice. A bias for preferential connection can result in better care for those who are "liked," but does not imply that others are necessarily actively disliked, just that some are liked more. Social prejudice that involves negative valuations of certain groups is a distinct concept, but is compounded by the effects of a bias for preferential connection. While a bias for preferential connection is seen as lowering barriers to care, since preferential connection occurs in settings and in a health system where physician time, access, and focus are by necessity rationed commodities, groups who are not given preferential treatment are therefore in effect disadvantaged by receiving a lower standard of care.

Social Prototypes

Social prototypes, as a theme, was characterized by doctors creating medical prototypes based on stereotypes about social categories. Diagnostic, medical prototypes are used at all levels of medical training and treatment to guide medical decision-making. Prototypes—textbook cases of how the medical profession understands etiology and presentation for a specific illness—are beneficial in that they serve as aides to guide diagnosis and treatment. The nature of diagnosis itself, within present-day Western

biomedicine, requires fitting data about a patient into an appropriate predetermined category—and prototypes help doctors fit patients to categories. Physician narratives suggest that physicians use social data resulting from bias, and not only medical data, to fit patients to categories, and that such social prototypes are used like medical prototypes in guiding both diagnosis and treatment. This theme was characterized by physician narratives that disclosed devaluing judgments made about patients based very explicitly on social categories such as race, ethnicity, gender, or class, and because of their association with medical diagnostics and the search for a coherent pattern informing diagnosis, are treated as objective medical truth. Devaluing and explicitly racist and sexist judgments appeared to create, in the words of one doctor, “prototypes” that guided assessment and treatment of patients based on social categories, and not only medical data. A bias for social prototypes clearly impacted and intersected with processes of medical decision-making, and appeared to close off a process of hypothesis-formation that depends on a kind of pattern recognition, or medical prototyping based on symptom presentation and medical data. A bias for social prototype impacts how seriously symptoms are interpreted and therefore whether diagnostic procedures are considered and offered, whether and to what extent patients’ chief complaints are taken at face value, and even how etiology of illness or trauma is perceived and conceptualized.

A [black female] doctor tells us:

041: Not to cut you off, but I know that we're not only thinking about clinical criteria, because as you walk into a room, if there are two patients in that room and one were a person of color and the other was not, and you asked which patient is HIV positive, more

likely a health care professional would pick out the person of color. I've seen that happen. I don't think that's purely demographically disease based.

I: So stereotypes -

041: I think stereotypes are rampant, whether or not we want to admit that. I think it's that we don't admit it and in many - I think we don't really recognize it as being present and impacting decision making.

In the following narrative, a [black female] doctor describes how doctors tend to see patients who are coming from a certain clinic in terms of negative social prototypes.

019: Sure. The thing that jumps out to my mind whenever this topic comes up is the labels that people use. We never use race or ethnic labels. Never. You don't do that. When I was in medical school it was the [clinic name] patient. Here it's the [clinic name] patient. I'm always fascinated by what people mean by that. Like what's the [clinic name] patient? I remember in medical school one day someone said it in a sort of derogatory inappropriate way and I asked them what they meant by that, and it was sort of like, "You know, the typical [clinic name] patient who comes to [clinic name]," and they didn't use race, but someone who comes in who's a drug dealer looking for something. It was a horrible depiction of a person, and clearly those people exist, but those people are not the dominant makers of any health care system. But what I think that does is that if the person sees that as a prototypic patient, then all the defenses, barriers, views, prejudices that you have with that person, you're going to present with every patient. That's the way you're going to view patients. I think here we do it to a lesser extent than there, but still, you hear the [clinic name] patient. What exactly does a resident mean when they say, "Oh, a typical [clinic name] patient"? That could be several things, but what they tend to mean is either an older, probably minority patient with a lot of chronic diseases, or a young Latino person with depression or pain symptoms. We all have those patients in our population, but they don't really make up the totality. But I feel like when you say that you do those patients and all patients a disservice by lumping them into some sort of category that clearly has inherent bias already attached to it.

I: And when people say something like "the typical [clinic name] patient," do you think that automatically - I'm just trying to make sure that I'm understanding all the implications, and I may be going a step further and adding stuff in, which I don't want to do - that the invisible marker of race or class is accepted and assumed by the person who's speaking, so that they can focus on all the politically okay things to say about the patient, but lumped into that is class or race or ethnicity?

019: Oh, absolutely. I think without a doubt that in that categorization - definitely is lumped in some supposition about race and definitely about socioeconomic status. Absolutely. Absolutely. But I think it's sort of safe and acceptable to verbally say the [clinic name] patient, the [clinic name] patient. Certainly not to say the black patient or whatever. And it's also - it doesn't make you the bad guy.

...

019: I probably can't give you a specific instance. I think whenever you have inherent bias or assume something about a patient it can definitely affect their care, because you already are not objective. You already have not stepped away to see the whole picture, you've already sort of filled in some of the blanks already, so I think with anything, when we make assumptions about people, and not necessarily about race, but anything, about sexuality. It inhibits - it has the possibility to inhibit the care you deliver, because you've already blocked the opening to some new data that may actually be just what you need to help this person. I can't think of any specific incidents that stand out.

Above, the doctor notes how such social stereotypes of “prototypic” patients impact care at the level of differential diagnosis, by limiting a doctor’s ability “to see the whole picture, you’ve already sort of filled in the some of the blanks already.” Here, biases based on social prototypes are seen as interfering with the acquisition and consideration of new data in medical decision-making—data that “may actually be just what you need to help this person.” Again, it is important to note that a black female physician, because of her own status as someone who has directly experienced being the target of racism, brings greater sensitivity to how social bias conspires with medical education to produce these processes.

In the following example, an [Asian female] doctor explains how Latina patients in particular are seen as prototypic in a very negative way, in the emergency room where she works. The following excerpts of narrative offer a specific example of prototypic bias, and how such prototypic bias can serve to invalidate chief complaints and block off the acquisition of important data in medical decision-making.

022: There are definitely great stories to tell you, but it's all about the frequent flyers, and I think that these stereotypes are actually less cultural. No, actually, no, there is one cultural bias, which is the Latino bias. Is that you being paged now?

I: No. You're like, [says her own name] phone-

022: When we last left off, want a Rolo? (referring to the food they are eating for lunch)

I: Oh yeah. You were talking about frequent flyers and that some sort of stereotype about-

022: Oh yeah. 'Cause you first asked Hispanicus, right?

I: No, I haven't.

022: That's what does - thrown around - unrevealed. Terms all around the ED.

I: What's that mean?

022: We get a lot of status Hispanicus patients, which is typically a Latino woman, young, between the age of 15 and 40, who shows up with bleeding from the vagina, or it's a trauma, or, who care what her chief complaint is, it's just status Hispanicus. No matter what you do, no matter what you say, I mean, like, it is the women hysteria, stereotyped to the max, and it really only applies to the Latino population. And I think that every resident will admit it if you ask them point blank that that's what they're thinking, quite often, as they're sitting there, talking to this woman, and of course it's all four teenage sons translating.

I: Right.

022: And you're like, okay, and you're really trying hard not to jump immediately to this like admission.

I: Yeah.

022: But you know, I actually-

I: Do they usually get a psych admission, or usually get?

022: You end up playing that input, what's going on. (benzodiazapine), given liberally, that kind of thing. And, I mean, I feel like, I think I am the only one of my contemporaries from medical school, and friends - I am the only one of my friends from

medical school, who is in a program, 'cause everyone does ED rotations no matter what your specialty is, right? But I'm the only one who can say that I have made the diagnosis of conversion reaction in the emergency department, and have stood firmly by that and have been proven correct. Is that terrible? It is, and yet there it was, in the 42 year old Hispanic woman, you know.

I: Wow.

022: Yeah.

I: What was the - in a nutshell? 'Cause those are usually fun conversion reactions. You're like someone who's so, paralyzed - they're paralyzed or so, they're blind, or-

022: We made the diagnosis, because the same diagnosis had been made for 6 months earlier. Similar circumstances.

I: Conversion reaction.

022: Stressful, yeah, stressful (vagitonic) Her son called from jail, or something like that.

I: Right.

022: Within minutes, the phone call. All the children, who seemed perfectly normal, and understanding too - what we were doing, say she started to seize, and that she collapsed. We called EMS. We come, we check her out, CAT Scan. Nothing. Labs. Nothing. Sent off chem 20, just to be sure, some tox screens and everything. Neurologic exam, everything perfectly normal, except for the fact she wasn't talking to us, and had her eyes closed, but you knew the drop test over her face, she must have (raised it) every single time. There's certainly this cognizance, we got neuro involved, got psych involved, neuro is like toxic. Psych, psych yes. We see this. We'll take her. They took her. So, we were like, alrighty.

I: We, I've never heard status Hispanicus, but [location] in the [name] clinic, the people who talk about the diagnosis of TBD, or Todo Body Delore.

022: (Exuberant laugh)

I: But if there's - I think - like to do - because the rhythm is different [location], the [name] clinic, so it's not status Hispanicus like, let's get a psych consult, let's get her on Benzos. It's much more like, how will I, you know, this stereotype of a patient that comes in, and always has a different pain, somewhere different, always has - or has the same types of pain-

022: That's hypochondriac, Latino woman.

...

I: But they - I mean, how does that play out, do you think? In terms of either how the doctors and nurses interact with the patient, or how the patient interacts with the doctors and nurses.

022: It probably depends on whether or not you view the world as an optimist or pessimist. The optimist wanna think that they mean well. They wouldn't come unless they really had a good reason to come. And the pessimist are like, they're trying to milk the system. Although I do have one great case of me and this attending. And granted, they were both sitting there going, say to the family - they brought in their 43 year old aunt from the Dominican Republic, got off the plane hours ago. Straight from [airport], over to [name of hospital]. "What's your complaint?" "Oh she hasn't been walking for the last couple of years!" I'm like, years, "hello?" "She's not herself, da-da-da" And really try to tease out the story, you know, talking to the patient, getting the interpreter, talking with the whole family, and saying, so, what you're saying - and we were flabbergasted, we're like "You, got off the plane with your aunt, so like tell us what happened?" "Uh, we've been waiting to bring her to America for years, and now that she's here, we figure we better go to the hospital, because the reason we wanna bring her up is because she's been kind of, really tired for the last couple of years, and she's not walking, and da-da-da." I'm like, uuh. My attending goes literally on a tirade in from the family, telling them that this is such an abuse of the system, this is not the way to do this, da-da-da-, and what's been going on in the Dominican Republic for the last 5 years, this is totally crazy, and then - but then the one thing that happens is, she just won't walk. She walked when she first got to the ED, but then she won't walk, to give us a urine sample - but then she won't walk, so because she can't walk, we can't get her out, and so we're trying to get the family to make her walk. We're like, "Make her walk!" And they're like, "We're trying!" And she won't walk, and of course my attending at this point - I was like - definitely hit this hump road, like "Alright, who knows, but listen, we've done worse, for God's sake, if she were your college age daughter, out of town, for the same complaint, as vague as they seem to be, you know what we do?" We just send her to the CAT Scanner and then get her out of here. And listen, this is all the family wants. They just want answers of some sort, and they want to get her hooked into the system, so what we'll do is we'll start with the CAT Scanner, and send her out. Well, you missed something. We diagnose MS.

I: She couldn't walk. Oh my God.

022: Based on the CAT Scan we get.

I: Whoa!

022: Is that not crazy?

I: That is an amazing story.

022: I'm like, that is the first time diagnosis-

I: Yeah, 'cause she had never gotten the proper work-

022: Exactly.

I: And she could have gotten it in an outpatient clinic setting.

022: This is how she ended up presenting. But definitely a part of the tirade too was, and I'm (unclear) green, and knotting [nodding?], and thinking, this is not politically correct, I totally agree, yeah, yeah. But you know, [name] is sitting there, going like, "And I hate this, and I hate to like stereotype people, but it's really the Hispanic population that comes in here and totally expects this kind of stuff." Da-da-da. Like, "And I hate to say it, but you never see any Asian people doing this kind of thing, and even black people in America don't do this kind of thing." You know, they're not bringing in their relatives off of, fresh off the plane.

In the above narrative, prototypic bias results in a woman who seeks care because she has not been able to walk for the last few years being told she is abusing the system. In this narrative, it appears the patient receives the diagnostic CT scan primarily because the doctor considers what the standard of care might be if a family member were to have a similar presentation. This consideration is an example of the deliberate use of “preferential connection” as a tool to counter bias.

In the following narrative, a [white male] doctor describes how a prototypic bias about Latina patients as over-expressing symptoms can invalidate chief complaints in the mind of a physician, and lead to diagnostic procedures not being offered. Because this doctor stays on-topic for an extended period of time, during which time he offers justifications for his thinking and actions, an extensive excerpt from the narrative is

included here in efforts to illustrate the subtlety and complexity of how medical decision-making can appear to have as its foundation a bias for social prototype.

013: Some of it goes back to some of the stuff that we were talking about before. You know, if certain populations - we were talking about the Latino population. If certain populations come to the ER for different reasons, not necessarily emergencies, then I think that will influence what gets done for them. If you are a, you know, young 40 year old Latino woman, and you've got chest pain, and I think that may play a role. And that people are used to seeing Latino people there more frequently for more problems that are less emergent. And there's a bias there that says, look, this is a woman isn't having heart disease, either one of those women probably isn't having heart disease. And the Latino people I think will (gestalt) is even less likely, 'cause the odds are that she came to the ER that for something that was less emergent is higher. You know, this is probably not a woman that necessarily thinks she is having heart pain. So, I think that that is going to play a role. You know, I think that people that use the ER as their primary care office are less likely to get the full-on emergency evaluation, because I think that the docs and the nurse sort of scale back and say this is more like a primary care visit. Do I think that there are communication problems between races? Yes. I think that it's very difficult to take the same sentence out of different people's mouth and know exactly what it means. And most of the doctors are white, and most of the doctors are male. And so when someone says they've got X symptoms, they are going to look at it through those goggles. And I think that hearing about those same symptoms from an African American woman, it's going to be harder to know what that means. So I think that there is a communications part of it that leads to that. But I think that I'm kinda of getting off the real meat of your questions.

I: I don't know, actually. You are bringing up different things that all seem related. The question is, sort of what - the general question is, what kinds of things have you seen in your clinical experience, either were obvious or had the flavor of healthcare disparities, where people got different types of treatment, and it seemed that it was due to their age, their gender, their race or -

013: I think, that for example, there's this sort of very typical of the (tacky) eye syndrome in Hispanic women.

I: What's that?

