Preference for Same-Race Health Care Providers and Perceptions of Interpersonal Discrimination in Health Care*

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Journal of Health and Social Behavior 2006, Vol 47 (June): 173–187

This article examines black Americans' preference for black health care providers. Using data from a national survey, we assess how blacks' perceptions of discrimination are related to preference for same-race health care providers. Overall, the belief that discrimination is frequent in different-race doctor-patient dyads is associated with greater preference for a same-race provider. However, the belief that discrimination occurs regardless of a doctor's race reduces preference for a same-race provider. Finally, general perceptions of discrimination are distinct from concerns about personally being treated unfairly, and low personal concern about unfair treatment reduces preference for a same-race provider among those who believe that interpersonal discrimination occurs frequently. These results suggest a complex picture of how perceptions of discrimination influence preferred race of health care provider among blacks in the United States.

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A 2003 Institute of Medicine report (Smedley, Stith, and Nelson 2003) documented that blacks receive unequal treatment in health care, and subsequent research has supported this conclusion (Guwani and Weech-Maldonado 2004; Cromwell et al. 2005; Groeneveld, Laufer, and Garber 2005). In many studies, the inequality persists even when access factors such as insurance coverage and income are controlled. Research seeking to determine the source of the inequality suggests that racial dynamics affect the interpersonal aspects of the doctor-patient relationship (e.g., van Ryn and Burke 2000; Malat 2001) and that discrimination—conscious or unconscious—may also affect treatment recommendations (Williams and Rucker 2000; van Ryn and Fu 2003). Observing disproportionate racial concordance between patients and physicians, some researchers have implied that preference for same-race health care providers may be a response to unequal treatment in health care (Gray and Stoddard 1997; Saha et al. 2000). Indeed, receiving care from black providers is one possible strategy for avoiding interpersonal discrimination in health care. However, little published research assesses how perceptions of discrimination in health care relate to preferred race of provider (Malat and van Ryn 2005).

In this article, we use data from a national survey to assess whether the perceived frequency of interpersonal discrimination in health care and the perceived personal likelihood of experiencing interpersonal discrimination are related to preferred health care provider race. This study will provide insight

* This research was supported by a grant from the Charles P. Taft Memorial Fund at the University of Cincinnati. We thank David C. Lundgren, Steve Carlton-Ford, Kimberly Goyette, and Marcia Bellas for providing helpful comments on earlier drafts of this paper. Address correspondence to Jennifer Malat, Department of Sociology, University of Cincinnati, P.O. Box 210378, Cincinnati, OH 45221 (email: Jennifer.Malat@uc.edu).

into how perceptions of discrimination relate to one potential response to perceived discrimination in an institution that has a history of treating blacks poorly and currently provides unequal care (Gamble 1997; Smedley, Stith, and Nelson 2003).

CONCEPTUAL FRAMEWORK

Preferred Health Care Provider Race

Race is a socially constructed concept whose boundaries frequently shift. While racial categories have changed over time in the United States, the distinction between blacks and whites has remained particularly durable. Importantly, the distinction has consistently maintained white privilege, though in different forms. Thus, despite being a socially constructed category, race has real meaning and consequences in the lives of Americans (Omi and Winant 1994). One such meaning can be found in interpersonal interactions, including medical encounters in which race is associated with both patients' and providers' evaluations of one another (e.g., van Ryn and Burke 2000; Malat 2001).

Research assessing the level of preference for same-race health care providers is relatively recent (Saha et al. 2000; Gerbert et al. 2003). Results from a national Kaiser Family Foundation survey suggest that approximately 20 percent of blacks prefer same-race health care providers (Malat and van Ryn 2005). One potential reason that blacks might prefer same-race health care providers is that they want to avoid discrimination in health care encounters, an untested idea that is suggested by many researchers (Council on Ethical and Judicial Affairs 1990; Thomas and Quinn 1991; Gray and Stoddard 1997). However, with only one in five blacks stating a preference for a same-race health care provider, factors that may reduce preference should be considered as well. This article focuses on the relationship between specific perceptions of interpersonal discrimination in health care and preference for same-race health care providers among blacks, with attention to both stronger and weaker preference. Importantly, factors other than interpersonal discrimination may influence preference, but the emphasis here is on these particular explanations.

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Discrimination from Nonblacks

A variety of scholars have written about strategies for coping with interpersonal discrimination. One branch of this research describes a strategy of anticipating and avoiding discrimination by circumventing negative encounters. For example, Pettigrew (1964) included this strategy in his work decades ago, and others have examined it as well (e.g., Simpson and Yinger 1985). Black feminist theorists have explored this idea as the notion that within the black community, black women create space that is relatively safe from racial discrimination (Collins 1991; Byng 1998).

