DOCTOR-PATIENT TRUST AND QUESTIONING MEDICAL AUTHORITY: A RACE, GENDER, AND SOCIOECONOMIC STATUS ANALYSIS

by

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To Mom and Steve

Thank You For Supporting Everything I Have Accomplished

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ABSTRACT

With millions of Americans visiting the doctor each year and major changes being made to the current state of health care, it is important that patients feel they can trust their physicians and will receive the best medical treatment available. However, increasingly physicians are participating in financial incentive plans that discourage the use of high-cost tests. This research examines how race, gender, and socioeconomic status shape trust within medical relationships and willingness to question medical authority using the 2002 General Social Survey data. Support is found for both a functionalist model of compliance and conflict model of power and self-advocacy. Blacks have significantly lower levels of trust than whites that physicians will put their health above costs and are significantly more likely to question medical authority. As socioeconomic status increases patients are less likely to question medical authority. As trust in physicians increase, patients are less likely to question medical authority. Gender did not predict trust or willingness to question medical authority. This research suggests the increasing importance of self-advocacy in health care as the system undergoes changes, and promotes a greater awareness of how collective legacies of racism, sexism, and classism can potentially shape the medical relationship and health disparities.

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INTRODUCTION

This research explores how a person's social location by race, gender, and socioeconomic status shapes doctor-patient relationships in the areas of trust and views on medical authority. I use a special health supplement of the 2002 General Social Survey in a two-step analysis. First, I examine how race, gender, and socioeconomic status shape trust in physicians and second, how trust shapes a patient's willingness to question his or her physician's medical authority. Specifically, this research asks which sociodemographic groups of people are more likely to trust their doctors concerning medical treatment and subsequently how trust influences their willingness to question medical providers about financial incentive plans that may discourage physicians from using certain medical tests. According to Guffey and Yang,

> Patients who have greater trust in their doctors are more likely to adhere to their doctor's advice, experience greater satisfaction with the care they receive, and report an improved health status (Safran, Kosinski, Tarlov, Rogers, Taira, Lieberman, & Ware, 1998; Thom Ribisl, Stewart, Luke, & the Stanford Trust Study Physicians, 1999). Greater trust is related to greater self-efficacy in treatment regimens and positive health outcomes (2012:1).

In this research, using level of trust to predict the likelihood that a patient will question his or her physician about the use of financial incentive plans, I hope to learn more about the potential importance of self-advocacy in health care. The knowledge and ability to question those with medical authority may lead to better health outcomes and better health care experiences all around. Identifying which groups are more trusting will require a look at how trust is established within doctor-patient relationships and how collective histories may continue to influence trust between doctor and patient. A greater understanding of interpersonal trust dynamics and the context of building trusting

relationships with physicians may also provide important information for minimizing demographic health disparities in the United States.

LITERATURE REVIEW

Trust in the Doctor-Patient Relationship

Past research on doctor-patient relationships addresses the level of trust that patients have in their doctors. The trust patients have with their doctors is closely related to how comfortable patients are in speaking with their doctors about health problems. According to Musick and Worthen, trust is one of the most critical aspects of the patient-physician relationship. They claim that trust exists at two levels. Interpersonal trust is defined as "trust [that] is built over time through the perception that actions are in accord with expectations" (2008:4). The second level of trust is considered to be social trust and "focuses more on common understandings about how institutions should behave according to normative standards" (2008:4). According to Hall et al. (2001a), another important aspect of trust is vulnerability. Although much of the research suggests that groups lacking in power such as the poor, women, and minorities are less trusting of medical authority because of past abuses, Hall et al. found that highly vulnerable groups are more trusting of their physicians or medical providers. They also suggest that in addition to sociodemographic factors, trust is typically predicted by factors such as the specific nature of the doctor or clinical relationship, forms of payment, and choice among doctors. Patients reporting longer relationships with physicians and ample choices among doctors reported higher levels of trust. Both of these findings suggest that people generally tend to be more trusting of physicians of their own choice and relationships that

have endured over time. The present research similarly assesses variations in trust by sociodemographic group. It further explores the likelihood that a patient will feel comfortable enough to ask his or her doctor whether he or she is participating in a financial incentive plan after controlling for levels of trust. As with previous research, I expect that the effects of sociodemographic factors may decrease after controlling for features of the doctor patient relationship, payment method, and choice among doctors.

