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Healthcare Providers’ Formative Experiences with Race and Black Male Patients in Urban Hospital Environments

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Abstract

Objective We explored health providers’ formative personal and professional experiences with race and Black men as a way to assess their potential influence on interactions with Black male patients.

Methods Utilizing convenience sampling with snowballing techniques, we identified healthcare providers in two urban university hospitals. We compared Black and White providers’ experiences based on race and level of training. We used the Gardener’s Tale to conceptualize how racism may lead to racial health disparities. A semi-structured interview guide was used to conduct in-person interviews (n = 16).

Using the grounded theory approach, we conducted three types of coding to examine data patterns.

Results We found two themes reflective of personally mediated racism: (1) perception of Black males accompanied by two subthemes (a) biased care and (b) fear and discomfort and (2) cognitive dissonance. While this latter theme is more reflective of Jones’s internalized racism level, we present its results because its novelty is compelling.

Conclusions Perception of Black males and cognitive dissonance appear to influence providers’ approaches with Black male patients. This study suggests the need to develop initiatives and curricula in health professional schools that address provider racial bias. Understanding the dynamics operating in the patient-provider encounter enhances the ability to address and reduce health disparities.

Keywords Health professionals · Racial health disparities · Health service delivery · Access to care · Race/ethnicity · Racism · Bias · African Americans/Black

Introduction

Whether conscious or not, bias and prejudice play a role in the delivery of health care to racial/ethnic minorities [1, 2]. In clinical settings, Black males are less likely to receive appropriate medical procedures than their White counterparts. Even after controlling for confounding variables such as severity of illness, insurance, and income, they are less likely to receive medical procedures including cardiac catheterization, coronary angioplasty, percutaneous transluminal coronary angioplasty (PTCA), and coronary artery bypass grafting (CABG) [3, 4]. The potential roles of bias and discrimination in the provider-patient relationship have been suggested but remain methodologically difficult to explore.
Provider bias has been suggested, but quantitative methods have failed to illuminate cause. The Institute of Medicine (IOM) found that the sources of racial and ethnic disparities in healthcare involve discrimination, mistrust, [5, 6] communication difficulties, and cultural barriers [2, 4, 7]. Furthermore, the IOM concludes that provider bias, provider stereotyping, and provider prejudice could contribute to the overall differential treatment of Black male patients in the clinical setting [1, 5, 6].

Numerous quantitative studies (Table I) have identified racial health disparities experienced by Black male patients [8–17]. Utilizing a computer instrument in conjunction with patient actors to test implicit association, Schulman et al. (1999) concluded that a patient’s race and sex independently affect how a physician diagnoses chest pain. The study demonstrated that simulated Black patients were less likely to be given the same invasive cardiac procedures in comparison to White patients, despite each actor having identical symptoms [15]. Despite the efforts of traditional epidemiological studies, the extent of provider bias remains elusive.

To address this knowledge gap and its attendant methodological difficulties, we employed qualitative methods to explore health providers’ formative childhood and personal and professional experiences with race and Black men and the potential influence on providers’ interactions with Black male patients.

Theoretical Framework

Race is a social construct. For the purpose of this study, we utilized Jones’s Framework of Racism (2000) to illustrate how racism may lead to racial health disparities. According to Jones, racism can be framed in three components: (1) institutionalized racism, (2) personally mediated racism, and (3) internalized racism [18, 19]. Institutionalized racism “is a differential access to services, goods, and opportunities by race.” Personal-mediated racism is “defined as prejudice and discrimination.” Internalized racism is “an acceptance by members of stigmatized races of negative messages about their own capabilities and intrinsic worth.” These levels of racism are not mutually exclusive: interactions between the levels are fluid and inform one another.

Methods

Qualitative interviews were employed to explore health providers’ formative childhood and personal and professional experiences with race and Black males. Utilizing convenience sampling, we identified physicians, nurses, and medical students (third and fourth year) within two urban university hospitals approximately 2 miles apart.