Research on stigma also suggests the possibility of coping with the threat of prejudice and discrimination by avoiding interactions with members of the out-group (Oyserman and Swim 2001). The concept of stigma and related research can offer guidance here, because in the United States blacks are a stigmatized group (Link and Phelan 2001). The likelihood that a member of a stigmatized group will avoid interactions with the out-group depends, in part, on the perceived risk of unfair treatment. For example, Pinel (1999) finds that individuals who more strongly expect to be stereotyped are more likely to avoid threatening situations with dominant group members. This suggests that blacks who perceive frequent interpersonal discrimination in medical encounters would be more likely to prefer encounters with same-race health care providers.

It is appealingly uncomplicated to suggest that those who are most cognizant of potential discrimination are more likely to prefer in-group interactions. Indeed, we hypothesize that blacks who believe that discrimination is frequent in different-race doctor-patient interactions are more likely to prefer same-race health care providers. However, other factors may moderate this relationship. In much of the research described above, the threat of discrimination is conceptualized as coming solely from out-group members, which is unlikely to accurately reflect how blacks perceive discrimination or how it operates. Discrimination may come from same-race persons as well. In addition, many studies fail to distinguish conceptually and analytically between perceptions of the threat of unfair treatment to the group and perceptions of the threat of unfair treatment to oneself. Both of these omitted factors could

reduce preference for same-race health care providers. In order to expand and clarify the relationship between perceived discrimination and preferred race of health care provider, we examine two additional theoretical possibilities that may be associated with reduced preference for same-race providers: the belief that there is "discrimination either way" and the perception that "it won't happen to me."

"Discrimination Either Way"

In order to understand how risk of discrimination affects preferences regarding race, it may be inadequate to conceptualize discrimination as coming only from out-group members. This may be particularly significant in interactions with higher-status individuals such as health care providers. Race ascribes more power to whites than to blacks in the U.S. racial structure, but individuals gain power in other ways as well. For instance, power is obtained from achieved statuses such as social class or occupational prestige. The possibility that individuals, black or white, could use their social location to treat blacks unfairly may be an important consideration in choosing a strategy for approaching a situation. In other words, vigilance against discrimination may be necessary in same-race interactions as well as in different-race interactions.

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The potentially competing effects of race and occupational status are examined in law enforcement as a question of whether black officers are "black or blue" (Weitzer 2000). This phrase is a colloquial way of asking whether black officers are more strongly aligned with their race group or the beliefs and power associated with their occupation. The initial research in this area reported that lower-socioeconomic-status black citizens have negative perceptions of black police officers due to feelings of betrayal by their own race. Alex (1969) explained that black police officers tend to be viewed as representatives of the white power structure. More recent research supports these findings. A study of residents living in three neighborhoods in Washington, DC, found that citizens who perceive the treatment of black citizens by black officers to be unduly harsh feel that black officers act "blue" in order to portray themselves as racially unbiased to white officers and citizens. Critical citizens believe that black officers who act "blue" are using the power of the uniform to mistreat blacks and demonstrate agreement with colleagues' expectations (Weitzer 2000).

Black patients may have similar perceptions of black doctors and health care providers. Black providers may respond to being a part of a mainly white health care system by adopting the dominant group's values and approaches to medicine. In addition, social class and professional dominance over management of health also confer power upon doctors. Although in a different position from police officers, health care providers also have power that can be exercised to the detriment of low-status patients. Even if black providers do not respond to their position in this way, patients may be concerned about the potential for mistreatment. Suggesting that patients might have such a concern, LaVeist, Rolley, and Diala (2003) found that having a same-race doctor does not reduce the odds of black patients reporting racial discrimination.

If the belief that black providers might discriminate is salient in shaping preferences regarding provider race, it would complicate explanations of the relationship between perceived discrimination from nonblack doctors and black patients' preferred provider race. If discrimination is likely to occur regardless of the race of the provider, then one cannot successfully avoid discrimination by seeking care from a same-race health care provider. Thus, perceptions of same-race discrimination may reduce preference for same-race health care providers. To get a fuller picture of how concerns about discrimination relate to preferences, the likelihood of discrimination from both black and nonblack health care providers—that is, "discrimination either way"—needs to be considered.

"It Won't Happen to Me"

In contrast to the vigilant perspective described above, some individuals may believe that discrimination often occurs in doctor-patient interactions but that discrimination is not likely to be encountered personally. This difference is referred to in social psychology as a personal/group discrepancy. That is, individuals are more likely to report higher levels of discrimination toward their group than toward themselves personally. This discrepancy, which also occurs in domains outside of

discrimination, can affect dominant group members, and it occurs in positive events as well (Moghaddam and Studer 1997; Moghad-7dam, Stolkin, and Hutcheson 1997). To our knowledge, the potential implications of the personal/group discrepancy for strategies for dealing with discrimination have not been explored in a quantitative analysis.