013: For the purpose of the tape again, to not be PC, but you touch any part of someone who says they have pain, and they yell, "eye-yi-yi-yi". And, you know, I think that it's not a PC thing to say, and yet I think that if someone comes in, and that's the way they express their pain, even though you know you've just, you know, it's - if all pain is

severe pain, and that's the way it is for a particular racial group - again we're talking about Latinos mostly - if they're a very expressive group, then - if they come in saying, "This is the worst headache of my life", the chances are you are going to think it's (cervorachemorage) [cerebral hemorrhage] and do an LP [lumbar puncture] for that - is lower. Because you know, that all headaches are the worst headaches are the worst headache of your life. And you know, you can't (tap) every headache. So, you know, if chest pain is always a 10, then I think that you are less likely to admit that as cardiac pain. Whereas certain other populations, like older African American woman - you could go up to them, and say, "Listen, I'm sorry ma'am, but I've got to stick giant needle right into your head." They'd be like, "Baby that's okay, you do whatever you want to, you're a good person." You think, God, how would I ever know if you were hurting. How would I ever know that you're have a crushing pain. 'Cause like, "Hey that's okay, I have a crushing chest pain, that's fine." (fictional humorous example to strengthen argument)

I: "I lost have my mind trying - I could go home and take care of the children" (dramatic extension of fictitious character) So, minimize kind of cheerfully.

013: Yeah, there are patients who do that, older African American women do that. They are very charming about - you know, but I think that in those patients they probably, you know, sometimes they're not going to get the care they need. And - because aren't attuned to the fact that they are minimizers. You know I think that - but there's a lot of individual variation in that too -it's not - there's a lot of overlap between races and genders. And personality types.

I: Are there other sort of classic patients that come in - like you've just given me sort of a classic older African American woman, classic Latino young woman, as opposed to a man. Although my experience has been similar -

013: Yeah, I'd say that the Latino men are more like the Latino woman than they are like anybody else.

I: Are there any other classic patients feel like you've gotten use to being -

013: You know, everybody always talks about this stoic Asian stereotype. You know, they'll never say anything's wrong. I haven't really experienced that much of that. But everybody talks about it...I'm just thinking of other more generalized types. I'll say this: Different people present with different symptoms for the same type of problem.

I: That's interesting.

013: So um -

I: For example -

013: Something that causes general malaise, right. I don't know, a virus or, you know, whatever. You know, you just don't feel good. Latino women will typically present with abdominal pain and dizziness. Younger women tend to present with abdominal pain. The middle age women will be dizzy. You see a lot of young African American and white women - they'll have chest pain. There are - the older white women - it's weakness. It's general, "I'm weak", or "tired." Um, Latino men tend to act like more similar to Latino than anybody else. So, dizziness. Less so, a little bit of abdominal - dizziness. But I'll tell you, you know, there's a lot of (gastritis) going right now, right around the world. Because that's the cover all diagnosis for something we don't know what it is, but yet belly pain.

I: Right.

013: What's the other - I'm trying to think what's the typical white male response to this. The first thing that jumps to mind, although I think it's not, it's not universal - especially in older people, they just sort of stop eating. Or constipation. Something like that.

Above, the physician appears to have created medical prototypes, based on race, ethnicity, gender, and age, for presentation of symptoms. His social prototypes for symptom presentation appear quite well-formed in his mind—except perhaps for his prototype of “the typical white male.” For this prototype, describing a social category of which he is a member, the physician seems to catch himself, and after presenting as medical truth “the first thing that comes to mind,” qualifies his response with “it’s not universal.” What makes medical prototypes so useful is that they are so easily brought to mind as a tool to guide diagnosis and treatment. However, when social bias infiltrates itself into the formation of medical prototypes, what is so easily brought to mind may have as a consequence disparate care.

In a continuation of this narrative, the physician describes how he understands his formation of prototypes for symptom presentation to reflect patients’ culturally-learned idioms of distress.

I: It's almost like final common pathway in different populations. If there is something wrong, this is how they present.

013: Right. This is the problem that they highlight as the things bothering them. For the general "I'm not feeling well." If you asked, "Do you have muscle aches and joint pains and a cough?" Maybe the same exact same percentage would say, "Well, yeah, I'm having those things to." But the thing that bothers people I think is different. What bothers somebody might be dizziness verses abdominal pain, versus weakness or fatigue.

I: What do you make of that?

013: Like, how do you make of that?

I: Yeah. Like how to you make sense of that for yourself, or what does it mean to you?

013: I don't - that I ever really tried to make sense of it. I think that...you know, I was thinking about it - the other thing that would characterize white men would also be chest pain. I think that there's a part of it - like in this country there's a lot of different levels of knowledge about bad diseases, you know. Everybody knows about heart attacks. Fewer people know about strokes. They're equally bad. But it's a matter of who's been educated on what. You know. Nobody knows anything about seizures. So, I think that you'll see a lot of people latch onto the disease that they know is bad to a certain extent. If you have 5 symptoms, and one of them is a symptom you get with a bad disease, then that's the one that you are going to worry about. Alright. If you have muscles aches and joint pains and runny nose and fever and chest pain, well, you know chest pain could be your heart, and therefore you're gonna think about that. I think that's to a certain degree, but I also - I don't think that's a huge factor. I think that a lot of it is, is just - this is the way of people of different cultures express their problems - in a much more - and I think this is really where the bulk of it lies. You know, if I grew up in an Italian American population - when grandma and uncle Joe and dad and mom got sick - this was the problem they expressed, well the - when I get sick and I have that problem, that's the problem I'll probably express. I think that it's, to a certain extent, a learned behavior from cultural upbringing, and this is what people do. They express their feeling bad in different ways.

I: Is that kind of thing something you feel like you've just seen over time or something you were actually specifically taught during medical training or residency or?

013: Um, I think it was mentioned in medical school. Everybody in medical school has to take these classes on cultural and medicine and - at least we did. You know, there's a lot of that - probably [name of institution] - considering the history. I talked

about attempts to overcome it. But I think that - it is mentioned here and there, but I think more of it is from what you've seen.

I: Just kind of informally seeing.

013: Yeah. This is your experience in taking care of patients for four years. You say that, you know, you learn the, the words that people use.

Above, the physician describes how his attribution of different idioms of distress to different groups of patients (with perhaps more varied idioms of distress and more complexity attributed to his own group, white men) is informed by his cultural competence training in medical school, and also by "what you've seen." In explaining how he has learned "the words that people use," this physician appears to have paid close attention to what his patients have told him. However, as a continuation of this narrative suggests, distinctions between imposing one's own understanding of a patient's experience on the patient, versus valuing a patients' ability to know her own experience, are pertinent to what is seen as valid in symptom presentation. And as the narrative elucidates, "what you've seen" becomes central to pathways of medical decision-making.

013: Or any given chief complaint - it's like being handed an envelope. And the envelope has - if someone comes to you with a chief complaint - you grab that envelope and open it, and say this is the history I'm going to then follow it. I'm gonna fill out these questions and do these tests and if you, if you're not aware of which envelope to grab, because the presentation varies so much, it makes it a lot harder.

I: Here's just a follow up on that, 'cause it's a really interesting comment.. It's not - so, initially, I mean a seasoned clinician recognizes the important complaint for the important symptom, and kind of tailors or guides the patient to get the rest of the - most important information to make sure it's not an aortic tear or perforated ulcer or that it's just-

013: Gastritis.

I: Gastritis, yeah. Or (pericarditis). A common one. So, they give you different envelopes to start with. Here's a follow up question. What's it like - 'cause that's kind of a collaborative or interactive process - where you guide the patient through the history. You ask what you know from experience are the most relevant questions. Is that interactive process of taking the history different with these different types of patients also. Not just the initial envelope they give you but how the interaction unfolds.

013: Um, I'm trying to think of it. Ask your question again.

I: You're sort of describing how once you're a seasoned clinician you kind of recognize the important chief complaint, and you know which questions are important to ask about. And that it can be a little bit harder this situation where patients from different backgrounds are offering you different chief complaints or different envelopes even though they all have sort of the same - we might recognize the white male envelope. But the other envelopes are going off in a different direction because it's (overlap talking)

013: Right.

I: And my question is actually, after that initial complaint, as you start to go with the additional questions and kind of guide them, does that feel different to patients. Does it unfold different - the actual interview process?

013: It think that to a certain degree it does, because again, as you become a seasoned physician you, even not so seasoned physician, you learn how to guide patients through the, the right complaint to the right answer. As you become a really seasoned physician, then I think that you learn to incorporate those other things into it. And so, maybe now you say, well, I've got a patient with dizziness, and I know that for this group of people, dizziness usually - these are maybe not the population that comes in with dizziness unless it's real. Vertigo or something like that. Whereas some patients come in with dizziness because, it's just, "I'm not feeling right." So, for those patients let's say it's dizziness - you may push them a little more to characterize that dizziness. And ask them to characterize the dizziness into one of the envelopes that you are willing to go down. And unless it fits into one of those clearly, then you're not going to pursue it. So if they say, "Look, I've got dizziness", and you say "Okay, well what do you mean?" And if they say, "Well, every time I turn my head to the left the room spins and I start throwing up", and you say "Okay, you're a Latino woman", but this is vertigo.

I: Right. I recognize clearly what this is.

013: This is an envelope I can pick. Where - but I think - to a certain extent you are going to make that Latino woman prove it's vertigo. Whereas if it's an African American woman, you're gonna say, "Dizziness is a unique complaint, what do you mean dizziness?" And you're probably going to pursue dizziness, as opposed to the Latino woman, where you might say, "I think this is your way of telling me that something ain't

right, but I'm not going to do an extensive (cerebellar) because I think that - where as I might do that on the other person. So, I think that if you recognize that as kind of the general complaint, or the way a certain patient tends to present, you may actually ask them to prove to you in some way - that this is something specific before you go chasing it.

I: That makes - that's clear. Wow. So, I guess a different way of stating the question I was asking is, does it feel different? Is it harder or easier to take a history from different types of patients?

013: Oh, um....

I: Different populations of patients.

013: Yeah, yeah, it's definitely harder to take a history from certain types of patients. I think that the elderly patients are harder because their symptoms are frequently non specific. And that's hard. Like I was alluding to you before - patients whose symptoms are - do not admit of degrees.

I: So chest pains always 10, headaches always 10.

013: It's very hard to take a real history from those people because you can't - it's just as hard if chest pain is always 10 as if it is if chest pain is always zero. I do think it's harder, but I'm not sure that it's harder for one group than it is for another. Everybody's got their own flavor.

I: Mhmm.

013: But I would say that there are certain groups that tend toward having symptoms that don't admit to degrees.

I: Right.

013: And those are going to be harder groups.

In the narrative above, the doctor has become quite practiced in grouping how patients tend to present into “generalized types” based on social indexes, though he notes he realizes presentations can be more individual as well. He describes how a prototypic bias of Latinas as over-expressing symptoms--a bias perhaps justified and further cemented in

his mind by his understanding of idioms of distress--intersects with his evaluation of whether or not a symptom is "real," and suggests how this evaluation then guides his medical decision-making in terms of which "envelope" he picks as being the correct diagnostic and treatment pathway. This doctor also suggests that he tends to put the onus on the patient to "prove" symptoms when he does not believe they are real. In a situation where he experiences taking a medical history as a challenge, he appears to therefore put the onus on the patient, rather than himself, to somehow make him believe what she is describing.

In the following narrative, a [white male] doctor describes the importance of pattern-recognition in medical decision-making, but expresses caution for how patterned thought impacts care when pattern-recognition intersects with a bias for social prototype.

I: So, that's something, so when, so then we're like recognizing a pattern, and that's something that in medicine is really valuable to do, like if you recognize a pattern and you extrapolate from it, you are a better doctor, you know what I mean?

033: Mhmm.

I: If you can quickly see patterns and go from clues to a final conclusion 'cause you're good at seeing patterns.

033: Right, although I think that the, I mean there's - there's a danger to patterned thought, that is, in any setting, especially in medicine. I think if you assume, you know, that's how you - that's how you get burned, you assume this is another, whatever it was the last time, it's another dizzy Hispanic patient, you know, that they're not having BT. That's - so when you see a Hispanic patient, and they say they're dizzy, you have to say, what is that? You know, if it's a general feeling of unwell, that's one thing, if it's you know - I'm about to pass out every time I stand up, that's another thing. But you know, but I think there is that.

I: So, that's like a double edged sword, as you could-

033: So, sometimes recognizing cultural differences works against somebody who has,

whose disease pattern is not following cultural models, I think that's the real issue, is that when, is the really dizzy Hispanic patient, or the, you know, something like that, that, or the Somali patient, who their double pain is appendicitis, you know, instead of a reaction to stress. I think that's, in one way, sometimes that - that those patients probably get worse care, because they say it's another disease about every patient.

Above, the doctor suggests how prototypic biases about Hispanic patients and Somali patients are quite prevalent in his experience. In these cases, both such biases happen to tend toward somatization—a situation that causes real danger because symptoms are seen as secondary to stress and therefore not taken seriously.

Doctors can also fail to take patients' symptoms seriously due to prototypic biases around why a patient is presenting for treatment in the first place. In the following example, a [black male] doctor describes an especially egregious example of how an African American medical professional "had the misfortune of having some chest pain and going to her own hospital where she worked," and nearly died due to the mobilization of prototypic bias. The physicians, preoccupied with ruling out whether she was a "drug-seeking" black woman patient, failed to detect a cardiac condition that resulted in myocardial infarction. In this instance, even the "caring for one's own" that characterizes the medical community's preferential bias for an employee of the institution was overridden by a gendered racial bias, with nearly fatal results. Prototypic bias can overrule what in retrospect becomes evident, undermining physician capacity to take an accurate history, make an accurate diagnosis, and appropriately respond to an emergency.

036: They do put barriers up. We had a few years ago where we just noticed that when patients were put out in the hallway, it was common practice, whether conscious or unconscious, the African American patients would all be out in the hallway, and the non-African American patients would be in the rooms, and we brought that up at meetings and we had some serious discussions about that. I think people got somewhat

sensitive to it and they realized that their practices were not proper. I'll tell you a case that happened, I'm not sure I should name hospitals, but it's 3,000 miles from here, this is not a case that occurred here. In reference to undermining people's complaint because of culture and race. There was an African American that was known for about 16 years. I actually used to work with her. She's working in [location], south of [city]. She had the misfortune of having some chest pain and going to her own hospital where she worked, to the ED, and - she's telling me this story after she got out. They sent her home, they completely ignored her complaints, and they thought she was drug-seeking. This is a very well-educated woman. She's an RN, she's one of the supervisors, she's been practicing for many years, etc., etc. She's head of a department, actually. She went home, she had some more chest pains, she went back to the same ED. She could overhear the doctors and the nurses talking about whether she is drug-seeking or not and she doesn't really have real chest pain, etc., etc., etc. So they ignored her and they sent her home again. She continued to have chest pain and she was going to go to a different hospital, but when the ambulance went for her she was so diaphoretic they took her back to the same hospital. She had an MI [Myocardial Infarction]. She didn't just have angina, she had an MI and she ended up in the hospital for a week. So this is an African American woman who is a supervisor in this institution, who presented three times to the same emergency department, and she told me she could hear the doctors talking about whether she's drug-seeking or not.

I: Did they do EKGs or anything?

036: They did some stuff, yeah, but they took her story lightly. As you know, the diagnosis comes from the history. And they completely undermined her history.

I: Right. So much of what we do depends on our subjective sense, which opens the door for all kinds of bias.