Participants resided within the Philadelphia area. Physicians and nurses were eligible if they (1) were self-identified as White or Black/African American1 and (2) were currently or previously employed as a clinical physician or nurse. Specialties included pediatrics, emergency medicine, primary care, cardiology, anesthesiology, psychiatry, and family medicine. Medical students were eligible if they (1) were self-identified as White or Black/African American and (2) were enrolled in their third or fourth year of medical school.

We developed a semi-structured interview guide (Appendix B) to conduct in-person-audio-recorded interviews. The guide contained 16 open-ended questions and follow-up probes within six primary domains: (1) childhood experiences, (2) medical education, (3) daily interaction with Black male patients, (4) power and privilege, (5) stereotypes, and (6) the impact of one’s race on patient. Race or the experience of racism can be a sensitive topic to discuss; therefore, the open-ended questions allowed participants to respond freely and answer questions as they reflect on their past experiences. No identifying information such as age, sexual orientation, or income was collected. The study was approved by the Drexel University Institutional Review Board.

Data Collection

MVP, a self-identified Black woman, conducted all in-person interviews. For training purposes, JAT observed one interview. The interviews took place in private conference rooms located in various settings within both university hospitals and were audio-recorded. Prior to each interview, MVP verbally reviewed the consent form with each participant and described the nature of the study, its risks, and benefits. Interviews lasted between 30 and 70 min were audio-recorded and transcribed by an external transcription agency.

Data Analysis

All transcripts were de-identified to assure participant protection. Transcriptions were uploaded into qualitative research software, QSR NVivo10. A coding workbook based on the interview guide and racial health disparity literature was created.

MVP independently conducted a qualitative analysis of each transcript. Utilizing the grounded theory approach, three types of coding were conducted to examine patterns exhibited in the data: (1) open coding, (2) axial coding, and (3) selective coding. MVP then convened with the research team to examine one transcript and compared coding patterns. Two coders

1 Black is defined as a person having origins in any of the Black racial groups of Africa.
(MVP, AD) then coded one interview using the coding structure to ensure adequate intercoder agreement. The percent agreement of 96.47% was calculated, and then, coding was reconciled to achieve a new percent agreement of 98.99%. AD coded a quarter of the total transcripts. The final percent agreement between the two coders for all transcripts coded was 97.87%. MVP coded the remaining 12 transcripts after agreement was achieved within the research team based on the codebook.

**Results**

Sixteen clinical health providers were interviewed (Table 1). Nineteen nodes emanated from the transcripts. While Jones’s framework provides three levels of racism, this paper primarily focuses on *personally-mediated* racism, as it is the most reflective of the patient-provider interaction. Our analysis found two themes. The first theme, *perception of Black males*, affirmed our goal to understand why Black men do not receive equal treatment in healthcare. It was accompanied by two subthemes (a) biased care and (b) fear and discomfort. The second theme, *cognitive dissonance*, described a feeling of tension experienced by Black providers, who experienced conflicting thoughts of Black men. They expressed an extra burden of occupational stress when challenged to defend their ability to perform their job based on biases about their race. While this latter theme is more reflective of Jones’s *internalized racism* level, we present its results because its novelty is compelling.

**Perception of Black Males**

Both Black and White providers shared similar reflections about Black men and described their perceptions of and experiences with Black males as *scary, violent, unreliable, less educated, and non-communicative*. They specifically described how media (e.g., television, advertising, reporting) impacted their views and how these media were predominantly negative.