Two main explanations, one motivational and one cognitive, guide the research on personal/group discrimination discrepancy (Fuegen and Biernat 2000). Both predict a discrepancy in perceived risk of discrimination in health care. The motivational explanation, which includes complete denial of personal discrimination, suggests that individuals report comparatively lower levels of personal mistreatment because they blame themselves for poor treatment, they are attempting to protect their self-esteem, or they are unwilling to identify a perpetrator (Fuegen and Biernat 2000). In the health care setting, inward blame for poor treatment or refusal to recognize discrimination in health care may lead to a gap between perceived frequency of discrimination toward the group and perceived risk of discrimination personally. Also, those with a personal/group discrimination discrepancy may be attempting to protect their personal identity and self-esteem by denying that discrimination might exist in their doctor-patient interactions, particularly with a trusted doctor.

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The cognitive explanation of the personal/group discrimination discrepancy posits that individuals report higher levels of discrimination toward their group because there is more evidence of discrimination at the group level; but individuals fail to account for the greater opportunity for discrimination against the larger group compared to the opportunity for discrimination against a single individual (Moghaddam and Studer 1997). That is, an individual may be more likely to report group discrimination because there are more cases of discrimination against the people in the group than there are in the individual's personal experience (Fuegen and Biernat 2000). Application of this explanation to the health care setting is straightforward. Historical abuses such as (but not limited to) the Tuskegee Syphilis Study are part of the group knowledge of blacks in the United States (Thomas and Quinn 1991; Gamble 1997). Additionally, current inequalities in medical treatment are covered in the popular press (e.g., Villarosa 2004). Reports of group-level inequality contrast with private clinical encounters where there is virtually no ability to make comparisons and identify discrimination, which may lead to a personal/group discrepancy in perceptions of risk.

There are two important points to be taken from this discussion of personal/group discrepancy. First, this theory suggests that we need to distinguish analytically between perceptions of risk of unfair treatment toward the group and perceptions of risk of unfair treatment toward the individual. Second, the theory suggests that some portion of the population will perceive a high threat against the group but will have a low assessment of personal risk. The people who believe it won't happen to them may be more likely to have lower preference for same-race health care providers than those who believe that discrimination can happen to them.

HYPOTHESES

Taken together, these theoretical considerations suggest that the relationship between preference for a same-race health care provider and perceptions of interpersonal discrimination involve a complex set of factors. On the basis of research presented above, we propose five related hypotheses. We expect that the final hypothesis will best account for preferred health care provider race.

Hypothesis 1: The perception that different-race health care providers frequently discriminate against blacks in clinical encounters is associated with stronger preference for same-race health care providers ("discrimination from nonblacks").

Hypothesis 2: The perception that same-race health care providers frequently discriminate against blacks in clinical encounters is associated with lower preference for same-race health care providers.

Hypothesis 3: The perception that both same-race health care providers and different-race health care providers frequently discriminate against blacks in clinical encounters is associated with lower preference for same-race health care providers compared to the belief that discrimination occurs

only in different-race interactions ("discrimination either way").

Hypothesis 4: The perception that different-race health care providers frequently discriminate against blacks in clinical encounters is statistically distinct from concern about personally experiencing discrimination in models predicting preferred health care provider race.

Hypothesis 5: The perception that different-race health care providers frequently discriminate against blacks in clinical encounters and low concern about personally experiencing discrimination is associated with lower preference for a same-race health care provider compared to having the perception that discrimination is frequent and having personal concern about it ("it won't happen to me").

METHODS

Data

We draw our data from a subsample of the 1999 nationally representative telephone survey, "Americans' Perceptions of Racial Disparities in Health Care," designed by the Henry J. Kaiser Family Foundation and conducted by Princeton Survey Research Associates. The survey provides a unique opportunity to examine the relationships among sociodemographic variables, perceptions of inequality, and perceptions of health care in a national sample of Americans, including an oversample of black Americans. Detail on the methods can be found in Lillie-Blanton et al. (2000). Briefly, the survey included a nationally representative sample of 3,886 adults living in households with telephones in the continental United States in 1999. A disproportionate stratified sample of random-digit telephone numbers was used to achieve an oversample of black and Latino respondents, though the analysis in this paper was limited to the non-Hispanic black sample (N = 1,189). The final response rate was 49 percent (Princeton Survey Research Associates 1999). In contrast to conventional wisdom, current empirical research suggests that low response rates are unlikely to bias parameter estimates (Curtin, Presser, and Singer 2000; Keeter et al. 2000; Teitler, Reichman, and Sprachman 2003; Tourangeau 2004).

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Dependent Variable

Respondents were asked, "If you had to choose, would you prefer to be treated by a doctor or nurse of your own race or ethnic group, or not?" Although the question wording encourages a specific response, two-thirds of the black sample indicated no preference. Consequently, in the analysis this variable has three categories: prefer same-race provider, prefer different-race provider, and no preference regarding race of provider.

Explanatory Variables

The independent variable for the first hypothesis is the perceived frequency of discrimination in different-race clinical encounters. This is measured by an item that asked respondents, "Thinking again about health care, how often do you think racism occurs when a patient and doctor are of different racial or ethnic backgrounds?" The response categories were "never," "not too often," "somewhat often," and "very often." The question that preceded this item defined "racism" as "people being treated worse than others because of their race or ethnicity." Thus, with this definition, "racism" is similar to racial discrimination as it is usually defined by social scientists (e.g., Feagin 1991).