036: She was in tears when she called me. She said, I can't believe they're treating me like this. I said, I've seen it happen, but - she was flabbergasted mostly that it was her own institution where she worked. So now, she spent seven to ten days in the hospital, and it's a good thing they took her back - three visits! Those things are very unfortunate, and that's the kind of stuff we come across on a daily basis.

I: It's that classical medical euphemism we use - unfortunate. I might use other words.

036: Yes, it's terrible. And it's happened to me too.

Above, the patient is head of a nursing department, seeking care in her own institution.

In this example, any power and preferential connection associated with that position

appears horribly outweighed by a bias for what is seen as a prototype in the eyes of the caregivers. The doctor being interviewed notes that similar things have happened to him as a black male, and suggests how prevalent such treatment is—"that's the kind of stuff we come across on a daily basis." One can only imagine what might happen to people who are not doctors or nurses.

In the following narrative, a[n Asian female] doctor explains how she makes assumptions about etiology of trauma based on a bias for prototype.

022: It actually was mom, and son in their Volvo, no, Saturn, they actually talked about it. We were like, "Oh, good." And everyone was like, "Wow!" It was like a terrible roll over that they were in, but they turned out to be totally fine, went home about three hours after they came in - and the staff was talking about it, like, I'm gonna go get a Saturn. Yeah, if I can't afford a Volvo.

I: 'Cause they all did well.

022: I'm gonna get a Saturn. What a good idea.

I: And, can you remember, did it seem like their, race or culture - the two different patients that that played out differently, in terms of how the staff interacted with them, or what? And I'm getting a flavor-

022: It definitely does, because mom and son, the staff is more comfortable, more bonding, and wants to do a more thorough job of expediting their state through the emergency department. Although part of that is also based on - see, people in emergency medicine I think, I think, 'cause the key is that, your adrenaline gets going, and then you hit the point where, once you've decided what the disposition is gonna be in your head, you come to terms with that mentally. You're pretty happy with that, and then you can totally deal with whatever else is thrown your way, including the curve ball that sends you in a different direction. So, the thing about the mom and the son, that it was easy to, it was easy to comes to terms with their disposition, 'cause once we knew they're out and cleared - they don't need to go to the operating room, they don't need to be admitted - then you're happy, you're comfortable, and you can jabber with them. Then you got stab victims, who were not cooperating, and the reason you are not cooperating with them and they're not cooperating with you, is because, you're all still wary of each other, and until they cooperate, you can't reach that point of comfort.

I: I'm gonna just flip the tape over.

022: Sure. [end of side A]

I: [tape begins at counter #57] Okay.

022: Yeah, you can't reach that point of comfort with each other where you can then be like, hey, bantering, what's going on?

I: So, but that's kind of - so that's not so much about whatever the race that the patient is or the ethnicity, or language, it's more like the mechanism of injury, 'cause the stabbing victims could be-

022: Even white guys too.

I: White guys.

022: Exactly, and we've had a couple of those. All just beer brawls, beer fights. Bar (restaurant).

I: Like you were describing. But then like that was a, like a white guy in his 20's who graduated from Yale, getting into a beer brawl, which is not like your stereotype idea-

022: It's not like your cocaine gone bad.

I: Right. So, were the stabbing victims, were they black or Latino, or Asian?

022: One guy was, I think he was looking at the other guy, actually I think he was Middle Eastern. The other guy was black. Black kid, unfortunately died on the operating room table.

I: And the mother and son?

022: The mother did totally fine, they were white, and-

I: Yeah-

022: You're right, in that uh, the trauma itself is sexy more, in terms of the bias, at the same time, you can't help but be colored by, "Well, what got you into this in the first place?" You know, like, anyone's prize [surprised?], is was this black guy and the Middle Eastern guy who were in the middle of the cocaine deal gone bad, and kind of like, I'm ashamed to say no. [tape turned of momentarily]

I: I'm sorry about that. Interruption.

022: Now that you're relieved. (laughs)

I: I am relieved.

022: Very good.

I: Oh, so you were saying, what's the last thing you were saying?

022: I can't remember.

I: About the - we were saying something about expectations-

022: Yeah, so like, so, terrible (unclear). It's not terrible, but basically, you know, black guy comes in, stabs, cocaine deal gone bad. Am I surprised? No. Could I be surprised if it were a white woman? Oh God yes. But then we'd be going down a whole other path, too, we'd be like, get the (unclear) [rape] kit.

In the above narrative, a medical decision-making “path” for presentations of trauma in the ER is described as being determined by a bias for prototype; if a white woman were to present in the ER with stab wounds, she would be seen as a victim and given a rape kit—a responsible standard of care. The men of color who presented to the ER with stab wounds were assumed to be perpetrators of crimes, did not appear comfortable in the ER, and the doctor did not feel comfortable interacting with them. The doctor described how “cooperation” with these men was a two-way street, and how “the reason you are not cooperating with them and they are not cooperating with you, is because, you’re all still wary of each other.” Of vital importance, she notes that “until they cooperate, you can’t reach that point of comfort.” It is unclear to what extent the doctors’ assumptions about these men of color impacted their comfort level with her. In this example, it is unclear what disposition was reached for the men of color, and it is also unclear how seriously

they were wounded, but it is clear that care went smoothly for the white family and that a disposition was easily reached, and comfort level easily attained, for them. Reaching a disposition is an important part of a “path” for medical decision-making, and it appears that biases of social prototypes can impact both speed and ease of making such a disposition.

In the following narrative, a [black male] doctor describes how a bias of social prototype about white people as complainers and demanding impacts treatment path and medical decision-making in a way that translates to quicker care and the granting of procedures.

021: Right. So therefore even me being a black person, a black person might have to wait longer than a white person. Sometimes I actually do this. Sometimes, if there's two people with equal amount of badness, I usually sometimes will see the white person first. You know why? They'll complain more. They complain all the fucking time, they make a lot of goddam noise, so it's easy to see them and shut them up and move them, and tell the black person I'm sorry that it took a little bit long for us to see you, but Mrs. Smith, what's the problem today? And then they - you go on and they're civilized, you don't have any issues with them. White folks complain up the goddam yingyang. All the time. They don't like to wait. They feel that whatever they have - and a lot of whites come with advocates, and their advocates speak loudly for them, and sometimes you'll have to tell them, do you know what? Do you see all these people in here? All these people are sick. We understand that your father is sick, but he's not as sick as a lot of these people here. He's sick and we recognize that and we're working on it, but we can't just stop everything we're doing to take care of your family member who's not as sick as everybody else that's over here. And so people are very selfish and self-centered when it comes to their family members, when it comes to injury and illness. And you have to help them sometimes put it in the proper perspective. The ER basically is not the place for all that, but sometimes that's how it goes down. So black folks and Latinos in particular usually don't complain too much when they come in. But whites complain all the time. And they're a very difficult population at times to deal with. And also they're an educated population too, and because they're an educated population they're more demanding. And they demand things a lot of times that they don't even need. And sometimes it's just easier to give it to them than it is to deal with them. It's hard to tell them sometimes that, well, your doctor sent you here to rule out an ectopic pregnancy, he told you that you need an ultrasound, and we say you don't need an ultrasound because

you're not pregnant. Well, maybe they can buy that they don't need it if they're not pregnant, but let's say they're pregnant but they had an ultrasound three weeks ago that showed an intrauterine pregnancy, so it's impossible for you to have - so sometimes it's a lot easier and cheaper politically just to do the procedure than it is to even argue with them. And sometimes that's exactly what I do. I tell them sometimes, you know what, I don't believe that you have this, and I don't see a real need for it, but I'm going to do this because it'll make you feel better. Not because I believe it. So I just do it. And it comes back - usually, not all the time - usually just like I told them. Then they feel better. I don't feel any better. But it's done and they go home happy. ...They make mountains out of molehills. But you still have to appease them. And the hospital appeases them too.

This aspect of bias for social prototype reflects a somewhat inverted power dimension for the medical terrain, in that a black male physician sees himself as having to “appease” white patients. This doctor notes that white patients tend to be appeased on an institutional level as well—in a way that other patients are not. Despite the patients perhaps leaving happy, it is unclear how this prototypical bias for white patients might lead symptoms to be taken less seriously in an attempt to reduce “noise”; the doctor does note that he is usually right, but “not all the time.”

Reducing “noise” appears salient as a dimension of prototypic bias, and as this [Latino male] doctor explains, appears vital to the processes of medical decision-making themselves.

031: I think so, I think so. And I definitely think with Spanish patients, people try to reduce the noise, the background noise pain. I don't even know if that is a term kind of - there's this background noise, they just try to reduce, and in the effort to do that, it's the patient who is not trained, you can totally lose what the real reason they came in for.

...

I: And so that's a different way I now interact with people because of medical education.

031: I think that's true, and I think that's an effort to minimize noise or to deal with, what is that thing I want to incite, that cognitive incongruence. Where like, you have two ideas, that should not be on the same boat, so you kind of throw one out, and so I think that we often, we're often - what's valued is that you quickly determine what's wrong with a patient and that you come up with a coherent story, and so if people are not giving you all the details you want, or details that don't fit with the story, you tend to dismiss them, instead of rethink the initial hypotheses. You know, and so I think that happens often. The other thing, that on the opposite end, of not believing is leading the witness, you know, so, which happens often to, I mean, you, it happens often in the emergency room, and leads to bastardization of the initial chief complaint into whatever they want to happen so that they can move on.

I: Send the patient to the next doc.

031: Exactly.

I: On a recognizable pathway.

031: Exactly, and so often leading the witness, I think could be just as detrimental as dismissing things that they say.

Biases of social prototype can involve some of the ugliest social stereotypes.

When such stereotypes infiltrate themselves into the creation of medical prototypes as a form of pattern recognition in medical decision-making, a doctor is in danger of providing racially-biased and dangerously misguided unequal treatment. Biases of social prototype can operate by seriously undermining how a patient's history—a foundation for accurate differential diagnosis, effective disposition, and many other further pathways of medical decision-making—is framed, and how seriously chief complaints are taken.

Summary of Section on Bias

In the narratives illustrating facets of bias, physicians spoke to themes associated with: paternalistic assumptions about lack of patient agency; preferences for certain patients based on felt connection or identification—preferences that, in medical settings,

often come at the cost of disadvantaging other patients; and distorted, deeply judgmental stereotypes based on social categories that infiltrate themselves into the formation of medical prototypes. Each of these themes is associated with significant impact on processes of medical decision-making. A bias of paternalism impacts whether and to what extent a patient is considered able to engage in discussion around treatment, able to comply with treatment, and able to value not only advances in technology, but her own health—and such a bias can justify undertreatment in a context of biomedicalization where several parallel but unequal treatment pathways are each considered a normative standard of care. A bias of preferential connection can result in greater ease and speed of care—and exemplary care—for some, but such care comes at the cost of others in a context where time, focus, and sometimes treatments themselves are rationed commodities. A bias for social prototype can impact how seriously chief complaints are taken, how easily disposition is determined, and how presentation to the hospital, etiology of trauma, and medical history itself is conceptualized. These biases do not necessarily operate exclusively of each other, and in several of the narratives they were shown to operate concurrently, multiplying their destructive effects. However, they appear relatively distinct in terms of the thinking that underlies them, their operation in the treatment relationship, and their pathways of intersection with medical decision-making. Biases for social prototype seem, on the surface, the most visible and the closest to what we think of as utterly unacceptable systematic prejudice assuming inferiority of a particular group. However, biases that seem more subtle, invisible, or vaguely-described by doctors such as paternalism or preferential connection also result in quite visible

unequal treatment. Physician bias not only effects medical decision-making, but, as described in some of the narratives, serves to compound the social, economic, and institutional factors that create disparities.

Physician narratives of bias involved physician capacity for awareness of how they were making judgments and how those judgments enacted themselves in their behavior and medical decision-making. The narratives suggest that awareness of bias was in itself grounded in lived experiences of bias, especially due to race. Black physicians were especially sensitive to the reality and consequences of bias, and provided some of the most eloquent descriptions of bias in these narratives. Such capacity for awareness is vital, and constitutes a reflexive process, but it does not in itself solve the problem of unequal treatment, nor does it necessarily suggest how to move forward and correct for bias. Many physicians expressed displeasure with how their judgments and behavior translated into disparate care. Yet many were unsure how to change things. For example, a white male doctor (033) noted that he found his paternalism “bothersome and I feel uncomfortable about that often, and I’m not entirely sure how to make it better.” Awareness of how bias can be enacted is perhaps a necessary foundation for further engagement in processes of reflexivity that work to counter bias and result in more equal treatment.

Reflexivity

[white female]

003: You have a two-year time period to try to make a difference, and I think - the goals of the Peace Corps are informative. It has three goals: one is to accomplish something while you're there, another is to learn something about the community, and the third is to learn something about yourself. I think those apply equally well to medicine, and that we forget, we're all caught up in accomplishing something, curing the disease, fixing it, and we forget that we're supposed to be learning about the patients and about ourselves. You can't be a good physician without those other two components.

In the narratives of disparities analyzed for this project, physicians often commented on how they learned to see patients in ways that were more relational, and less based on social prejudice and stereotypes. Central to this learning were processes of reflexivity—conscious awarenesses of social location and how social location influences production of knowledge. The areas of inquiry for the original study focused on better understanding how physicians can contribute to disparities. Yet, moments of described reflexivity consistently emerged as physicians looked to their own attitudes and behaviors to better understand the processes in the medical encounter responsible for unequal treatment. Moments of reflexivity tended to emerge in the narratives as commentary on how physicians understood their social location and subjectivity to influence production of medical and relational knowledge. Several narratives appeared to involve more extensive accounts of how reflexive learning can operate to effect more equal care, in the clinical encounter and at the level of the institution and community. Processes of reflexivity, as described in physician narratives of disparities, appeared multidimensional, with different dimensions appearing to intersect in different ways in various described moments. Two main themes associated with reflexivity appeared to emerge in the

narratives: conscious awareness that leads to inward-looking efforts to question assumptions, termed *encountering and countering bias*; and *connecting to and with differences* by seeking to enter a patient's subjective world, to better understand each patient's unique reality even if very different from one's own, and to overcome barriers to gaining this knowledge. Processes of reflexivity appeared motivated by dimensions involving emotionally based understanding of the operations of distance and connection, a sense of personal ownership of attitudes toward patients, and a conscious desire for accountability for personal attitudes and behaviors contributing to and correcting bias.

Encountering/Countering Bias

In order to counter bias, one first must be aware of bias and aware of how it operates. As one [white female, 001] physician noted, "I don't think it's consciously that I'm doing it, but I think you sort of do it." This doctor seems to distance herself from what she does not apparently do consciously, speaking of herself in the second person when describing a vague sense of what "you sort of do," in contrast to her phrasing "I'm doing it." Ownership of bias—an ability to see thought and action operating within oneself and then to take responsibility for it—seems central to awareness of bias.