> I grew up at the time rap and hip hop were just coming to be popular and I sometimes worried that the vision or image of what African Americans were, was very much a caricature. I mean – I loved rap growing up but it seemed that the image focused on the gangster lifestyle and gangster mentality; you know that was what I saw on a daily basis. It may be a significant part of somebody else’s life, I’m not trying to disparage that at all but I felt that sometimes Hollywood and media focus[ed] on that aspect and didn’t tend to focus on the Bill Cosby aspect. You know that African Americans can be doctors, lawyers, ministers, teachers, and politicians. Because of the media you see this focus on African Americans as criminals. You know, I’m a big Denzel Washington fan. And I was frustrated when he won his Oscar. He had a series of opportunities like Malcolm X and it frustrated me because they finally gave him the Oscar on Training Day. He got an Oscar for [being a] criminal. - It frustrated me that [he] didn’t win for some of his more distinguished characters that portrayed African Americans in a positive light. - (Joseph, Black Male Physician).

Physicians and nurses mentioned that they did not receive any training in race-related issues, stating, “we didn’t have conversations about race” and “Cultural competency? I don’t remember that term as a medical student.” However, medical students disclosed receiving a cultural competency course.

> We have this course that’s supposed to teach us cultural competency. And we would meet, once a week or once a month. We would have people from representative populations like LGBT or Jehovah’s Witnesses and then we would talk about how that made us feel. It [wasn’t] very useful.

> -(Lisa, Black Female Medical Student)

Overall, medical students felt that their course work in cultural competency was inadequate.

For many of our participants, the clinical setting was not absent of racial bias towards Black men, and they were not surprised by previous literature.

> We are a microcosm of society. So if there is racism, if there is harsh behavior, policies, just unfair treatment towards Black males in society, it’s happening in health care. It’s no different. - (Ruth, Black Female Nurse)

> Well, I regret to say [that Black males are] not met with great fairness. I think that the medical establishment by and large is hierarchal, conservative, fearful, and not ready to relinquish its power. - (John, White Male Physician)

Participants described how a provider’s bias could impact how they interacted with patients.

> If you have a White patient who’s in their 50s and has lung cancer from smoking, and people are... not gonna
blame him for it. But you've got a 50-year-old guy with HIV, and they're gonna say that he did something to cause it. *(Ian, Black Male Medical Student)*

And for many participants, the treatment of Black males in the clinical setting was no different than your everyday interaction.

So I definitely think...that the general population has unconscious biases towards Blacks compared to Whites. And this is true for physicians; as well...I like to believe that they're unconscious...I like to believe that [as] physicians—we want to take...care of patients...But I do think that based on what's seen in the media and based on...past life experiences, physicians have these unconscious biases. And I think they play themselves out in various ways. *(Vanessa, Black Female Physician)*

Biased Care

In support of previous studies, all providers described examples when Black male patients were not offered procedures because they were assumed to be economically disadvantaged or medically non-compliant.

*I've had...[Black] patients who I think have not been offered procedures because of either where they were economically or where they were assumed to be economically because of their race...I had a patient who clearly needed to be catheterized for their presentation and it was suggested that we do medical management. And I remember talking to the cardiologist and just saying that I didn't understand why we're doing this...As soon as we started talking, he said, "oh well, of course, we'll cath him." And so, like that, it changed...[I] certainly have enough anecdotal experience to think that people are probably [being] treated differently based on race.* *(Paul, White Male Physician)*

I used to work [in] oncology. I had a patient who...was kind of dismissed amongst the medical team...[and labeled as] defiant— and not really offered all of his options...I think because he was a huge—not aggressive in the sense of you felt like he was violent—But...he was a huge, darker skinned Black male, and I think that people saw him as intimidating. And it was just easier to just kind of bypass him and do the minimal that you had to do. *(Dawn, Black Female Nurse)*

While we anticipated hearing both blatant and subtle examples of racist encounters, we were surprised by providers’ direct disclosure of personal experiences of race and racism.

Fear and Discomfort

White providers described their lack of exposure to Black men. For some, graduate school was their first noticeable exposure to people of different races/ethnicities. When working with Black male patients, the following participant described situations of discomfort and/or fear.