The perception of discrimination in same-race clinical encounters is assessed with a parallel survey item. Respondents were asked, "What about if the patient and doctor are of the same racial or ethnic background?" Again, the response categories were "never," "not too often," "somewhat often," and "very often."

To test personal concern about unfair treatment, we use an item that asked, "Thinking about the future, how concerned are you that you or a family member will someday be treated unfairly specifically because of your race or ethnic background when seeking medical care?" While this question does not use the term "racism," as questions about perceived frequency of racism from same- and different-race doctors did, the definition of racism given in the survey ("people being treated worse than others because of their race or ethnicity") is

similar to the language in this question. The response categories were "not at all concerned," "not too concerned," "somewhat concerned," and "very concerned."

Control Variables

Multivariate models control for gender, age, education, income, and insurance status. Age has a curvilinear relationship with preferred health care provider race. Preliminary analysis showed that the proportion preferring same-race health care providers could be grouped into three age categories: 18–44 years old, 45–54 years old, and over 55 years old. Therefore, age is operationalized as a categorical variable.

Information about the respondents' educational attainment was recorded with eight categories. For the analysis, business, vocational, and technical degrees were combined with two-year and associate's degrees. The education item is included in the models as a continuous variable.

In the survey, income was measured with three items, though respondents only answered one or two items, depending on their cooperation. The first asked respondents whether their income was greater than or less than $25,000. Respondents were asked to provide more detailed income information in a follow-up question based on income categories either above or below $25,000, following from their previous response. Altogether, 16.4 percent of the black sample is missing data on one of the income measures. Therefore, we imputed income data for those who answered the first income question but not the more detailed second question. Within each of the two more detailed income items, we assigned the mean black income for their educational attainment to the cases missing income data.

Insurance coverage was assessed with two items. The first asked if the respondent was covered by a health insurance plan; the second asked those with coverage what type of insurance plan they had. The response choices for these two items were combined to create an insurance coverage variable with the following categories: "no coverage," "private insurance," "Medicare," or "state or other public program."

Analytic Plan

The statistics presented here are weighted to adjust for different likelihoods of selection into the sample and to make the results representative of the national population. All of the statistical parameters presented in this paper are estimated using the statistical package Stata (StataCorp 2001). Stata offers two techniques to adjust standard errors for complex survey designs. For this paper, the bivariate chi-square statistics are calculated using the "svy" commands. We used the "robust" command to adjust standard errors in the regression models. The "svy" commands produced trivially larger standard errors. The value of the coefficients does not depend on the technique used.

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Multivariate analyses utilize multinominal logistic regression models that control for age, gender, education, income, and insurance coverage. Multinomial logistic regression models simultaneously estimate binary comparisons among the categories of the dependent variable. The tables present the comparisons between those who prefer a same-race health care provider to those who have no preference, and the comparisons between those who prefer a different-race health care provider to those who have no preference. The coefficients estimating the comparison between preference for same-race providers and preference for different-race providers can be determined by calculating the difference between the coefficients for the models presented. Significance of explanatory variables is determined by assessing the difference in the –2 log-likelihoods (–2LL) for nested models. Tables also include significance of the coefficients based on the *z*-test statistic in order to aid in interpretation of results. However, for small and medium sample sizes, the difference in the –2 log-likelihoods is a better indication of significance (Agresti and Findlay 1997). It is important to recognize that the significance of a variable to the model is not calculated for a single comparison on the dependent variable (e.g., between prefer same–race provider and no preference only) but for the complete multinomial model and all of the possible comparisons on the dependent variable. The tables present the relative risk ratios (exponentiated coefficients) to facilitate interpretation of the results.

To evaluate hypotheses about moderating effects, multiplicative interaction terms are used. The product of perceived frequency of

discrimination from different-race and same-race doctors assesses the belief that discrimination is frequent "either way." The product of perceived frequency of discrimination (either from in-group members or out-group members) and personal concern about unfair treatment indicates whether the respondent believes that discrimination happens, but it won't happen to him or her. In order to facilitate understanding of significant interactions, we discuss the interaction results in terms of predicted probabilities, which were calculated in Stata from the regression models. For probability calculations, all variables were held at their means except the explanatory variables, whose values are specified in the text.

RESULTS

Table 1 shows the distribution of the variables. 20.7 percent of the respondents stated a preference for a same-race health care provider, 12.6 percent stated a preference for different-race health care providers, and 66.7 percent responded that they have no preference regarding the race of their health care provider. When asked about the frequency of discrimination in different-race doctor-patient interactions, over half of the respondents said they felt that discrimination occurs somewhat often or very often (57.4 percent). Just over half as many respondents, 27.3 percent, said they felt that discrimination occurs somewhat often or very often in same-race interactions. Finally, almost two-thirds of the respondents were somewhat or very concerned about personally experiencing racial discrimination in the future (66.2 percent). Table 1 also presents the distribution of the control variables. The distributions of some of the variables have been presented previously (Lillie-Blanton et al. 2000; Malat and van Ryn 2005).