In the previous section on narratives of bias, awareness of biased thought and action was a precondition for doctors describing their actions in the ways that they did, and in narratives that suggested how doctors became aware of bias, they appeared to become aware of bias in different ways. When one doctor realized she was distributing her e-mail address to some patients and not others, she was able to compare her own

behavior across situations. Other doctors, similarly, were able to realize awareness of bias because they were able to compare the differences in the ways they made medical decisions, or to compare the differences in which treatments they offered patients. One doctor used an imagined preferential connection, a consideration of how another doctor's college-aged daughter would be treated for the same presentation, as a way to confront bias and offer treatment to a Dominican patient that led to the diagnosis of a previously undiagnosed multiple sclerosis. Some doctors were able to realize their own bias when something a patient did or said "surprised" them.

Perhaps one barrier to a conscious awareness of bias, aside from what one is able to see in a situation, is a rather strong emotion: shame. One [white female] doctor describes how people "don't want to have" racist assumptions because awareness of having these assumptions carries with it so much shame.

020: I think we're all racist. I think that's just the way it is, and that you have to – and yet we're all smart enough and probably for the most of us, liberal enough to think that's wrong. And you're afraid you're gonna say the wrong thing. But you might, you might really blow it.

... I: The thing about the second and – I just wanted to go further into what – as you've got the conclusion now that it's really hard to teach on this subject or to make changes in clinical experience and practice, because on some level we're all racist.

020: And that you feel ashamed about that. You don't want to have these assumptions, or stereotypes. But I think they're there in all of us.

Above, the doctor suggests that when people see, and perhaps own ("have") racist assumptions, shame is an inevitable outcome. Perhaps in her attempt to move beyond shame, she suggests that people realize they are not unique in their capacity for holding racist assumptions. This doctor also suggests that when people do realize they have racist

assumptions, they hold back out of fear, whether for good or ill—people are “afraid” they don’t know the best course of action, and are fearful they will do the wrong thing.

Even when people are aware of bias, such conscious accounting of bias does not necessarily mean that it is owned or translated at all into more equal care. Some doctors appeared to put the onus on their patients to “prove” their symptoms, when it was biases on the part of the doctor that led chief complaints to be disregarded or disbelieved. Other doctors appeared to put the burden of proof on the patient to show capacity for engagement or agency, when it was the doctor’s bias of paternalism that assumed such patients were not capable of caring about their health or about advanced technology to begin with. For many of the reflections on bias presented in the earlier section, it appeared that only in retrospect, in response to the interview questions, did physicians re-examine their exchanges and identify situations betraying bias. At the time these interviews were conducted, the medical profession was engaging the topic of physician contribution to health disparities in the face of growing objective evidence, and this changing climate also contributed to physician reflections about their own bias. One [white male, 006] doctor, when he clearly realized he held negative assumptions about his Haitian patient, stated, “...this guy didn’t undo the framework that I had. He didn’t-- I’m open to someone undoing the biases. He didn’t undo them....” Of course, it is in the nature of racism, sexism, and other social biases that it takes little or no data to confirm the “framework,” making it highly unlikely that the “someone undoing the biases” can be the patient from the stereotyped group.

Once awareness of the presence of bias is achieved, what is a next step? Perhaps doctors need to be able to “undo the biases” for themselves, by learning about their own internal resources for countering and correcting harmful biases. Putting the burden of proof on oneself, and owning not only bias but the responsibility to correct for it, seems central to effective processes of reflexivity. One [white male, 011] doctor seems to realize how important it is for him to learn how he can enact more equal care, saying, “And as a white boy myself, I feel I probably should be on the side of the student rather than on the side of the teacher.” In this statement, the doctor seems to suggest he realizes he has a lot to learn—and is able to see himself as a student and as rather young, perhaps (“boy”), in this developmental process. One [white female, 025] doctor expresses some ownership of her role in creating disparities, and expresses a desire to learn but also a sense that she has no idea how to go about engaging in this process of learning: “I think it would be very interesting to know why these health care disparities exist. I want to know. I’m afraid that I’m a contributing factor and just have no idea.”

Awareness

Physician narratives suggested that once people are aware of how bias operates, to whatever degree, it is possible to make efforts toward guarding against letting bias impact medical decision-making. The theme of awareness is characterized by a basic attentiveness to bias operating within oneself, during a medical encounter. Such awareness of how bias operates, when accompanied by felt or understood ownership of bias, can lead toward efforts to counter bias.

In the following narrative, a [white female] doctor explains how awareness of how bias operates can lead to efforts to counter bias.

028: I think we all fight against atypical chest pain, particularly in women, and I think it can happen in some populations more than others, so I think I've seen people trying to really be sure that they're not dismissing something based on a history of prior experiences where it wasn't something serious. I think it happens with adolescents all the time, assuming that there's some risk behavior that led to whatever their problem is. It's always there to a certain degree. If you're aware of it, you can try and guard yourself against it. But there's also something to the fact that part of your education is to recognize patterns and to try and recognize patterns and identify them, so it's not that you ignore them, but you have to realize where they're coming from and what evidence supports it and what evidence doesn't.

Above, the doctor suggests that countering bias involves an ability to also be aware of where the bias is “coming from” in processes of medical pattern-recognition in order to better weigh evidence. This awareness is especially important for groups such as those mentioned here, women and young people, who are considered inept judges of their own experience and subject to the bias of paternalism. This physician suggests that to “guard yourself against” such biases, awareness of bias and how it may operate becomes an important precondition. Further, she cautions against recommending that one must somehow “ignore” the kinds of patterned thought that can include bias, and instead emphasizes the importance of motivated reflexivity required to “try and recognize” bias in order to deconstruct and counter it.

Below, another [white female] doctor explains how awareness of her own subjectivity—subjectivity that includes bias—leads her to make continual efforts toward conscious awareness of relational dynamics in a way that presumably guards against unequal treatment.

002: Yeah, that's true. I think people think of themselves as enlightened, and people are very polite, and on the surface everybody believes that what they're doing is delivering high-quality medical care to every patient that comes to them. I think that's the self-image of the institution and the providers that work there. But I think - it affects - I think of myself as at least awake to these dynamics in my own life and my own relationships, and I'm aware that it affects every relationship that I have in the hospital, that I'm always conscious of where somebody's coming from, and I am aware that because I'm aware of that I'm behaving differently. I probably tend to overcompensate by being particularly gracious and over-indulgent with patients that I feel might be predisposed to feel disrespected.

Above, the doctor describes how her awareness of how her own subjectivity impacts relationships with others leads her to be “always conscious” of the subjectivity in others. In the quote above, she is using her awareness of the ways others can be unaware of how their own subjectivity operates to remind herself to be more watchful, since “most people think of themselves as enlightened,” including herself. While it is unclear how effectively she is able to evaluate others’ subjectivity, she does seem to appreciate her own capacity for bias due to initially unacknowledged subjectivity, and to search for evidence within herself to counter potential bias, rather than putting the burden of proof on the patient.

In the following narrative, a [white female] doctor explains how her awareness that she is not taking a patient’s symptoms seriously leads her to search for evidence within her own life to help her better appreciate what the patient is saying, to put herself in her patient’s place speaking to a physician and trying to explain a symptom that doesn’t seem to make medical sense. Here, this tool of personal awareness appears necessary for countering potential bias.

008: You know, trying to sort for myself, whether that was my own, my own assumption overlay, that when she describes symptoms, that, I wish I could remember some of the

words that she used. But she seemed to describe some of the things that in her mind was very clear to hear what the symptom meant. And it didn't make any sense in my medical framework. And she had an accent. So, maybe it was my own construction of, you know, my own thought, like, "Oh, she has more traditional beliefs" or, not even traditional, but just different. I'm trying to think, and I wish I could come up with a specific example but I can't. I can hear her voice in my mind, but it's more the emphasis in her telling me with a certain look on her face that she feels a certain way, but it's not-

I: And she knows exactly what she means by the symptom, but you're not sure what she means and not sure what to do with it, right?

008: Exactly.

I: How to explore it, or how to make sure it's, even what, even what category, it sounds, yeah. I think I get it now.

008: It's interesting. I've subsequently learned that some of the stuff that I thought didn't make sense to me, well, have made sense. For example, she would tell me, she didn't like to take her insulin sometimes because it would make her feel bad, and when her sugars were not low. I've subsequently learned that people who have chronic hyperglycemia, can feel symptoms of hypoglycemia with normal glycemia. So—

I: It's just low for them.

008: Right. And so you know, my interpretations of what makes sense are imperfect.

...

008: You know I feel myself aware of that reaction myself, and at times knowing I that I need to put it aside. Because I think about my own experience, like for example if I go for a long run, and get winded, my gums hurt. And not that this doesn't make any sense, I could sort of come up with how it might make sense, that's, you know, my - that's where I feel (ischemic) or something, but I know it happens all the time, and it, and it makes some type of sense for me. And sort of keep that type of thing in mind because-

Above, the doctor is able to find evidence within her own life for how symptoms even she experiences may not immediately or easily lend themselves to making "sense" medically. She is able to translate this knowledge into an awareness for how her "own assumption overlay" may prevent her from taking her patients' experience seriously. She appears attuned to awareness of her own subjectivity within a medical encounter, and

appears able to evaluate her own subjectivity, noting “I feel myself aware of that reaction myself, and at times knowing that I need to put it aside.” In evaluating her own subjectivity, the physician appears able to consciously reflect on how and why her reaction might be misguided, by reminding herself of evidence within her own experience for how symptoms might not immediately make medical sense, yet still be quite valid, keeping her own experience “in mind.”

Another [white female] doctor describes, in the example below, how she is able to consciously compare her behaviors across medical encounters.

018: I take care of different groups of patients better because I'm trying to be aware of what I do for different groups, and why don't I do that for them? And most of the time I should be doing it for them too.

Above, the doctor describes how, after she is able to make a conscious comparison of her behaviors across situations, she is able to then question herself and hold herself accountable.

Physician narratives suggest that awareness of one's own subjectivity is a necessary precondition for guarding against bias enacting itself in medical treatment. Physicians describe how, once they can keep “in mind” awarenesses of their “own assumption overlay,” they can then make choices about whether and how to compensate or “put it aside.” Seeing bias is suggested as a necessary step to counter bias. In order to see bias, physicians must not “ignore” or avoid their thoughts or their own subjectivity, but instead must be motivated to pay close attention and “try and recognize,” “trying to be aware.”

Questioning Assumptions

An ability to question oneself and to also question one's assumptions about patients appears to intersect with awareness in processes of reflexivity that lead to efforts toward countering bias. The theme of questioning assumptions is characterized by an ability to, once aware of one's own subjectivity and how it may impact what one sees, keep that subjectivity consciously "in mind" in order to make choices about how assumptions might be countered. While awareness might be considered a process of "encountering" one's subjectivity and potential bias, questioning assumptions might be considered processes of, while encountering subjectivity and bias, searching within oneself for evidence to then counter bias and to know when to put aside assumptions based on bias or lack of knowledge.

In the narrative below, a [white female] doctor describes how, in order to engage in accurate diagnosis, doctors need to question assumptions.

008: Right. And we're always, whenever you're, I mean the whole, the whole process, the whole diagnostic process rests upon (separating) the wheat from the chaff. And I think that you can't go forward without using that tool. However, you know, that tool, cannot - you have to know when to put it aside. I mean, it's like anything; pattern recognition. You can't, you can't, you can't function in life if you can't make assumptions based on certain patterns. However, if you don't know how to discount them, or put them aside and question them, you, then the extreme of that is unrelenting bias or prejudice.

Above, the doctor notes that making assumptions about what aspects of patient knowledge are valid for diagnosis is a key part of medical decision-making, but that when people cannot see and then question or discount their assumptions, the extreme result is "unrelenting bias." This statement suggests that, perhaps a less extreme version of not questioning or countering assumptions is therefore a more subtle bias or prejudice.

In a continuation of the narrative above, the doctor suggests that assuming “too much” about anyone may not be a good idea, in a medical setting.

008: Um...(big sigh)...I think, well, I don't know if this is a con that arises from decisions made on how to present it. I think it's sometimes hard to, get people to think about these issues in an open way just because I think people tend to have emotional reactions or feelings of defensiveness. People don't necessarily want to contemplate how their biases or their - things that they are not aware of or mindful of - might make them less ideal doctors, for certain people. Um, in, you know, I don't know how to get around that. One thing I've thought is, in, at that conference - everyone - cultural competencies were coming up in this way. That, that doesn't necessarily relate to knowing about a specific culture, 'cause there's a million specific cultures 'cause there's a million specific cultures that one might need to know about, and in my opinion, well, that it had more to do with a certain awareness or openness that there are - there's a cultural context for each person that they bring to the interaction. And certain things are very identifiable and problematic, in terms of being prone to your misunderstanding them or vice-versa. But there's a lot of - I guess I find it more useful to think of it in a broader sense. Even the person who, I think looks like me, and I might think, thinks like me, that there are - even things within family cultures - it may be a better, it may be better not to assume too much. In that interaction. I don't know, it's kind of vague,

Above, the doctor seems to contrast contextual matters that are “very identifiable and problematic” with perhaps more subtle and vaguely-articulated, less clearly-identifiable matters that may impact a medical encounter. This doctor appears to question assumptions she may make even about people who are like her—people who presumably are more accurately portrayed in her assumptions—because she is aware of how much she does not necessarily know.

Similarly, in the narrative below, a [black female] doctor explains how she doesn't “assume to know that I know” the life experiences of people who share her skin color.

019: Yeah. I think clearly the experience of being black or African American in the United States helps you relate to patients who are black in the United States. I think

that's a common thing. There's a core set of assumptions that no matter what class you are, for the most part you have some common level of experience. That certainly helps. I've talked about that in that there may be more benefit of a doubt extended to that person, a little bit of a level of trust, although within some room for error there. I don't have a good answer to that question. It's hard to say. I would not use the word, in my case, relate. That would imply that I grew up poor - I don't assume to know what my patients' life experience has been, or what their culture - what I try to do is not make assumptions. I don't think I assume to know or to understand what their experience has been, because I think everyone's experience is so different. We may - you may take two black people from the same - everyone's experience is so different. So I don't assume to know that I know what their experiences are.

Above, the doctor describes guarding herself against making assumptions about the life experiences of her patients. She emphasizes that her own awarenesses of complexities of her own subjectivity help prevent her from making assumptions in the first place, about patients who share her skin color but not her social class. As this doctor is African-American, this example of “not making assumptions” is not meant to suggest that “color-blindness” is possible, but rather that a keen attentiveness to one’s own subjectivity may be especially useful in reminding physicians that patient experience is complex and is something that requires more than facile understanding, and is something that does not lend itself to insight based on immediate assumptions. In this example, the physician, after recognizing that “there’s a core set of assumptions” about African-American experience, is able to put aside any sense of certainty that she knows the life experience of her less-economically-privileged patients.

Physician narratives that touch on the importance of questioning assumptions tend to emphasize a keen awareness of one’s own subjectivity as a precondition for questioning and then putting aside knowledge based on the assumptions that may come most quickly to mind. Physicians who spoke to the importance of questioning

assumptions also seemed to link the questioning of assumptions to seeing a complexity inherent in each individual's experience—even for people who might appear on the surface to be like them.