Mark Hagland, editor-in-chief of *Healthcare Informatics*, claims, "many health plans offer physicians bonuses…for following 'utilization management' guidelines [that] usually reward physicians who make conservative decisions on what care they give to patients" (Hagland 2011:146). The ethical dilemma that Hagland speaks of leads one to question whether a doctor will reduce the amount of money that is going into his or her pocket in order to run more expensive medical tests that may or may not be necessary. With more focus on cost-saving care, medical providers may be less inclined to test patients in order to rule out certain ailments. For example, if a patient came in complaining of headaches and vision problems, a doctor might be inclined to send the patient away with a prescription for ibuprofen and orders for bed rest. Without financial incentive plans, a doctor might order a CT scan to rule out possible brain aneurysms just to be on the safe side. It makes sense that with increasing health care costs and cuts to spending, patients should be open to becoming more involved in their own health and question their health care providers. McPhee et al. explain that "physicians balance two potentially conflicting professional responsibilities: providing optimal care to patients and conserving society's resources." They go on to explain six dilemmas faced by physicians today. Cost containment approaches may impact 1) the quality of care, 2) the

physician-patient relationship, 3) physicians' fears of litigation, 4) relationships with colleagues, 5) physicians' incomes, and 6) perceptions of the equitable allocation of resources (1984:604-605). Clearly, the cost-containment approach to medicine may negatively impact patient trust and quality of health care given potential fear that quality of care will be compromised in the interest of cost cutting. This research is important because the levels of trust patients have in their doctors and their willingness to question medical authority can have important consequences for both compliance with treatment programs and the quality of health care received.

In 1999 the US government made the decision to define "health disparity" in response to an overwhelming problem that was brought to light. The National Institutes of Health (NIH) first defined health disparities as "differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States" (2008:7). In 2000, the National Institute on Minority Health and Health Disparities provided a more specific definition noting that "a population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population" (United States Public Law 106-525; 2000:2498). This newer term acknowledged that an increase in the rates of a disease and survival rates were important when determining which populations are health disparity populations. The constant evolution of this term reveals the growing concern over health disparities in the United States.

According to Williams and Jackson, little has been done to successfully decrease health disparities over the last 50 or so years (2005:327). Moreover, there have been

proposals made that could potentially increase these health disparities. For instance, the researchers claim that "during the Office of Management and Budget (OMB) review of how race and ethnicity should be assessed, the complete elimination of any attempt to classify persons according to race was proposed" (2005:1728). Clearly, federal policy proposals that race and/or ethnicity no longer be measured indicate an even more urgent need to bring health disparities among socioeconomic groups to the forefront. Time and time again, research reveals that not only are disease processes different among race, ethnic, sex, and age groups, but according to Fincher et al. "medical literature reveals data suggestive of differential treatment practices by clinicians based on: 1) race/ethnicity; 2) patient gender; and 3) patient socioeconomic status" (2004:360). These researchers assessed the characteristics of the sociocultural system, health care system, and interpersonal system and how each affects both doctor and patient. In terms of sociocultural aspects, doctors and patients were found to respond differently based on socially constructed belief systems and societal messages about race/ethnicity, socioeconomic status, and gender. In terms of the health care system, doctors are "socialized into the culture of professional medicine and are witness to the systematic treatment of different race/ethnic, socioeconomic, and gender groups" (2004:361). Patients, on the other hand, have health-related and group-specific beliefs and attitudes which have led to collective trust/distrust. In terms of interpersonal interactive systems, doctors have their own "perceptions of illness and health, knowledge of management of care or treatment, and communication patterns with patient and decision-making" (2004:361). Interpersonally, patients will have varying levels of confidence or distrust in physicians and the medical system. They will also each have their own "levels of health

seeking behavior and/or compliance and communication level with physicians and decisions to seek or accept treatment" (2004:361).