Bivariate Results

Table 2 presents the bivariate relationships between preferred health care provider race and the independent and control variables. The perceived frequency of discrimination from different-race health care providers is significantly related to preferences ($p < .01$). For example, compared to those who believe that discrimination is never an issue in different-race doctor-patient dyads, those who perceive that there is very often a problem are more than three times more likely to prefer a same-race health care provider (8.5% vs. 30.4%). The relationship between the perception of discrimination in same-race clinical encounters and preferred health care provider race is not significant ($p > .05$). Finally, concern about the possibility of personally being treated unfairly is associated with greater preference for a same-race provider ($p < .01$). Those who are least concerned about being mistreated are five times less likely to state a preference for a same-race health care provider (32.5% vs. 6.2%).

Chi-square tests of association indicate that age and income are the only control variables associated with preference for same-race health care providers ($p < .05$). Specifically, blacks over age 55 are the least likely to state a preference for a same-race health care provider, and those in the highest tercile of income are most likely to prefer a same-race doctor.

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Multivariate Results

Discrimination from nonblack doctors. To assess the first hypothesis, we add perceived frequency of discrimination from nonblack doctors to a model (not shown) that includes indicators of gender, age, education, income, and insurance coverage (see Table 3). The inclusion of the hypothesized variable results in a significant improvement ($p < .01$) over the model with only control variables. The effect is in the expected direction and is similar to that shown in the bivariate table: More perceived discrimination in different-race clinical encounters is associated with a greater likelihood of preferring a same-race health care provider than of preferring a different-race health care provider or than of having no preferred health care provider race.

"Discrimination either way." In order to test hypotheses 2 and 3, we build from the previous models. Model 2 in Table 3 assesses hypothesis 2 by introducing perceived frequency of discrimination from same-race clinicians to model 1. We find that perceived discrimination from black doctors has a significant effect on preference for same-race health care providers ($p < .05$). Recall that assessment of the significance of the independent variables is based on

TABLE 1. Distribution of Variables

	%	Unweighted N
Dependent Variable		
Preferred health care provider race		
Same race	20.7	255
Different race	12.6	157
No preference	66.7	768
Explanatory Variables		
Discrimination from different-race MDs		
Never	7.3	85
Not too often	35.4	427
Somewhat often	41.3	464
Very often	16.1	172
Discrimination from same-race MDs		
Never	24.1	274
Not too often	48.6	544
Somewhat often	23.9	282
Very often	3.4	41
Concern about personal future experiences of discrimination		
Not at all concerned	16.1	196
Not too concerned	17.7	208
Somewhat concerned	27.2	292
Very concerned	39.0	481
Control Variables		
Gender		
Male	44.6	489
Female	55.4	700
Age		
18–44	59.5	734
44–54	15.7	196
55 or more	24.8	237
Education		
Grade 8 or lower	4.8	36
High school incomplete	16.9	140
High school degree	37.5	412
Some college, no degree	15.3	220
Two-year college or vo-tech degree	11.3	141
Four-year college degree	8.8	151
Graduate or professional school	5.4	83
Income (mean category)	($31K–$35K)	1073
Insurance		
Private	55.9	692
Medicare	14.3	145
State or other public	12.1	142
None	17.8	199

Note: Includes only non-Hispanic black respondents.

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improvement over a model that does not include the independent variable of interest (indicated by the change in the –2LL at the bottom of the table) and simultaneously takes into account all comparisons between the categories of the dependent variable. *z*-tests of the significance of particular variables are shown in the table to suggest which comparisons are particularly meaningful. The results in this model suggest that stronger belief that discrimination is likely to occur in clinical encounters with same-race providers is associated with a higher likelihood of preferring a health care provider of another race than of preferring a same-race health care provider or of having no preferred health care provider race. Thus, hypothesis 2 is supported.

To test hypothesis 3, the interaction between the perceptions of discrimination is shown in model 3. The interaction has a statistically significant ($p < .05$) and substantively meaningful effect. Converting the coefficients to predicted probabilities facilitates interpretation of the findings. The predicted probability of preferring same-race health care providers is nearly three times lower for those who believe strongly that there is discrimination "either way" (.19) compared to those who believe that dis-

TABLE 2. Cross-Tabulations of Independent and Control Variables with Preferred Race of Provider