While awareness of one's own subjectivity may be an important precondition for questioning assumptions and then putting assumptions aside to counter bias, awareness itself—of complexities of others' experiences, for example, or of greater understanding of the complexities of one's own subjectivity--appears also to be a product of questioning assumptions. Encountering one's own subjectivity may be an important precondition for seeing complexity in a patient, suggesting that processes of reflexivity are important for new knowledge to emerge in a more relational medical encounter.

Connecting to/with Difference

The empathic challenges and joys involved in meeting others where they are, of “walking a mile in another's shoes,” have been addressed in multiple literatures. Indeed, these challenges and joys are viewed by many as central to living life. Among the best known, moral philosopher Martin Buber wrote about the relational rigors and compelling ethics of moving beyond a human relationship stance in which we regard only ourselves as subjects and others as objects, or “I/it” relationships, and moving toward regarding others as equal subjects of their own experience, or “I/Thou” relationships. Within medical encounters, physicians from different specialties and training traditions differ in how much they value empathic connection as a source of medically meaningful knowledge, as in the medical humanities approach, or view it as a potential impediment

to successful delivery of care as in more technological approaches to the “culture of medicine.” The challenges posed by emotionally-based or empathic connection as sources of physician knowledge are intensified by the demands of diagnosis, time, and other factors that make such encounters inherently fragmenting, inadvertently silencing, and can dehumanize. Physician narratives spoke to the requirements of both encountering one’s own subjectivity, and awareness of how bias operates within medical encounters and within processes of medical decision-making. In the following section, physician narratives speak to further strategies for connecting to and with difference to make knowledge gained within medical encounters more based on relational give and take. These strategies build upon awarenesses and the relational space such awarenesses create as doctors strive to better meet patients where they are.

“Understanding”—Entering a Patient’s Unique Relational World

Physicians described the importance of, in the words of one physician, better “understanding” a patient’s unique subjective world. From a purely medical perspective, a [black male, 034] doctor explains how “so much of our work involves trying to feel what the patient is talking about, or trying to get a sense of what the patient is talking about.” Better understanding what a patient is talking about is facilitated by better understanding a patient’s perspective and a patient’s subjectivity.

In the following narrative, a [white male] doctor describes how he makes efforts to understand patients who he feels he has “not sort of had a good connection with.”

033: I think the best combat for any of this stuff, is sort of trying to develop appropriate relationships and listening to what they have to say, and those sorts of things - and so I would hope that - I find that the people I find myself explaining things to are people that I have not sort of had a good connection with, through the process, and, I'm not certain how that relates to race. You know, ideally, I think that there are some initial, there may be some initial barriers, but that my hope is that by treating somebody with respect, and treating them, and listening, and understanding their situation, that by the time when we get to a course of action, we have made that connection, and that it doesn't take a lot of extra, and maybe that's why I'm always late, is that I really try to do those things.

In the example above, the doctor shifts from the first person “I” to “we” when he, after describing his own actions of listening, explaining, and treating someone with respect in efforts to “understand their situation,” speaks about how “by the time when we get to a course of action, we have made that connection.” He speaks about developing individual relationships appropriate to a medical setting, but relationships nonetheless.

In the following example, a [white male] physician emphasizes the importance of seeing people as individuals.

006: Exactly. But I would like to see cultural competency be looking to see, what's this individual's culture? Who lives in this society, yes, yes, yes, but also what's - we all have a unique culture in a way. I would want people to become competent in learning people's individual culture. Not how does she fit in her culture, but break the framework and build a framework. The model of, if somebody could walk around inside of you with a flashlight and see how does it work? Completely go inside of you to see your model.

Above, the physician contrasts an extreme of seeing someone only as a function of her culture with seeing someone as having her own unique subjectivity. He seems to suggest that, in order to gain a better understanding of that subjectivity, a framework must be first broken and then rebuilt, suggesting that a previous framework might involve some kind of knowledge that would impede new understanding without the previous framework being somehow dismantled.

The physician's "framework" is not invisible to patients. In the following narrative, a [white male] doctor explains the importance of understanding a patient's world enough to understand how a patient's perception of physician attitude—or the patient's perception of the kind of preconceived mental framework a physician may bring to the clinical encounter--may impact the patient's presentation of symptoms.

026: Yeah, I think that, again, the stereotype is that people Latino or Hispanic backgrounds are very vocal in expressing their pain. What I've also noticed and it's probably just anecdote. It often seems like socioeconomically, poorer patients try to overstate the amount of their pain because they are trying to get you to believe that they actually have pain. Even you walk into the room, and before you even said anything I think they've assessed whether or not they need to make you believe that there is actually something wrong. So, they'll have a perception of how they're gonna be treated.

Above, the doctor appears to realize that how patients present may be, in part, a function of how they assess physician attitude even before anything is said verbally in the clinical encounter. Indeed, the psychology research literature tells us that people are quite adept at implicitly "getting" nonverbal cues associated with attitude. This physician, with this realization, appears better able to deconstruct a stereotype about Latino patients over-expressing pain. He appears to do this by claiming ownership of, rather than blaming the patient for, a situation where patients may over-express symptoms based on what his own attitude may be or how he may be perceived.

In the following narrative, a [black male] doctor suggests that his understanding of and how he relates to Latino patients is based on knowing the Latino community, as opposed to operating from a framework based on not knowing the community

021: Oh, how you relate to each one. From working in East LA I kind of have a real good understanding of Latinos, Latino people in general. So they're very easy people, they're not hostile people. They're very respectful people. So I just kind of approach

them in that manner. They're very stoic. Given that they can be very stoic, I try to be real careful about seeing them, examining them, and working them up. As much as people talk about this racist terminology, Hispanic panic - I don't see a lot of that.

I: I haven't heard that term. I hear new terms that describe the same thing.

021: Hispanic panic, ay yi yi, all that kind of crap.

While this doctor appears to have created a framework for himself to describe a community, this framework appears based on exposure to, comfort with, and knowledge of that community. The physician here does not seem to be in a position of having to break down stereotypes that may stem from lack of exposure, lack of comfort, and lack of knowledge. It is unclear whether patients may sense his respectful attitude and therefore present as more “stoic.” Regardless, in contrast to the behaviors other physicians have associated with Latina patients, this doctor explains how “I don’t see a lot of that.” In addition, in this narrative, he has recognized the bias encoded in the terminologies of “Hispanic panic” or “ay yi yi” which physicians use to minimize the presenting symptoms of Latina women, as discussed in the previous section on bias.

The theme of respectfully attempting to understand a patient’s subjective world is, in the narrative below, linked by an [Asian male] doctor to a motivation to know and interact with patients in a way that goes beyond medical diagnosis and treatment, in a primary-care setting.

009: Because, I think being a clinician, especially those of us in primary care, for those of us who really enjoy the interaction, the interpersonal interaction with their patients - it's much more than just being a good student diagnostician and up to date on modern therapeutics. We want to interact with the person, and sort of take care of the whole person, if we can, within the constraints of time and money that we, you know - financial constraints that we all face. And if we don't, if we're not able to do that, even under those

constraints, then somehow for me it feels like I'm not doing all I could be doing, and would want to do for a particular person.

...

And it sounds like in your clinical setting, it's sort of a local culture in your clinic about how to deal with patients. Any patient. Regardless of where they're from and...when you said for the most part, suspicions and guardedness get overcome. What do you think it is that overcome that in your practice experience?

009: I think it's just getting to know each other. And I think there's - you have to just get to know your, each other, the patient has to get familiar with the clinician, vice-versa, and you know, just showing common respect for where they are coming from. Answering their questions. Doing your best trying to understand things from their perspective. That takes some effort. You just can't be typing away, or writing your notes and saying, "Okay, here's your prescription, bye." And make very cursory eye contact with a person. I mean, sitting across the table where, from your (stool) to your examining table. And looking at them, and talking to them, and respecting their questions and their concerns. So, I think that kind of interaction almost always seems to overcome the barriers.

Above, the physician suggests “getting to know each other” as a solution for overcoming guardedness on the part of a patient, and explains that respect combined with effortful attempts to “understand things from their perspective” in a clinical encounter can, in his view, work to overcome potential barriers. This narrative suggests how affect—“enjoy the interaction”—and accountability—wanting to “take care of the whole person” despite the constraints of time and money, and feelings of “not doing all I could be doing”—may impact a doctor’s ability to interact with and better understand a patient as a unique individual, which itself guards against medical errors due to “pattern recognition” that becomes so rote an important element is missed.

In the following excerpt, a [white female] physician suggests how home visits may facilitate the kind of interaction that allows a doctor to better understand a patient’s subjectivity.

004: It's a profound feeling, entering into someone's home and realizing the impact you can have just by knowing where they're coming from and by developing a trust and a level of interaction that you could never achieve in an office. In addition to all the other convenient things like bridging barriers to care and the obvious things, it's really profound for both the patient and the physician. So not only is it necessary, but it creates an entirely different interaction which I find invaluable. I love it. I think that's the model I prefer to work in, in addition to being a hospitalist as well.

Above, the physician comments on how being inside a patients' home creates a whole different "level of interaction" than could be achieved, in her view, in a medical office. This doctor, like the previous doctor, suggests how affect—in this case, "love" of work when she gets to interact more closely with patients—may drive the model of care she prefers to work within. This doctor also suggests that a sense of accountability plays a role in seeking out home visits; she realizes the "impact" she can have with the kind of knowledge gained from meeting someone where they are in their home.

Narratives of better "understanding" each patient's unique world involve physician motivation to engage with a patient where she is, and also involve physician motivation for and capacity for entering a patient's unique world by providing space in the encounter for new knowledge to emerge. Such efforts toward understanding seem to emerge within dialogues that involve, on the part of the physician, relational listening, perspective-taking, and more experiential knowledge of communities.

Physicians described the importance of seeing their patients in a way that promoted a sense of equity in an interaction. Equity involves respect, but goes perhaps beyond that to restore or create a more equal balance of power in the medical encounter, in attempts on the part of doctors to bridge difference, enter a patient's unique world, and value knowledge based on the patient's world and experience. The medical encounter is a setting where, perhaps compounding the power difference in assigned roles of doctor and patient, a doctor's elevated position in the larger social world tends to further minimize the power of a non-MD patient. Reflexivity involved in bridging these power differences, in attempts to better meet patients where they are, was characterized by physician motivation to move toward equalizing disparities in knowledge and power, and to demonstrate more equitable valuations of a patient's personhood. These processes counter the biases associated with paternalism, in which the patient is assumed not to know enough about their own experience to contribute to decision-making and treatment follow-up.

In the following narrative, a [Latino male] doctor describes how working in his dad's tire shop as a child influenced how he interacts with patients.

031: And I learned so much about life. I learned that you need to talk to people like people. And that's what medicine is grossly lacking. That doctor's standing on a pedestal, and talk to patients, and that's why I think that I'm viewed as unorthodox, and that's why sometimes, other people, like at [hospital], or even here at [hospital], they can't understand how I talk to people, and I think honestly, they're envious, because they can't do that.

I: Just hang out and talk to people.

031: They can't talk to people regular. They have to talk to people like a doctor talking to a patient, whereas I from an early age learned to talk to people like you talk to people.

...

031: Well, I think - I realize that some people, like patients, some people want to know everything that you're doing. Some people don't care. They just want you to finish. And I learned that early on you extend to them, you explain to them what's going on, and then you look for cues, as to whether they want more or less information. The other thing that I learned, is that if you treat poor people the same way that you treat rich people, that they will always come back.

And that you never talk down to anybody, regardless of where they're from. And that my dad taught me, because he said, he was always telling me, "[name], we get \$6 dollars for fixing a flat whether it's on a Mercedes or whether it's on a shit bag." So it doesn't matter really and so, and he would always say, to the people that were working there, with me, "They are paying our food, so we have to take care of them," and so I always felt that - and my dad would never turn someone down if they needed, like, if he closes at 6, but if you came at 6:05, he would take care of you, and that has influenced me a lot.

Like in my clinic if they dump extra patients on, I keep seeing them. And then the other thing that I learned from my dad, is that my dad was selling a product which was fixing a flat or selling a used tire, but really the difference between the product he was selling, and the product the other people were selling, 'cause there were other tire shops in the area, and they all fix flats. There was no difference between the patches we put on tires and the patches they put on tires. But people would come back to my dad, and I realized early on that people would come back to my dad because of the way my dad treated them, so the product that he was selling was not only the tire, or the patch, it was him.

...

031: So, the other, the only other thing I learned from them, is that the moment you show arrogance, you lose all credibility. So you can't be a dick.

I: Can you remember learning that kind of young?

031: (he may be nodding yes)

I: Yeah.

031: And it was something that I was exquisitely aware of. Because I'm telling you, by the age of 12, when I would go there, whatever, I knew that, I knew more than anybody there. Like these people, some of them were illiterate, like they could not - and I knew that I knew more about technical things, math, science - I knew more about the way the world worked than they would ever know. But I couldn't, I never wanted to be - I never wanted to be the boss's kid. I wanted to be just one of them. And so I worked hard to

gain their respect on their playground, so I would work to change tires as fast as I could, keep up with them, and they respected me, that I respected what they did, enough, to try to keep up with them.

In the narrative above, the doctor describes how he learned valuable lessons about not only respect, but about humility and extending equal care to everyone from watching and modeling his father. He contrasts the behavior of doctors who speak from an elevated position of power, “on a pedestal,” with his goal to “talk to people like people” and, in effect, work to equalize power differences. From an early age this doctor became “exquisitely aware” of how others might, by virtue of his elevated knowledge, view him as arrogant. His motivation, though, from an early age, was to be respected and “to be just one of them.”

In the following narrative, a [black female] doctor describes how she connects with her patients in a community health center.

010: You make yourself like a human being to them. You make yourself not on a high doctor pedestal, like a human being with problems. And some patients come with infertility, and they're very suspicious, and I tell them [unclear] then it was 8 years. And I have been. But I'm trying. I keep on trying. Just because your blood pressure isn't 120 / 80 doesn't mean you should stop. You should keep on trying and believing that one day your blood pressure will improve. Once you give them goals, you tell them, this is how I want your blood pressure to be. And I will say the top number, usually for diabetics, must be lower than 130. The bottom number must be lower - you have to say it like that. You can't say blood pressure 130 over - systolic and all that - they don't know what you're talking about. Why? I give them the example of a pipe. You see, it all has to be very graphic - of a pipe that is not made of something really rigid. So if the pressure is too high, it might burst. I say, it bursts in your eyes, it bursts in your kidney - it doesn't really burst in their kidney, but that's the only way I can get them. But when the pressure is like this, the pipe will not burst. They understand that. But they sort of don't - with the ones who have coronary artery disease, a pipe, and things get in the walls, they just get thinner and thinner and thinner until there's no blood going to your heart. You have to put it in that form of words. You have to give them personal examples from your life. For me, prayer was one of the ways I really bonded. To pray with a patient. I think it sort of went around. But if it's something that is unacceptable, I feel as though American

physicians say you're not supposed to bring your spirituality into your conversation. When someone comes to you and you say, have you prayed? Even if they are religious, they [interviewer coughs] For that reason - you don't have to be a Christian. You just need to - because a lot of them are very spiritual people. That's one advantage that we African doctors - another thing was touch. You hug patients when they do something that pleases you. The Haitians love kissing. They call you dearie, they call you endearments. A patient comes and their blood pressure is controlled for the first time. That's worth a hug and a kiss. That's a way of building up that trust. I think I came away from the community health center with the realization that once they trust you and they feel that you care, they will comply. They will go to [name of hospital] for their colonoscopy, no matter how many times it's canceled.