The concern with patient trust in medical authority in relation to patient satisfaction and patient compliance has only emerged in the past 20 years. Recent research suggests that trust in medical authority increases satisfaction with medical treatment and patient compliance with treatment plans (Anderson and Dedrick 1990). It was not until 1990 that a widely accepted measure, commonly referred to as the Trust in Physician scale, was developed in order to measure patient trust. In developing this scale, Anderson and Dedrick argued for the need to develop an "instrument to assess a patient's interpersonal trust in his physician" in order to better understand "patients' desires for control as well as for explaining patients' behaviors related to management of illness" (1990:1092). In their research, interpersonal trust is defined as "a person's belief that the physician's words and actions are credible and can be relied upon" (1990:1092). Their findings revealed that age and education of patients were related to interpersonal trust but that race was not a significant predictor of trust. A few years after the Trust in Physician scale was developed, researchers began to fine-tune trust measurement scales. The Primary Care Assessment Survey (PCAS) is a "self-administered written questionnaire . . . for a study of primary care delivery systems. The PCAS focuses on a specific doctor-patient relationship, rather than asking about a single visit or episode of care" (Pearson and Raeke 2000:510). Pearson and Raeke claim that the PCAS seems to best demonstrate high correlations between patient trust and physicians' communication, level of interpersonal treatment, and knowledge of the patient. After this scale, Kao et al. (1998) developed the Patient Trust scale by rewording some of the critical questions on

the Trust in Physician scale. They also added new items including confidentiality, reliability, and patients' trust in their physicians to provide necessary care under various cost constraints and administrative restrictions. Although the GSS data do not allow for recreating the Trust in Physician scale, following the work of Kao et al. (1998), the present research will focus on the responses given to the question of whether patients trust a doctor to put their health care above costs. Similarly, this research will look at the likelihood that patients will question medical authority by directly asking their physicians if they participate in a cost incentive plan. The dimensions of trust in this analysis are thus limited to trust about financial incentives and costs. It does not incorporate other important aspects of trust related to patients' beliefs that their physician is competent in preventing, identifying, and treating disease. However, with the increasing importance of financial incentive plans within health care today, this facet of trust is important and worthy of investigation.

Trust, Compliance, and Questioning Medical Authority

Compliance with medical treatment programs and questioning medical authority stem from the ability of patients to trust their physicians. According to Gilbert, "nurses and other health care professionals consciously build trust as a fundamental aspect of their relationships with [patients]" (2005: 569). Gilbert goes on to explain that trust can be placed in two categories: interpersonal trust and impersonal trust. Interpersonal trust is "conceived as an outcome of skilled intervention on the part of professionals and the result of personal qualities, education and adherence to professional codes of behavior" (Gilbert 2005: 569). This type of trust is developed between individuals as they interact with one another. However, Gilbert claims that interpersonal trust is developed on the

foundation of impersonal trust. Impersonal trust is "based on the proposition that trust pre-exists the involvement of any individual and, crucially, does not require knowledge of any other individual within the system" (2005: 569). Therefore, impersonal trust is systemic trust that must exist on a macro level within a community within the health care system before interpersonal trust, and later on compliance or questioning of medical authority, can be established. In light of this research literature, one can make the connection between trust and compliance. According to Dibben and Lean (2003) in summarizing other research,

> Patients who participate in decision making have a commitment to decisions about treatment (Brody 1980) and achieve higher levels of compliance (Hays and Dimetteo 1987). It is evident, therefore, that compliance requires the development of open, co-operative relationships between responsible patients and compassionate doctors (Fenerstein et al. 1988). Such broadly reciprocal relations are particularly the case in long-term chronic illness, where the patient's role in the illness management process is recognized to be of particular importance (Aguillar 1997; Lean et al. 1990; Prochaska et al. 1992). These relationships are consequently dependent on the development of trust between the parties, and the way in which the trust develops beyond the first meeting will have a significant impact on the success or otherwise of the care provided (Dibben et al. 2002; Thorne and Robinson 1988) (2003:243).

The connection between trust and compliance points out the importance of the type of research represented by this work. A better understanding of patients' trust in physicians and the health care system can potentially provide knowledge to improve relationships of trust and subsequently patient compliance as well as satisfaction with quality of care. This knowledge ultimately may help to close the gap in health care disparities by race, class, and gender.