	Same Race	Different Race	No Preference	*p*-value
Explanatory Variables				
Discrimination from different-race MDs				
Very often	30.4	12.4	57.2	.01
Somewhat often	25.3	10.9	63.7	
Not too often	14.4	14.9	70.7	
Never	8.5	12.2	79.3	
Discrimination from same-race MDs				
Very often	22.7	17.0	60.4	.94
Somewhat often	19.6	14.0	66.4	
Not too often	21.6	12.7	65.7	
Never	21.8	10.0	68.2	
Concern about personal future experiences of discrimination				
Very concerned	32.5	11.5	56.1	<.01
Somewhat concerned	19.0	7.9	73.0	
Not too concerned	11.9	16.2	72.0	
Not at all concerned	6.2	17.6	76.2	
Control Variables				
Gender				
Male	24.3	10.2	65.6	.09
Female	17.9	14.5	67.6	
Age				
18–44	22.2	11.7	66.1	<.01
44–54	31.0	15.4	53.6	
55 or more	9.7	13.3	77.1	
Education				
Grade 8 or lower	2.0	17.9	80.2	.59
High school incomplete	21.8	11.7	66.6	
High school degree	19.5	10.6	69.8	
Some college, no degree	23.2	16.0	60.8	
Two-year college or vo-tech degree	23.4	10.6	66.0	
Four-year college degree	27.6	11.6	60.8	
Graduate or professional school	18.4	20.0	61.6	
Income				
First tercile	20.9	12.9	66.2	.02
Second tercile	20.7	14.3	65.0	
Third tercile	26.6	11.1	62.3	
Insurance				
Private	22.4	13.7	63.9	.27
Medicare	19.7	14.5	65.8	
State or other public	11.5	10.2	78.4	
None	22.9	7.9	69.1	

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Notes: p-values for chi-square test of association. Includes only non-Hispanic black respondents.

crimination occurs very often in different-race encounters but never occurs in same-race encounters (.56).

"It won't happen to me." Hypotheses 4 and 5 are assessed by adding to the models from the previous hypotheses. To assess hypothesis 4 (model 4, Table 4), we add the measure of personal concern about future racially unfair treatment, and we find that its effect is significant and in the expected direction ($p < .01$). Each higher level of concern is associated with a nearly two-times-higher probability of preferring a same-race health care provider over a different-race provider (comparison not shown) and 1.7-times-higher odds than stating no preference. Both personal concern about racially unfair treatment and perceived frequency of discrimination against the group by different-race providers are significant in the same model, confirmed in analysis not shown,[1] suggesting that these are unique factors in predicting preferred health care provider race.

To test hypothesis 5, we need to examine the interaction between personal concern about unfair treatment and perceptions of discrimination. Because the interaction of frequency of discrimination from same-race and different-race physicians is significant (see model 3), this interaction is maintained. In addition, the interactions between frequency of discrimination (both same-race and different-race) and personal concern about racially unfair treat-

TABLE 3. Relative Risk Ratios for Multinomial Logistic Regression Models Predicting Preferred Healthcare Provider Race

	Model 1		Model 2		Model 3	
	Same Race	Different Race	Same Race	Different Race	Same Race	Different Race
Discrimination frequent from different-race MD	1.63**	.91	1.69**	.79	.65	1.17
Discrimination frequent from same-race MD			.91	1.36	.49	1.88
"Discrimination either way"						
Discrimination frequent from same-race MD × discrimination frequent from different-race MD					.73	1.15
Male	1.22	.59*	1.23	.57*	1.19	.58*
Age (18–44 excluded)						
45–54	1.54	1.76	1.56	1.69	1.59	1.68
55 and older	.31**	.63	.32	.59	.31**	.59
Income	1.11	1.00	1.11**	1.00	1.10	1.00
Education	1.00	1.05	1.01	1.03	1.01	1.04
Insurance (no coverage = excluded)						
Private	.65	2.02	.65	2.02	.64	2.05
Medicare	1.14	2.59	1.14	2.56	1.16	2.59
State coverage	.46	1.27	.47	1.19	.46	1.20
Δ –2LL (df)	**24.57 (2)†**		**6.22 (2)†**		**8.08 (2)†**	
Unweighted N	994		994		994	

† $p < .05$ based on difference in the –2 log-likelihoods of nested models (preferred test)
* $p < .05$, ** $p < .01$ for z-test of significance of coefficient (secondary test)
Notes: Includes only non-Hispanic blacks. "No Preference" omitted category of dependent variable.

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TABLE 4. Relative Risk Ratios for Multinomial Logistic Models Predicting Preferred Healthcare Provider Race

	Model 4		Model 5	
	Same Race	Different Race	Same Race	Different Race
Discrimination frequent from different-race MD	.72	1.21	4.41*	1.04
Discrimination frequent from same-race MD	.56	1.87	.74	1.75
Concern about personal unfair treatment	1.70**	.90	3.01**	.97
"Discrimination either way"				
Discrimination frequent from same-race MD × discrimination frequent from different-race MD	.81	1.14	.24	1.23
"It won't happen to me"				
Discrimination frequent from different-race MD × concern about personal unfair treatment			.44	.75
Discrimination frequent from same-race MD × concern about personal unfair treatment			3.64	.48
Male	1.06	.59	1.10	.61
Age (18–44 = excluded)				
45–54	1.66	1.65	1.80	1.68
55 and older	.32**	.59	.35**	.58
Income	1.10	1.00	1.11	1.00
Education	1.00	1.04	1.01	1.05
Insurance (no coverage = excluded)				
Private	.70	1.99	.68	2.01
Medicare	1.33	2.41	1.28	2.39
State coverage	.45	1.22	.46	1.27
Δ –2LL (df)	**32.76 (2)††**		**10.04 (4)†**	
Unweighted N	994		994	

†† $p < .01$, † $p < .05$ based on difference in the –2 log-likelihoods of nested models (preferred test)
* $p < .05$, ** $p < .01$ for z-test of significance of coefficient (secondary test)
Notes: Includes only non-Hispanic black respondents. "No Preference" omitted category of dependent variable.