I: For you.

010: For you. You can get them to - I had the health records of people having mammograms, people having Pap smears, people who were willing to wait the whole day at [name of hospital] to get their drugs, because they knew I cared about them.

Above, the doctor describes doing a number of things to equalize power and knowledge in the medical encounter to better connect with her patients—and to “make yourself like a human being to them.” For this to happen, she sees herself as having to step down from “a high doctor pedestal.” She adjusts how she explains her medical knowledge based on how the patient understands his or her own body. She also engages in prayer with her patients when appropriate, and hugs them. Her efforts to connect with her patients seem to show them that she cares, and perhaps create and strengthen a treatment alliance; in her view, knowing that she cares appears to make her patients feel more entitled to or deserving of care in the face of structural barriers.

In the following narrative, a [white female] doctor sees her efforts toward equalizing knowledge in medical encounters as not only a job, but a “duty.”

025 ...the information I need. I get so frustrated when I ask someone, how long have you been sick? Oh, since the day after my son's graduation. That's not helping. It's not

helping. I get all frustrated. But now I realize that I have to - it's my job, it's my duty to be able to ask the questions in a way that the patient can understand.

...

025: Patients who are less trusting, patients who are less intelligent, patients who are just quiet. Some people just grew up in houses where you just didn't talk. I've seen residents or interns go in and say, so tell me about your siblings, and if the patient doesn't know what the word siblings means, it's sort of embarrassing to them. Patients don't often want to say, can you explain that? I don't know what that means. They'll just make something up or answer the question wrong or answer what they think you're asking. So I don't say that, I say, are your brothers and sisters well? It's much easier.

I: And if they say something that's misunderstood, out of embarrassment and politeness they won't correct the doctor. They'll just let it ride, that misunderstanding. If they say something and the doctor doesn't understand exactly what they meant.

025: It's like, I'm not a computer programmer, and people start talking about jpegs and tif files, and you want to understand, especially if it's a person who's another professional. If you're talking in medical terms to them, they think, I'm smart, I should know, I should be able to talk to this person!

Above, the doctor claims ownership over engaging her patients in discussion and asking questions “in a way that the patient can understand.” She appears aware of what may be going on in a patient’s subjective world, and she even imagines how it would feel like for her to be around people who speak about computer programming, a language of knowledge she does not understand.

Seeking out and valuing knowledge from others on the medical team who are in lesser positions of power—and making them feel comfortable or equal enough to question medical knowledge and authority-- is seen as an important mission by a [white male] doctor, in the following narrative.

005: You've got to make sure that the registration personnel pass that along to you. There's a whole program called teams training that originated in the army helicopter service. They were having too many crashes and they found out that the co-pilot would notice that they were low on fuel or close to the ground but he felt inhibited telling the pilot who outranked him and was in a bad mood, and the same thing happens all through

the hospital. There are these low-level people who just were told the answer, and are just shy about telling the person who's got to make the next decision. So for registration people to come up and tell you oh, I saw this in his pocket, or his brother told me this in the waiting room or so on. You need to encourage a culture where everybody feels safe telling everybody else stuff, and the nurses will challenge - I've never given this drug before. Will you explain this to me a bit? Or, I'm not sure that's the right diagnosis you're pursuing because I overheard this conversation in the waiting room. I do everything I can to encourage people to relay that information and not be the omniscient doctor. I've had my ass saved so many times that way, with random information that came in from an unexpected source.

I: In addition to access to different information, there might be other things also?

005: Oh yeah, the nurses think of themselves as the patient advocate and they always come to the doctor and say the blood pressure's a little bit low, the heart rate's low. I like that. I should be able to explain to them why that's okay and we're not doing anything about it. If I can't reassure them, then I should think twice. Part of the teams training is the two challenges rule. If somebody challenges you twice, you have to respond to it. The one eyeroll - if somebody rolls their eyes, ask them if they have a problem with it. Don't just gloss it over. Use the whole team you've got. None of us is as smart as all of us. You get this wonderful spy system, with everybody feeding you information.

This doctor describes his motivation to “not be the omniscient doctor” not necessarily because he cares what others think about him, but because he realizes he does not hold all the knowledge necessary for the care of his patients—seeing others as equally knowing is the best way to enact effective care and best medical practices. He describes how he truly values knowledge from medical staff in all walks of power, and he appears to see himself as accountable to not just his patient, but to everyone on his team.

In the following narrative, a [South Asian female] doctor describes the importance of not only seeking out and valuing knowledge from other people on her team, but also from people in the community she serves.

012: Like the problem with doing literal translations rather than cultural translation, is that literal translation assumes we know the questions to ask. Or we know how to understand what someone is saying back to us. And what we have in our clinic is actually - we have a group of providers - ancillary staff, who are available within 5

minutes of you asking for a translator. Which is for most of our major languages, including Spanish, Cape Verdean, Haitian Creole and Vietnamese. Who work more as partners with you. [Name] has worked here, you know has worked in health care for decades. And within 5 five minutes of her entering a room, if I choose to let her have the power to do what she does best, which she is passionate about, which is health education for this community that she's known and worked with for decades. Then I gain an incredible ally so that - there's so many times - like whether it's someone coming and they're taking a home remedy, and she'll tell me what the ingredients are, because she knows what those are.

I: Unbelievable.

012: Where there's something like that to something like this, where A, the patient feels known and connected because it's often the same providers and ancillary staff that works with the same patients whenever possible. But also they can uncover so much more information and explain things in a way that makes so much more sense for people. Because it's not, it's not just a direct literal translation. I find sort of working as allies with people rather than sort of top down approach is incredibly valuable in this setting.

...

012: The things - that's the thing - I don't think we know the answers. And I don't think we (overlap talking)

I: We have to go to the community and let them participate.

012: Right. We can be the assistance and allies with the community. But in the end, we can't know what a community needs nearly as well as the community does. And I think that development that's based on a community and what it needs is much more powerful as a process.

...

I: For a patient. They're not as high as for, you know, that person's cousin, to make the wrong choice. Or the community member to make the wrong choice for the community. So, the stakes are different.

012: I think you are absolutely right. And I think that if...I think that uh, more of patient care interactions should be about listening. I think that would help. But I think really, you know, recognizing that patients can have a lot to say about what can be done to improve their health. Really giving them ownership and power, and doing that can make a profound difference. Using community organization to help you achieve-

I: Achieve that-

012: Achieve whatever your goals are.

Above, the doctor speaks about how she lets an ancillary staff member, whom she views as a “partner,” “have the power,” and also speaks about giving “ownership and power” to people in the community. This doctor describes how she values knowledge of health educators, community members, and patients as superior to her knowledge in various ways. In this example, the doctor sees health educators, community members, and patients as having the agency to know and determine what is best for them.

In the following narrative, a [white female] doctor suggests how accountability, to patients and communities, seems to intersect in various ways with motivations to equalize knowledge, power, and personhood.

018: I'm really glad that I take care of some well-educated patients with other choices, because they make me do things that I then say, well, I'm doing this for this person, I'm describing the anatomic mechanism for this person, then I'm going to do it for my patient who can't read. If I think it's important for this patient, it's also important for that patient. But if I weren't forced to do that by the kinds of questions - just sort of a broad example - actually, illiterate patients can ask very complicated questions, too, but, okay, what's my accountability, if I do things one way for an educated patient, I'm going to do it the same way. By the same token, explaining things carefully in smaller than 25¢ words for patients who are not educated is sometimes what educated patients need too, because they're under stress and not using their educated brain all the time. There's a real - it works well.

Above, the doctor sees her illiterate patients as quite capable of asking complex questions, and when deciding how to best present knowledge in a way her patient can understand but without leaving out descriptions she may provide a more educated patient, asks herself, “what’s my accountability?”

In a continuation of this narrative, below, the doctor appears to elevate and seek out knowledge and ideas coming from patients. She appears to apply strategies of pattern recognition to communities based on understanding the communities very well, as

opposed to applying pattern recognition to communities based on cursory knowledge and stereotyped impressions.

...018: Over and over again, seeing certain kinds of patterns. So I think I have an understanding of what diabetes means in a context that I wouldn't if I had a sporadic handful of Dominican patients or whatever. And, because I can say, I have this great idea of something that will work - it's not my great idea, it's my other patients' great idea, they figured it out and told me so that I can tell another patient. Where does this wisdom come from? Not from me! It comes from my patients. So I can pass that on and I wouldn't be able to do that otherwise.

...

Below, the doctor appears to elevate the personhood of her patients, and seeks to instill humility in other doctors and to keep humility in herself.

018: ... a lot of people were wearing Justice for Janitors stickers, and my patients looked at that and they were so happy. 21 years that I don't have people telling me proudly about their work? That's terrible. That it's so hidden, something they feel like they do nothing compared to what I do. It's there and it is a big part of how people walk through the world and educate or advocate for their children. The disempowerment, economically and stigmatization-wise from the kinds of jobs that people have. I think, going back to the training session, class is very, very invisible. I think the pull is for medical students and trainees to take on the mantle. It helps them feel more comfortable in roles. If you don't know anything, you can look the part or talk the part, take on the jargon. Then you can feel more comfortable in that role. There's a downside to that, because you really do separate yourself, even if you came from there, and there are more people who did come from there, but there's not a major pull for people to stay rooted in where they came from. I certainly don't believe that because you were poor and went to a state school and then went to Harvard that you should go into primary care because it's your obligation, and everybody else gets to go to whatever, I don't think that, but somehow that everybody should understand that class pull.

I: It sounds like you're suggesting that class competency is an important part of cultural competency. You do a lot of training of med students. What are your thoughts about cultural competency training, using that term very broadly, and - it seems there are pros and cons to it.

018: I'll give you a little episode. One of my patients, may he rest in peace, was an ironworker. He built big buildings in Boston, and he literally sat on top of them and dangled his legs, high up in the sky, and he had an alcohol problem and he was in the hospital. He had esophageal cancer, but ended up dying of advanced liver failure. I was visiting him on Sunday and there was this herd of medical students, residents, whatever,

they wanted to see him and it was the usual disrespectful scene, putting him through the maneuvers, and I was standing there - it was disrespectful of me, too, I was trying to talk to him and of course he was encephalopathic and didn't quite remember who I was - but anyway, I loved this guy. They were doing all these things, and I said, do you know the Hancock Building downtown, and they looked at me like they were going to test me for encephalopathy! I said, this man sat on top of it. He built it. This man. This man built that building. Have you ever done that? I was just furious at them. It was an ineffective way of delivering the message [laughs], but when I have a longer-term relationship with people I try to talk about things like privilege and accountability and also just to try to make people's lives real, the parts of people's lives that they don't see or know about, so that - you can't respect somebody if you don't know who they are. I think you can do that on a one-to-one level, but it doesn't quite change the socialization, that that has to be at a program level, more systematic level where it gets reinforced. I think most people go into medicine for good reasons, and they are good nice people, but I think it really takes more than that to overcome the privilege that you just get from that.

I: It would be interesting to find a way to train that respect into everybody, but certainly medical students and doctors.

018: I think it's partly, what are your life experiences? Have you gone through your whole life as somebody on the track to be a doctor, one of the most privileged people in the world, or have you ever done anything where you weren't treated well? Have you ever done anything where you had to struggle? I think that's some of it. It's not the only thing, but it is a way -

I: So personal experience and how they -

018: Yeah. These medical students in Guatemala, I just wanted them to go pick coffee. Here's the difference between nursing and medicine. There's a nursing school down there. They thought they were going to do medical work, there were too many medical students, so the nursing instructor said, after this, I'm going to give each of you the amount of money that a coffee picker makes in a week. It's market day. Go try to spend it and feed your family for a week. Of course you can't, it's not enough money, but just go try and do it and learn what there is to learn. Come back and write a reflection piece and we'll talk about it. That's the kind of thing. There are opportunities, even if they're pretty contrived, where you can really learn something that puts you outside of your own experience or privilege. There's no shortage of stuff like that, if somebody decides that that's as important as working for the summer at Uppsala lab. I think there are strategies for doing it. It can't be just a flash in the pan, it has to be thought out and consistent and rewarded and reflected upon so people draw the lessons and don't just say, well, my lesson is I'm never going to do that again! Something about humility. One of the things that happened in Guatemala, and one of the things I talk about a lot to one of the people down there who's a priest from the US who does human rights stuff. His model for approaching people is to start first with what does that person bring and what do I have to

work within that person? That would be an interesting model for people from the United States to begin within any other culture but their own. If that were at least somehow factored into how people approach all patients, not just patients - the truth is, this whole thing about ethnicity and race, it's always a cultural issue. There's always a divide, even if it's somebody who could be your mother, you're still the doctor, they're still the patient. There still are huge differences between what you bring to the situation, so you always have to ask, who are you? Where do you come from? If I start with a stance of respect and humility, what do I have to learn from you? That's not at all to say that I don't have something to bring. If I didn't think I have anything to bring, what have I been doing all these years?

In the narrative above, the doctor describes how she hopes to, in training her medical students, “make people's lives real, the parts of people's lives that they don't see or know about.” She speaks about how her educational efforts to empower her students to see and know, however, are a challenge and must be made more systematized in order to “change the socialization.” An ethic of accountability is central to this narrative—accountability to patients, communities, and also to the education of students. This doctor also speaks about her affect—“I loved this guy”—and describes how seeing her patient apparently disrespected in the context of a medical encounter made her “furious” and how she was moved to protect her patient by attempting to make her students see his worth as a human being, and to in fact elevate his worth above their own.

In efforts to equalize power and knowledge in a medical encounter, physicians appeared to step down from their “doctor pedestal,” and also appeared to elevate and see as elevated the knowledge, power, and personhood of their patients and of others on the medical team and in the community. Physicians spoke about strategies for meeting people where they are by making medical explanations and discussions comprehensive yet sensitive to patient knowledge, rather than forgoing providing explanation or engaging in discussion based on assumed lack of agency or assumed lack of medical or

educational savviness. Some physicians spoke directly to an ethic of accountability, while others framed their commitment to equalizing power and knowledge as the best way to provide effective and high-quality care.

Seeking Out, Learning From, and Serving Marginalized Patients

The theme of seeking out, learning from, and serving marginalized patients emerged in narratives that described a physician's motivation to work with and seek out people who are different from herself and who may be marginalized. This theme was characterized by a sense of affiliation with and interest in difference, motivations to learn from difference, and also by felt accountability to empower others. Some physicians described an ethic of service that seemed to expand their professional identity to include the practice of medicine as a vocational calling. Positive affect directed toward others who are different also characterized this theme.

In the following narrative, an [Asian male] doctor describes how his experience living outside of the United States, and his exposure to "a whole wide world" as a child has supported his interest in learning how patients from "other cultures" see the world.