*It's a sense of comfort...I feel like [I'm] more able to give [White patients] advice...I feel like I understand or know where they're coming from, where it's harder for me to walk into someone who's different for me. I don't know. It feels almost presumptive, like I don't know that much about their family life. [But]...if it's a White upper middle class family, then I'm [thinking], I pretty much understand what's going on at home with you. And like I've been there. *(Anna, White Female Medical Student)*

Cognitive Dissonance

Black providers not only provided examples of differential treatment but also described their own experiences with racism in clinical settings. Vanessa, a Black female physician, described her experiences with patients specifically wanting providers of the same or different race.

*I've had experiences where...Black patients...didn't respect me based on—maybe what they thought their idea of a good doctor is—a White physician...and then I've had Black patients who were like, "Oh my goodness, we're so proud of you! It varies. I had a [White] patient who was on the autism spectrum. I was doing my best to try to coordinate services for him...[but] it was challenging to get because he has developmental issues. And every time I walked in the room he said, get that Black devil out of my room...So the fact that I was going above and beyond and jumping through hoops and then was called a Black devil was pretty frustrating.*

Black female physicians and medical students described circumstances when they were referred to as nurses. Black male physicians and medical students described examples when they were referred to as technicians or custodial workers. Despite
wearing their White coats, Black providers were subjected to similar stereotypes. “[Your] White coat, if you’re wearing it, it’s almost your shield.” (Ian, Black Male Medical Student).

This last quote conveys the stress that always being cognizant of race confers to Black providers.

I definitely feel as though for the most part, you don’t want to rock the boat. You don’t want to draw attention to yourself especially if you are a minority and you feel like, you don’t want to come across as being the angry Black woman. You don’t want [to come] across as being the scary Black man. – (Lisa, Black Female Medical Student)

For all Black participants, there was a sense of cognitive dissonance: they held prestigious positions in their field, but they still exposed to everyday biases and stereotypes (similar to their patients).

Discussion

Our study is one of the first known qualitative inquiries to investigate how racial bias develops from the perspective of the healthcare provider. Utilizing Jones’s theoretic framework of racism with a focus on personally mediated racism, we examined how providers’ personal formative experiences and racial biases may play a role in their diagnosing and treating Black men. While previous quantitative studies have posited racism and discrimination as explanatory contributors to treatment and diagnostic disparities, very few have explored the dynamic of their potential origins. This is clearly sensitive inquiry and can only be done through qualitative methods in an environment of trust. We identified the following themes regarding the patient-provider relationship, perception of Black males, biased care, fear and discomfort and cognitive dissonance. Our findings suggest that a provider’s formative experiences with Black men and the negative portrayal of Black men in media may influence their clinical decision-making.

One of the prominent issues interwoven in each theme was the influence of provider perception relative to Black men. While none of our participants disclosed any of their own personal reluctance to treat Black males, they did describe examples when their colleagues resisted protocol regiments based on racialized assumptions of the patient. Black males were stereotyped and discriminated against; these examples of personally mediated racism (PMR) explain how a provider’s conscious or subconscious racial script may create a blueprint that guides expectations and encounters with Black men. Physician’s formative experiences with Black men and provider bias are plausible explanations, and our study demonstrates how the patient-provider relationship can be tainted with acts of PMR [1, 4, 17, 20–22]. During the clinical encounter, physicians may make assumptions about Black male patients resulting in differential treatment [23–26].

Our analysis also highlighted the impact of media and its role in portraying Black men. Both Black and White providers described Black men as violent, scary, and unreliable. Participants communicated examples where Black men were blamed for their disease. Black providers reported feeling torn by the pressure from media and systems that choose to construct a pathological narrative of Black men. As Anna disclosed, White providers sometimes felt uncomfortable when working with Black male patients and used code words such as “violent” or “angry.” Nicole described feeling “scared,” if a Black male was behind her; this continues to highlight how providers’ thoughts about race and racism can impact the patient-provider relationship. Some had limited formative experiences with Black males, and for many, their only exposure was through media. This theme is particularly important, as we can see how code words can be detrimental to Black patients when considering treatment options. Furthermore, these examples showcase the powerful impact stereotypes place on the livelihood of Black patients.