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ment must be considered. Cell sizes become very small in the interactions. Consequently, for this model the perceived frequencies of discrimination in same-race and different-race clinical encounters are dichotomized ("never" and "not too often" vs. "somewhat often" and "very often"). The interactions are significant ($p < .01$) over a model that includes the dichotomous coding of the variables, as indicated by improvement in the model shown at the bottom of the table (Δ –2LL/df). Overall, the results support the hypothesis.

To interpret the interactions, we will discuss predicted probabilities based on this model. Among those who believe that discrimination is frequent in different-race medical encounters but not in same-race encounters, high concern about being treated unfairly increases the probability of preferring a same-race doctor by 42 percent compared to those who have low personal concern about being treated unfairly (from .25 to .35). The predicted probability of preferring a same-race provider among those who believe that discrimination is infrequent in both same-race and different-race encounters is nearly three times higher for those who are personally concerned about being treated unfairly (.21) compared to those who are not concerned (.07). Not surprisingly, the highest probability of stating no preference regarding provider race is among those who perceive no discrimination in same-race or different-race encounters and who have low personal concern about unfair treatment (.76).

CONCLUSION

In this article, we set out to assess the extent to which preference for same-race health care providers among blacks is associated with perceptions of interpersonal racial discrimination in health care. The interaction of specific perceptions of discrimination were of particular interest. Overall, we found that preference for same-race health care providers is associated with a complex set of perceptions about discrimination.

First, the extent of perceived greater frequency of discrimination in different-race clinical encounters is associated with greater preference for same-race health care providers. This result gives empirical support to the expectation that general perceptions of unfair treatment in health care are related to the attitudes and preferences of blacks seeking care.

However, further analysis showed that additional factors complicate this effect.

The results from the next part of the analysis suggested that perceived frequency of discrimination in same-race medical interactions also influences preferences. The results showed that the perception that in-group discrimination is frequent reduces preference for same-race health care providers. Furthermore, the belief that discrimination is frequent in same-race encounters moderates the effect of perceptions of discrimination in different-race encounters. In other words, among those who believe that there is discrimination in different-race clinical encounters, the perception that discrimination is likely "either way" reduces preference for same-race health care providers. From the perspective of these respondents, seeking care from black providers may not offer protection from unfair treatment. These findings suggest that conceptualizing discrimination as coming only from nonblacks is inadequate for understanding perceptions of racial inequality. Importantly, these findings point out that responses to interpersonal discrimination may involve more complex considerations than attention to race. In this case, the perception that health care providers, regardless of race, are influenced by their position of authority or constrained by their profession may account for this effect.

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Future research should explore the dynamics of same-race health care interactions. Several studies show that same-race pairings result in higher patient ratings of doctors (Malat 2001; LaVeist and Nuru-Jeter 2002). Yet the results presented in this article importantly suggest that some black patients do not see same-race providers as a sure protection from interpersonal discrimination in health care. The one study that has assessed whether black patients are more likely to receive appropriate treatment from black doctors found that racially concordant pairings did not improve the likelihood of blacks receiving cardiac catheterization (Chen et al. 2001). Research is needed to understand in more detail how race and other factors affect the encounter. For example, how do social class and race interact to influence patients' perceptions of providers? Research on perceptions of discrimination in health care suggest that blacks perceive discrimination due to social class more often than discrimination due to race (LaVeist, Rolley, and Diala 2003). How both race and class affect discrimination perceptions and experiences deserves more attention.

The final hypotheses tested in this paper were built from the notion of the personal/group discrepancy, seeking to assess whether personal concern moderates the effect of general perceptions of discrimination in health care. First, we found support for the hypothesis that threats of unfair treatment toward the group and toward the individual are distinct in predicting preferred health care provider race. These results suggest that individuals assess risk to the group and themselves separately when forming a preference about provider race. Future research on how inequality in health care affects decision making among black patients should assess general perceptions of inequality and personal concerns about unfair treatment separately.

Concordant with our final hypothesis, we found that those who perceive frequent discrimination in clinical encounters and who are personally concerned about unfair treatment have a higher probability of preferring same-race health care providers than those with a low level of personal concern. This final moderating effect—that of personal concern about unfair treatment—suggests a complex picture of how perceptions of discrimination influence preferred provider race among blacks. This picture suggests that perceived frequency of discrimination in same-race and different-race encounters are weighed against personal risk of unfair treatment.