009: It has increased my awareness that there's a whole wide world out there. And for the most part people from other countries and cultures, have a very legitimate alternative perspective that by and large deserves consideration and attention. And it's not just a matter of, you know, the US is always right, and that's the only culture and perspective that matters in the world. So, from a very young age, I always felt like, you know, that we need to be very careful as Americans - not to ignore other points of view. So, it's vaguely much more sensitive to that. Much more appreciative of how wonderful and how many good things there are, that can be found in other countries and other cultures. Um, much more respectful of that. So, when I meet someone from out of the country, I'm very interested in what their culture is about. What their life experience has been like.

What brought them to the United States, since most of the time I meet them in this country. And what their perspective is of America, you know. What do you think about this part of America? What do you think about the government? What do you think about the policies?

I: It's really interesting.

009: I just find that to be fascinating. And if I have the time, the luxury of time I always want to ply them for that information. And I think they like talking because then they don't feel like – it gives them a chance to express what they really feel.

In the narrative above, the physician describes interest in knowing and valuing “what the life experience has been like” for others. He describes seeing alternative perspectives as “very legitimate,” and strives to give his patients “a chance to express what they really feel,” thereby creating space in the treatment relationship for patient knowledge and patient life experience to emerge, especially narratives that might otherwise have been silenced. Throughout this excerpt, the physician shows positive affect--“wonderful” and “many good things”--about and a sense of affiliation with his diverse patients. This narrative was chosen to illustrate a physician’s appreciation for working with diverse patients, but also contains elements suggesting other facets of reflexivity as it can operate in the medical encounter: openness to the perspectives of others--“very careful not to ignore other points of view”—and an awareness of the potential fallibility of his own perspectives; an appreciation for valuing others as equals even within the medical encounter; and a desire to enter a patient’s unique world.

In the following narratives, two [white female] physicians speak about how, in a more general sense, they are motivated to expose themselves to difference and diversity.

003: There's nothing there. There's no downtown, there's like a Dairy Queen. So I never quite could understand - I think - I've always been very open and interested in folks from different language and ethnic backgrounds, partially because my father was very liberal, very interested in people, as part of his job as a university professor he was with a lot of international students, Indonesians, Nigerians, different students would come to the house, be proxy family with us, celebrate holidays, we'd get to know them. My parents were always very interested in different people like that.

004: Nobody in my family travels, I'd never been out of the country, I lived on the West Coast my whole life, very very very very white, but I could tell you, I knew I did not want to be there. It wasn't a matter of scrambling the heck out of Dodge - I wanted to do that too - but there's a lot of those little clinics on 31st and Main, all over the place, in [city] if I wanted. Maybe there was some sense of, there's more diversity out there and I want to touch on that. Not that there's anything wrong with working there, because everybody needs healthcare, but –

In the excerpts above, both physicians express an interest in people and settings that are different from those of their own background, and seem to contrast their own interests with a presumably less-interested and less-worldly, and less diverse— “very very very very white”—locale in which they grew up. In these excerpts, there is a sense of de-identification with a homogenous white background, and also a sense of being “very open” to difference and wanting to “touch on” the “diversity out there,” whether associated with prior experiences getting to know people from “different” backgrounds [003] or lack of such experiences [004]. These two doctors may have travelled different paths, but they appear to arrive at a similar place of appreciating and seeking out those who are different from themselves. Both paths—of positive exposure, and of awareness for how little one has been exposed to others—appear to motivate these particular physicians.

Physicians also expressed appreciation for their lives being made more interesting by virtue of interacting with diverse people and patients. In the following narrative, a

[white male] physician discusses how he considers the diversity of the emergency room a major attraction for him in his decision to work there.

005: I got to watch my father interact with people from different backgrounds.

I: So it seemed normal and comfortable and natural?

005: Yeah. The opportunity to do that was one of the attractions to working in the emergency department, where there's a variety of patients.

I: So you were seeking that – why?

005: It enriches your life. It's so easy to wind up interacting with just one type of person, in college, and most kinds of schools, and clinics tend to specialize in a particular disease in a particular neighborhood. It's just a natural thing for birds of a feather to flock together. You can lose a lot of insight and life becomes a little less interesting.

Above, the physician sees his patients as providing a service to him—his work in the emergency room with diverse patients “enriches” his life. He contrasts his work in the ER with other settings—particularly educational settings, but also many medical settings—where there is “just one type of person.” This physician appears to see himself as gaining tremendously from his diverse patients, and potentially losing, perhaps also tremendously, when sequestered in settings that are not so diverse.

In the following narrative, another [white male] physician speaks about how interacting with his favorite patient, an elderly African American man, gives him a chance to talk with someone he would otherwise never have met.

033: I think that part of our education is the opportunity to interact with people, and one of the great joys of being a physician in my life is that I interact with people that I would never otherwise meet, and some of the most wonderful things come out of that. I mean, my absolute favorite patient is a guy with heart failure, who's 85 years old, who is African American, and his wife is 85 years old, and they've been married for 60 years,

and they come in, and we talk about heart failure for about 5 minutes, and then we talk about their life for a half an hour every time, and I just so look forward to it. I would never have met someone like him.

I: Right. Or really get to know him over time.

033: Right, and he, they ask for my baby pictures, and we talk about their family, and their church, you know all the things - but it's like a, I think that those, that are continuing education, meeting experience with different people, makes you more sensitive to the issues of different people. And I have talked with them on multiple occasions about what it's like to be black in [city], what it's like it have grown up in a segregated society, and I've gained an insight through my patient interactions that will help me with other patients, so I think that part of our experiential education changes us in a way that is positive if you let it, so I think, but I think that our formal education probably is not as - I don't know that you can - I think some people have tried, but I don't know that we've given enough to understanding the communities that sort of - I mean, it's different if you're training in [city] than you're training in [city], or if you're training across the street. If you are training over there, you need to know a lot more about what the sort of particular issues in Russians are. You know, if you're training here, you need to know more about Asians, or people from Somalia or places like that, that we see a lot of, that you can have more-

In the narrative above, the physician refers to his interactions with patients as benefitting him personally, as “one of the great joys” in his life. In this excerpt, the physician seems full of positive affect when speaking about how his life is impacted by his interactions with patients—in addition to speaking about “great joys,” the physician speaks of “the most wonderful things,” “my absolute favorite patient,” and how “I just so look forward to it.” He uses the phrase “we talk”—a phrase suggesting mutuality and dialogue, and also suggesting a more personal nature to the encounter than medical fact-finding, to describe both the medical part of the encounter, and also to describe the more lengthy part of the encounter where “we talk about their life.” In this narrative, the physician appears to see spending time talking with his patient as an enjoyable “opportunity” to which he looks forward. This opportunity is both personal and professional; this

physician sees his time and experience engaging patients who are different from himself as a vital educational opportunity that will enable him to better serve others—an educational opportunity that he sees as changing himself “in a way that is positive if you let it.” The physician contrasts such experiential education with more formal education that has not “given enough to understanding the communities” in which physicians work. Given the apparent mutuality in this encounter, and the clear enjoyment and respect this physician brings to the encounter, this learning opportunity for the physician does not appear to be one of asking marginalized patients to become cultural brokers in a potentially exploitative way (cf Kliman, 2005, p. 54).

In the following narrative, a [white female] physician speaks in a general sense about seeing difference as a source of positive emotion and knowledge for herself, and about wanting to continue learning from difference based on a previous experience doing so.

020: Yeah, it wasn't - it was a theme, but it wasn't anything I ever really thought of. I mean, my college - one of my college roommates, my closest from college, who is Japanese American, and she - parents - she was first generation, and her parents are from Japan, and I remember - I was just fascinated with learning about her life, and her culture, and her language. And that helps too, 'cause she was very open about and not ashamed of it in the least, and really likes to share that. And that I think made me sort of groove on learning about other places and cultures, and what, what different things they bring to our lives.

Above, the physician appears to translate her experience learning from her college roommate into a desire to learn about places and cultures different from her own. She sees this learning as important for enriching her own life.

Physicians also see their lives enriched by a professional identity that includes service, and provision of equal care, to those less fortunate as a vocation or calling. In

the following narrative, a [black male] physician describes his lifelong goal of service to others who are less fortunate than he.

034: And my quest has always been to help the less fortunate. And try to figure out what's going on. So, that has always been my goal, and I think just my presence here, I do that, especially when I was a primary care doctor, I found I did that more. But even as an inpatient physician, I do that, and then now my goals in life are to succeed even more, and be a good example, and debunk a lot of the ideas, that things have to be perfect for us to get ahead. I think that is the major thing-

Above, the physician holds himself accountable to his goals, and strives to do even more than serving the less fortunate—he strives to “be a good example” to others, seemingly holding himself accountable to anyone he might come into contact with. Intertwined with his professional identity is an ethic of accountability that requires him to appreciate how he is viewed by others.

Below, another [black male] physician describes how he explicitly considers himself “a public servant.”

036: Well, I can truly tell you that - I frequently tell this to students when I teach them, that I consider myself a public servant. And I do truly consider myself a public servant. I view myself as someone who is a public servant who takes care of people in times of extreme need when they're sick. And I take care of all people alike, and make sure that all people get quality care. That's how I approach my job every day. And whenever I can't do it that way, I'll leave. I won't do it anymore. that's just my own philosophy, and that's how I teach my residents, that's how I teach the students, and that's how I teach my fellow attendings.

Above, the physician describes a professional identity—how “I view myself”—as a public servant who provides equal care to all. He suggests that his professional identity informs his practice on a daily basis, and is constantly in mind and central to how he interacts with others--“That’s how I approach my job every day.” Also intertwined with his professional identity as a public servant is an ethic of accountability that allows

recognition for how he might respond if he cannot any longer provide equal, quality care to all--“I’ll leave.” This physician, like the physician in the previous narrative, strives to be a good example to others—to residents, medical students, and even colleagues. He sees the ways in which he strives to be a public servant, day-in and day-out, as benefitting not only his patients, but his colleagues and the medical profession itself via his role as a teacher and example.

In the narrative below, a [black female] physician speaks about how she sees her work, in providing quality care to and empowering those less fortunate than herself, as a major affective reward, in and of itself.

I: And part B of that last question is just the opposite - what types of patients or characteristics of patients give you a real life, like, make the whole - put a spring in your step for the day or the week?

041: Two types: one where - like if I - and this has to do with minorities again, because this is what I’m most tied to. If I have somebody from a minority group who’s had a lot of bad stuff happen and we’re in clinic and we bond and it seems like that person is really trying hard to turn around their lives or have things work out a little bit better for them, and I feel like I can contribute to that, that really makes me feel good. That’s one. The other type is a young person of color who is seeking help on their own. It could be help for anything in the clinic setting.

I: It’s kind of cool. Both of those scenarios are moments where as a clinician or as a doctor you may feel like you can do more than just medical technician stuff, that you actually -

041: And those are truly the two circumstances that - and there are probably others too, that are it for me. I will complain about work versus fiscal remuneration and so forth, but actually in those settings, I actually would do it for free.

The physician above tells us how her work to be there for others and empower others “really makes me feel good.” She appears quite aware of the many barriers to quality care for people of color, and aware of how her work can “contribute” to empowerment

and to overcoming barriers to quality care. Noting that she would work for free in settings where she can make a difference, this physician further suggests that she herself benefits from her work as well.

A [white female] physician speaks to how she benefits from her work with underserved patients, in the narrative below.

002: I think outpatient. I'm pretty committed to working with low-income patients, those who are in some way marginalized. That's where I feel myself both called and challenged, and it's more interesting to me intellectually and emotionally and politically. I actually have a fantasy of working in a prison. That's what I really want to do.

Work with marginalized patients is “more interesting” to this physician, and appears to align well with her politics—the physician seems to suggest that being “challenged,” for her, is both a positive experience and also in keeping with where she feels herself called professionally. She speaks to her motivation—“I really want” and “I have a fantasy”—to work with people even perhaps more marginalized than those with whom she currently works, striving to better herself in her professional goals by seeking further challenges.

In the following narrative, a [white female] physician speaks about how important it is for her to remain true to her sense of her personal accountability to marginalized patients. In keeping with her accountability to her patients, she expresses concern about the professional training of students who seek to work with underserved populations but who may not have critically examined their roles in ways that would most enhance accountability to the populations they seek to serve.

018: ...I think also because I grew up with a sense of a critique of people who were political in some ways but did not ever assign themselves to accountability to anybody but their own privileged peer group. I think that's something I didn't want to do as I crossed the line and became a professional myself. I'm sure that just by doing that, it

does that. I'm not the same as my patients. I could send my kids to private schools if I wanted to. I wasn't the same, but I tried to hold tight to some sense of walking alongside, or something like that. And I try to imagine, whenever I do anything, like when I stop being [position] at [clinic], I always have - I have a panel in my mind, of my patients. For the ones who are dead, I try to imagine, what if I tried to explain to Mrs. B___ why I'm doing this. Would I be able to? And for the ones who are alive, I do explain to them. I say, I'm thinking about doing this, what does that mean? My advisors, my panel. I feel like if I can't imagine explaining it to people whose lives I think I've defined myself as serving, then I'm just kidding myself. It's bullshit and I'm not different from anybody else. But if I can, then I'm still on target, or something like that.

...

018: I don't think privilege is an active concept among medical students and residents, or accountability, like, you're going to work in that community, for whom? To advance your own career? I just came back from Guatemala and there were medical students down there, way too many medical students. They were there for themselves. They were notching their belts, the Guatemalan experience. It wasn't service learning in the true sense. They weren't there because there was a need that they had any clue what it was, and that need hadn't been defined in any way to include them. So that is a bigger part of it. I don't think that's been tackled or identified.

Above, the physician's identity itself appears shaped by her work in partnership with marginalized patients "whose lives I think I've defined myself as serving." This physician appears to hold close to her heart, and perhaps her identity, a sense of being "still on target." She appears highly aware of ways in which she is different from her patients, by virtue of her professional status, her economic power, and her privilege, and appears motivated to have devised a strategy to literally "walk alongside" her patients in her mind on a regular basis, "imagining" how a panel of her patients would consider her actions. This physician appears quite motivated to hold herself accountable to her patients—and her critique of medical training that does not hold accountability or privilege as an "active concept" seems motivated by her desire to, in her words, identify and tackle areas for more effective service learning.

In the following narrative, a [black male] physician also sees opportunities for enhancing accountability to underserved communities in which physicians often train.

021: Yeah. You need to have more nonwhite attendings, you need to have more female attendings. You need to make people realize that you're not just learning off of these patients, that you have a responsibility for people, and we need to open a window so people actually not only train in a community but end up working in the community. Most people when they finish residency, they live in the city or the area where they completed their residencies. Most studies show that. But those same people that are working on everybody in East LA and South Central don't stay in South Central and East LA!

Above, the physician sees an ethic of accountability—and perhaps the realization of personal benefits such accountability can bring—as vitally important for the medical profession and for the people whom it purports to serve.