Another unique finding of this study was the reality of cognitive dissonance as a source of disparate occupational stress in Black providers. As exemplified in Vanessa’s “Black devil” and Lisa’s “angry Black woman” quotes, all Black providers shared anecdotes based on reaction to their race in the clinical setting. Black providers were always cognizant of their racial identity. This was not the case for White providers, who were unable to provide examples of when patients challenged their decision-making skills based on their race. We found that the combination of constant awareness of one’s racial identity, coupled with being questioned, having your authority negated, and not wanting to appear “angry,” could be significant sources of occupational stress. This is a disparity, as White providers did not report these experiences. There is significant evidence of multiple forms of provider distraction and the impact on patient healthcare quality and safety [27–31].

Public Health Implications

Traditionally, medical personnel are taught cultural competency in the context of language [32, 33], but perhaps, this convention must shift. Understanding how racial bias dictates social and learned interactions within the patient-provider dynamic will help researchers develop interventions that actively counter racism during the clinical encounter.

As portrayed in Fig. 1, there exists a linear process of differential treatment. We recognize that the patient-provider relationship is multifactorial; however, for the purpose of addressing specifically PMR, it is important to focus on the medical education system. From a primary prevention perspective, health professional schools must actively dismantle
stereotypes associated with Black men. Familiarizing and accepting Black men and dismantling the stereotypes associated with Black culture are key components to improving how providers treat patients. Racially discordant providers may not understand cultural issues related to Black men and may have limited formative experiences [34–36]. Furthermore, there may be a disconnection within the interaction that leads to reluctance to suggest treatment. Creating culturally competent training programs for all medical staffs in the form of grand rounds, employee-driven departmental discussions or mandatory annual compliance training can also help address provider bias. Providing tangible tools for providers to counter their own racial stereotyping is essential to eliminating top-down propaganda that Black men are violent and non-adherent.

Examing health disparities experienced by Black patients is especially important for developing policies in academic institutions and the healthcare industry overall. Current organizations such as the Black Men’s Health Initiative and the National Institute of Minority Health and Health Disparities are working to address Black men’s health concerns. These programs have successfully changed policies, raised awareness, and become advocates for Black men in the USA [37–39]. Professional health education programs should partner with these organizations to enhance providers’ perceptions of Black men.

Limitations

This was a convenience sample taken from two geographically localized urban hospitals. We had limited resources and time constraints, and our sample size also lacked diversity (Latino, Native-American, etc.) as we chose to only speak with Black and White providers; future analysis should include other ethnic minorities. We did not address issues concerning Black men with multiracial identity, as participants self-disclosed their race. We did not fully explore genetics and environmental factors. We did not formally consult with our participants regarding the results (credibility); however, we did scrutinize the results of this study, addressing confirmability, and created a comprehensive interview guide outlining the steps of the study (dependability). The literature review summarized in Table 1 led us to focus on providers’ experience with black male patients. However, a significant limitation to the study is that we did not talk to patients in these practices. It would have been helpful to understand their perspectives as to how they are perceived by the providers who serve them. The social support available to these patients as well as other cultural preferences related to healthcare interactions such as religion and use of non-physician medical providers (clergy, shamans, etc.) would be necessary to fully understand those perceptions.

Conclusion

It is clear from the literature that the cause of racial disparities in healthcare emanates from something more than what previous studies have found in controlling for insurance status, medical complexity, and income. The reasons have remained elusive. This study is a first step in shedding light on what may explain the differential. Perception of Black males and cognitive dissonance appear to influence providers’ approaches with Black male patients. This study suggests that provider biases exist. This proposes the need to develop initiatives among currently practicing providers and create curricula in health professional schools that address provider racial bias. Understanding the dynamics operating in the patient-provider encounter enhances the ability to address and reduce health disparities.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Human Participant Protection Human subjects within this study were exposed to minimal risk.

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