These results raise many questions for future research. For example, even among those who perceive frequent discrimination in racially discordant medical encounters but not in racially concordant encounters and who have a high level of personal concern about experiencing discrimination in the future, the predicted probability of preferring a same-race health care provider is still quite low (.35). Understanding how black patients form preferences regarding doctor race will require more research on perceptions of providers and which factors are important to black patients choosing a provider. Do perceptions of discrimination affect interaction in the clinical encounter? Specifically, for example, is patient communication with a provider affected by patient perceptions of health care discrimination and personal concerns about unfair treatment? Is adherence to treatment recommendations influenced by these factors?

There are limitations to these findings. One limitation is that all constructs are measured by single items. Future research should seek to confirm and expand understanding of the results presented here through use of multiple indicators of the theoretical constructs. Furthermore, future research should examine the issues raised in this paper with differently worded items. The dependent variable in particular may have better captured "preferences" if the wording had asked respondents what their preference would be if they "could choose," rather than if they "had to choose." The former wording might have freed the respondents from considering constraints on their choices.

One factor in respondents' lives that might influence their preference regarding provider race is their relationship with their present provider. First, African Americans who are happy with their nonblack doctor may be less likely to prefer a same-race health care provider because they evaluate the question in terms of their current situation. Second, patients who prefer to see same-race health care providers may have been motivated by this preference to do so, which is the reverse of the relationship modeled here. The third theoretical effect suggests a spurious relationship, with access to black providers influencing both preferences and the likelihood of having a same-race doctor. While approximately 12.3 percent of the adult population was black in 2000 (U.S. Census Bureau 2001: Table 37), only 4.4 percent of physicians were black (U.S. Census Bureau 2000), and 7 percent of medical school graduates were black (Barzansky and Etzel 2001). Blacks were better represented among nurses, at 8.8 percent (U.S. Census Bureau 2000). Respondents who do not have access to black health care providers[2] may be reluctant to state a preference that is unavailable. Simultaneously, respondents without access to a black provider will report a nonblack provider. Thus, degree of access to same-race providers would create a spurious association between preferred health care provider race and race of regular provider. In models not shown, race of respondents' doctor and satisfaction with the doctor were included as independent variables in the models presented in Tables 3 and 4; the results described above persist.[3] However, because the direction of the effect of race of regular doctor on preferred race of doctor cannot be determined from these cross-sectional data, the coefficient estimates were biased. Future research utilizing panel data, more detailed survey items, and unstructured interview techniques could give additional insight into preferred provider race.

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Another limitation of this study is that respondents may be reluctant to state a preference to an unknown survey interviewer. Further, responses may have been influenced by the perceived race of the interviewer, which is not given in the data set. In addition, these analyses do not capture cultural differences among blacks in the United States. While blacks are often conceptualized as being a part of a single culture, there are cultural variations based on, for example, region, nativity, and social class that may make some black Americans more or less comfortable with black and nonblack doctors. Also, there may be other factors not measured in this survey that have specific influences on the formation of preferences regarding health care provider race. Internalized racism—in this case, the belief that black doctors are less qualified than white doctors—may decrease preference for same-race health care providers. Other researchers have suggested that internalized racism might influence blacks' decisions when seeking care (Jones 2000; Taylor, Neighbors, and Broman 1989), but this hypothesis has not been tested. Finally, assessment of the practice location of doctors may also affect preferred health care provider race. Because black doctors are more likely to work in urban centers that have fewer resources, some people may base their preferences on the perceived lower quality of care available in the locations where black doctors are more likely to practice.

Despite these limitations, the analysis presented here provides a useful look at preferred health care provider race. We have examined preference for same-race providers as a strategy for blacks seeking care from a health care system that provides unequal treatment. The findings suggest that perceptions of interracial discrimination and personal concerns about experiencing discrimination lead to stronger preference for same-race health care providers, while perceptions of intraracial discrimination weaken preference for same-race health care providers. More research is needed to understand how perceptions of inequality affect patients and to understand the strategies that blacks and other minorities use to navigate the health care system.

NOTES

1. In models not shown, the –2 log-likelihood ratio test of significance was used to confirm this claim. The indicators for frequency of discrimination in different-race interactions and the "discrimination either way" interaction were introduced to a model including concern about unfair treatment, frequency of discrimination in same-race interactions, and the control variables. The result was a significant improvement in the –2 log-likelihood ratio ($p < .05$).
2. The data set does not include information about the respondents' level of choice of provider.
3. The final model was only marginally significant ($p = .09$). This is likely due to limited statistical power to estimate the additional six parameters (no regular doctor, black doctor/high satisfaction, black doctor/medium satisfaction, black doctor/low satisfaction, nonblack doctor/medium satisfaction, and nonblack doctor/low satisfaction, with nonblack doctor/high satisfaction as a reference category).

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