Physicians spoke to several facets of how working with and serving marginalized patients becomes a positive source of knowledge and personal enrichment. Some physicians saw such work as making life more interesting, and appreciated difference as something that brought value to their own personal lives. One such physician explicitly spoke about how he not only enjoyed such work, but considered it a form of continuing education. This education, for him, did not appear to involve exploitation of his patients as “cultural brokers” (cf Kliman, 2005, p. 54), but appeared to involve respectful and mutual dialogue, the sharing of family stories, and a great deal of positive affect on the part of the physician. Some physicians spoke explicitly to a professional—and personal--identity as a public servant and as an example to others, and they spoke of how such service ultimately benefitted them and was in line with their professional goals and political and personal cares. One physician said she thought of her life as “defined” by the patients she strives to work with in partnership. Physicians also expressed an

intensity of awareness around accountability to patients and communities, and as part of their commitment to accountability, identified areas for growth in the medical profession and culture of training.

Meeting people where they are, in the medical encounter, encompasses domains of knowledge, power, and practice. There is no one single way to best meet people where they are, and physician narratives of disparities suggest multiple pathways for making the medical encounter more relational and for enhancing possibilities for dialogue and empowerment, service and accountability. Physicians sought better understanding of the specific worlds of each of their patients through respectful dialogue, perspective-taking, and relational listening. Physicians sought to partner with their patients by shifting the balance of power in a medical encounter, seeing patient knowledge and experience as elevated, and seeking to empower not only patients, but also nursing staff and community members participating in a patient's care. And physicians sought to work with and serve marginalized patients, seeing not only the great benefits of doing so to their own lives, but also seeing quite clearly their accountability to patients, communities, and the training of their peers.

Summary of Section on Reflexivity

In the narratives illustrating facets of reflexivity, physicians spoke to themes associated with: encountering and countering bias through awarenesses of subjectivity and of how bias operates within oneself; and building upon such awarenesses to connect

to and with difference by meeting a patient where she is, despite barriers inherent in the fragmenting and potentially dehumanizing context of a medical encounter. Each of these themes is associated with awareness of subjectivity and positionality, and with challenging social biases that can infiltrate themselves into processes of medical decision-making. Awarenesses of one's own subjectivity are vital to recognition of bias, a precondition for seeing how it operates and for putting it aside. Such awarenesses are also important for physicians to find themselves capable of searching within themselves and their experience for evidence to counter bias, rather than putting the burden of proof on their patient to counter biases that, when putting the onus on the patient, necessarily then become enacted into a medical encounter. In a desire to avoid bias, it is important to not ignore bias, as the literature on aversive racism has documented, but rather to face bias, to encounter it, so that it can be effectively countered, that is, confronted and altered at the levels of attitudes and behaviors influencing patient care. In building upon awareness to further connect to and with difference and meet patients where they are, physician narratives of disparities illustrated themes involving: entering a patient's specific world to better "understand" their situation, perspective, and subjectivity—with such understanding enhanced and facilitated by experiential knowledge, dialogue, and relational listening that allow space for patient subjectivity to emerge in the medical encounter; equalizing power and knowledge within the medical encounter, valuing patient knowledge and holding oneself accountable to engaging a patient in medical discussions, and seeing patients as having the agency to know and determine what is best for them; and seeking out work with marginalized populations as a positive source of

knowledge and a positive source of professional identity whereby one is accountable to patients in providing equal and quality care, and accountable to the training of others.

The narratives suggest that awareness of bias was in itself grounded in lived experiences of bias, especially due to race. Black physicians were especially sensitive to the reality and consequences of bias, and provided some of the most eloquent descriptions of bias in these narratives. Facets of reflexivity do not necessarily operate exclusively of each other, and in several narratives can be seen as operating concurrently, perhaps enhancing their positive effects. There is no one single pathway for reflexivity, but consistent with conceptualizations of reflexivity, facets of this construct can be used in various ways unique to each medical encounter and the subjectivities involved. Seeing how reflexivity can operate in medical encounters may prove useful in learning how to put reflexive processes into practice.

CHAPTER IV

DISCUSSION

Efforts to counter disparities in healthcare within the United States have been, since the publication of the IOM report *Unequal Treatment* in 2003, growing in momentum. The possibility that patients might experience racial discrimination within a relationship with physicians requiring a foundation of trust and respect strikes everyone involved as a deep violation of civil rights and human rights. The clinical encounter between a doctor and a patient is one level at which healthcare disparities can become enacted. The IOM missive *Unequal Treatment* drew attention to the presence of physician bias, yet acknowledged that how such bias becomes enacted in clinical encounters is poorly-understood and requires much further research (cf Good et al., 2003). The growing literature on the role of physician bias in contributing to healthcare disparities documents the seemingly subtle yet potentially devastating and relentlessly accruing presence of racial bias and racial preferencing in patient care. Barr (2008), writing as a practicing physician and medical sociologist, notes that while explicit racial bias may seem relatively rare, other forms of more subtle bias need to be uncovered and addressed in ways that physicians will find recognizable and motivating. In addition to

enacting a mandate, efforts to address healthcare systems impacts on health disparities have contributed to creating a movement (Chavez, 2003, p. 393). Movements, by definition, involve countless contributions from people empowered to join efforts in seeking change. This research is meant to provide one more contribution to the movement toward equality in health and healthcare, by using physicians' own narratives on bias and reflexivity to identify themes in the operation of bias and possible pathways for challenging and transforming physician enactment of bias in the medical encounter. While it is vital to keep in mind that healthcare disparities are created by sociopolitical, historical, and institutional forces, the multiple levels at which disparities become enacted can and have been studied, in efforts to elucidate via research the processes involved in producing disparities. When better understood, these processes can be better countered. Such research must be thought of as complementing and furthering efforts to change sociopolitical and institutional factors, and efforts to ameliorate historical and current atrocities. Locating research in this way may empower those who use it to better understand its limitations, yet also better search for ways that research can indeed provide vital contributions to social justice work.

The main goal of this study was to, based on physician narratives of disparities: 1) identify themes in processes of bias within the medical encounter; and, 2) identify themes in processes of reflexivity that may help physicians more systematically identify and counter bias as a way of providing more equal care. Thematic analysis yielded three distinct themes for bias: *paternalism*, involving assumptions about patient lack of capacity and agency to engage in discussions around treatment and treatment itself;

preferential connection, involving preferential attitudes toward members of one's identified group that come at a cost to others who are not treated so preferentially when physician time and focused attention are in effect rationed commodities; and *social prototypes*, involving the creation of medical prototypes based not only on medical data, but also or even more so based on data contaminated with devaluing social stereotypes. Themes for reflexivity described processes that served to: *encounter and counter bias* by becoming aware, via attentiveness to one's own subjectivity, of the ways in which bias can operate and also the ways in which one can search for evidence within one's own experience to counter bias; and *connect to and with difference* by building upon the self-knowledge involved in encountering and countering bias. In the theme of *connecting to and with difference*, physicians spoke of seeking better understanding of a specific patient's unique world via attentiveness to their own subjectivity; of equalizing knowledge and power in the medical encounter; and of seeking opportunities to serve diverse and marginalized patients as a positive source of knowledge and professional identity, explicitly holding themselves accountable to equitably meeting the needs of all patients.

Findings of this study suggest that narrative approaches are useful in efforts to elucidate bias at the intersection of physician education and cognition, and social and cognitive bias. The literature on implicit bias offers compelling but decontextualized understandings for how race-based biases of positive or negative affect may automatically occur in presumably any social encounter. Recent research that administered the IAT to pediatricians suggests that, while pediatricians in the study held a

weaker racial implicit bias than the general population, they also held an implicit bias against “perceived patient compliance” for Black patients but not white patients (Sabin, Rivara, & Greenwald, 2008). Narrative approaches may help identify areas for further testing with experimental methods; experimental and narrative research methods can serve to complement each other in efforts to better understand bias in the medical encounter.

Narrative approaches in understanding physician bias and reflexivity may also contribute to new directions for research in other related fields. Literatures of medical decision-making address cognitive biases associated with decision pathways (Croskerry, 2002), but hardly, if at all, address how social bias infiltrates itself into processes of medical decision-making. Narrative approaches involving physician disclosure of social bias as such bias effects medical decision-making pathways, and involving physician attempts at reflexivity, may suggest new directions for work in elucidating how medical decisions are made and how quality care is provided in encounters with marginalized patients. Literatures devoted to patient-centered care suggest ways to enhance physician focus on the unique cares and needs of each individual. Narrative understandings of physician bias may suggest a need for further research on how physicians may be limited in providing patient-centered care when bias is enacted in an encounter. While patient-centered care may work to guard against bias, by virtue of its focus on individuating, it may be necessary but not sufficient to counter the various ways bias may operate in medical encounters. Research addressing bias-reduction strategies in concert with patient-centered care may prove especially useful.

Narrative approaches may also contribute to new and exciting work in cognitive neuroscience. Preliminary findings from a key and widely-respected research group in the new field of social neuroscience suggest that activation of the medial prefrontal cortex (mPFC), an area key to myriad functions of social cognition, is “dramatically reduced” when subjects look at images of people who evoke emotions of disgust versus images of people who do not evoke disgust (Harris & Fiske, 2006). Subsequent research from this group replicated these findings and also isolated processing of such images to a region of the brain anatomically distinct from areas that process social emotions, but consistent with areas that process responses to objects (Harris & Fiske, 2007). This subsequent research also aimed to counteract the effect of disgust by asking subjects to estimate age and food preferences for people; the authors note that while such tasks did not raise levels of activation of the mPFC to the levels associated with pictures of people who did not elicit disgust, such tasks did increase mPFC activation above what it had been, suggesting that “individuation increases activation” (ibid, p. 45). Fiske and colleagues (2002) have developed a “Stereotype Content Model” in the form of a grid showing high and low axes of competence and warmth, that further explains disgust as a combination of low perceived warmth and low perceived competence; pity/paternalism is evoked by high perceived warmth but low perceived competence. Enhancing physician perceptions of warmth *and* competence may be another potential area to guide further research and practice; narrative approaches may suggest broader and more complex conceptualizations for both perceived warmth and competence. In medicine, in addition to social biases that may involve emotions of disgust, physicians can be thought of as

confronted daily with complex physiological failings and sufferings that may, perhaps, elicit disgust, perhaps especially in certain areas of emergency care. It is unclear in the literature how physicians may habituate to exposure to complex physiological failings and the emotions they may elicit, but countering emotions of disgust may be another useful area for future research, particularly if disgust is one of the emotions associated with implicit bias (Dovidio et al., 2008) and can perhaps reduce or shut down vitally-important areas for social cognition in the brain. Strategies for reflexivity may prove useful in humanizing patients and countering emotions of disgust.

Drawing on research suggesting the importance of individuation as a strategy for promoting the knowledge of diverse others and reducing racially biased stereotyping, Burgess and colleagues (2007) suggest individuation as the main overarching theoretical strategy for reducing bias among health care providers. Burgess and colleagues (2007) note that their work is “intended to provide a starting point for the important task of reducing bias in health care” (p. 885). Narrative approaches can offer new directions for elaborating on strategies for bias reduction that are based on important findings in social psychology. In this study, individuation can be seen as operating across all subthemes of reflexivity, in different ways. While individuation—like patient-centeredness--appears vital to countering bias, without understanding processes of medical decision-making and how bias impacts such decision-making, strategies for individuation alone may not be enough to fully reduce bias.

Burgess and colleagues (2007) recognize that strategies for individuation are not sufficient to counter bias. These researchers suggest that, in keeping with the social

psychology literature of stereotype suppression finding that attempted suppression only creates a “rebound effect” (p. 883), providers must learn to better approach and recognize their biases in order to counteract them. Burgess and colleagues (2007) suggest that such approach and recognition needs to be encouraged in a way that does not evoke shame, as shame, for most people, tends to lead to further avoidance. In this study, these facets of reflexivity did not emerge as themes saturating the data. However, physicians did suggest that biases not be ignored, and that it might prove helpful to realize that one is not alone in working to counter harmful biases. Just as a first wave of research documenting the consequences of physician bias on quality of care and health outcomes moved physicians to examine bias, this new wave of research using scientific techniques can be used to support new ways of addressing aversive racism. Approaches to training for culturally respectful care that use a model developmentally-sensitive to both individuals and institutions may be particularly effective in reducing the shame that can become a significant barrier to approaching and recognizing bias.

Burgess and colleagues (2007) also note the utility of positive affect for individuating. Consistent with this concept are findings in this study that suggest physician joy and interest in seeking out marginalized patients is related to physician ability to connect to and with difference. While positive affect is only one facet of physician joy and interest, overarching cognitive processes of individuating may also be at work—and the physician narratives of disparities therefore provide yet more insight into how such processes of individuating may look in practice.

In addition to suggested areas for further research and training as described above, the findings of this study highlight a specific need for looking at special populations mentioned in the narratives that are subject to egregious biases of social prototypes, and working to create models for shifting how doctors see these patients. It is important to remember that disparities in care can result in not just worse care, but death. The need for models to counter biases of social prototypes, that in the process do not reinforce stereotypes by categorizing patients based on social status, cannot be overemphasized.

Limitations of this study are many. The purpose of the physician interviews was to describe contributions of the culture of medicine to disparities in care. Physicians were therefore not asked directly about bias and reflexivity, the two main areas of inquiry for this study. And these two main areas of inquiry, themselves, may have been made to seem more distinct theoretically due to a methodological focus on bias and reflexivity as distinct categories, rather than a focus on overarching social-psychological processes or identification of common factors. Further, both the principal investigator and the interviewers were medical sociologists; areas of original inquiry, interview questions, and interview content were more tailored to this field (in which this researcher has no background), and did not necessarily dovetail in any facile way with concepts and professional insight specific to psychology. The interviews chosen for inclusion in this study involved physicians who worked at several different sites, but all within one health care system and geographic locale, making generalizations to other systems of care or geographic locales impossible. (Although within the broader culture and profession of medicine, perhaps generalizations can be made). Further, the physicians involved in this

study were selected by their peers and by the interviewer for exemplar status, in that they were considered both able and willing to think about and discuss matters related to disparities in care. It is unclear how such physicians may differ in their thinking from physicians who may not be seen in such an exemplary way. Because the interviews were conducted for another study, this researcher has no access to the physicians interviewed for this study, and therefore cannot ask follow-up questions or probe for further meaning when statements seem ambiguous.

Despite these limitations, physicians did speak to themes associated with bias and reflexivity, and because the interviews were so extensive, the data around bias and reflexivity were robust “enough” to find patterns in the narratives. Further, perhaps an unintended benefit of asking physicians about disparities and what they have seen, rather than asking more specific and direct questions about their “own” biases, was an emergence of narratives that might not have been so directly accessible had people been asked in a more direct, and less projective, fashion.

Since there is no single way to provide culturally respectful care, this study intends to suggest how findings associated with bias and reflexivity can impact each unique and specific medical encounter, and to complement exciting new and emerging research in the field. This study is not meant to suggest a uniform process across all situations, or a “right way” to counter bias or practice reflexivity in a medical encounter, but attempted to organize what emerged in the narratives in a meaningful way while, per the injunction of one physician, “writing to the test” what can be most difficult to see.

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