Functional Sick Role versus Power Perspectives

Parsons (1975:257-278) posited that the sick person plays a role within society. As a structural functionalist, he believed that maintaining order and structure in society requires social practices to be seen in terms of their function and predictability. From a functionalist framework, the doctor-patient relationship is a critical one that can affect many aspects of a patient's acceptance and compliance with a doctor's orders. This is highly related to trust given that a patient must trust his or her doctor in order for both doctor and patient to fulfill their roles in the relationship. In describing the sick role, Parsons identified four different characteristics. First, in adopting the sick role a person can be exempt from carrying out his or her "normal" and expected roles. Secondly, a sick person is not held responsible for the sickness by the rest of society. Third, a sick person is expected to get well. It is not considered socially acceptable to remain sick for an exorbitant amount of time. Finally, a sick person is expected to seek help from a competent medical professional and to actively participate in getting better. In fact, Miczo asserted that "attributions of responsibility are contingent on the ill person making a good faith effort to get well" (2004:348). Hence from a functionalist perspective, patients must trust in medical authority and comply with doctor's orders in order to function responsibly within this role. It follows also that patients who readily assume the sick role when confronted with illness will be those who are more likely to trust in traditional medical authority. However, Miczo, drawing on other literature, points out that there is some overlap between the sick role and the patient role. He goes on to say that,

> One of the criticisms of the sick role is that it is medico-centric (Gallagher, 1976), emphasizing the authority and social control function of the physician as a legitimator of illness. Under the care of a physician, patients are socialized into submissive, dependent roles, which is likely to affect their perceptions of the entailments of the sick role (Arluke, 1988). In contrast to the legitimation process of the patient role, then, the sick role may be conceptualized as the process by which the ill person makes decisions about seeking medical care (Wolinsky, 1988). The outcome of this process may or may not be a visit to the doctor (Mechanic & Volkart, 1961) (Miczo 2004:355).

In contrast to the sick role model, more recent research has taken a closer look at the doctor-patient relationship, particularly concerning power dynamics between doctor and patient. Pauley (2011) explains that there is a degree of negotiation that must occur between doctor and patient. He notes that "as patients grow savvier in self-directing their own health care, the need for physicians to better negotiate divergent goals and values with their patients, patients' families, and professional colleagues also grows" (2011:139). Prior to this new founded "self-direction," doctors were able to more easily control the interaction between doctor and patient. Doctors maintained the upper hand by having more knowledge, expertise, prestige, organizational support, and stability. However as patients, through the use of modern technology, become better informed about their illnesses they also become advocates for themselves and for their own health care, and subsequently begin to close this power disparity. Strickler observed that there is an aspect of livelihood associated with this power disparity as well. He notes, for example, "when a consumer-researcher from Boston University was asked whether mental health care providers want them [patients] to get 100% better, she replied with a laugh, 'of course not, then they would be out of a job'" (2009:317). When there is

financial gain to be had by a medical authority, there may be a conflict of interest. Power disparities may cause conflict within doctor-patient relationships, which in turn can affect the levels of trust in physicians and the likelihood of patients' questioning authority. Moreover, patients with historically less power such as women, minorities, and the poor are likely to experience intimidation in the face of medical authority and may not feel confident confronting doctors or challenging their prescribed care.

Race/Ethnicity, Gender, and Socioeconomic Status

In this research, I examine how a race, gender, and socioeconomic lens can be used to examine levels of patient trust and willingness to question medical authority. Some researchers have questioned the usefulness, or appropriateness, of classifying different races or ethnicities for purposes of studying health care. Although there are more genetic commonalities between races than differences, race is still an important social construct in relation to health care. The socially constructed reality for people of different races and ethnicities is still very important to the interactions and responses they receive from other people. Therefore, race and ethnicity still play a major role in the relationship between patient and physician. Williams argues that there is a growing awareness that race is a pivotal category subject to change.

> The definition of racial groups has changed over time in the United States in response to changing sociopolitical conditions (Hayes-Bautista and Chapa 1987). There is a biological aspect to race but there is more genetic variation within races than between them, and racial classification schemes do not represent biological distinctiveness (Polednak 1989). Thus, it is likely that racial differences in the distribution of disease and in patterns of utilization of health services are determined more by social factors than by genetic ones (1994:262).

As with race, it is important to clarify the difference between sex and gender when speaking about health care. Gender typically refers to socially constructed differences between men and women, whereas sex refers to biological differences. In this research, I will examine the category labeled as "sex" within the data from the General Social Survey containing the subcategories 'male' and 'female.' However, based on the following explanation, I will actually be considering the doctor-patient relationship in regards to gender, or the socially constructed idea of gender that guides the interactions within this relationship. For years, the terms "sex" and "gender" were used interchangeably, however many researchers believe that this confusion was detrimental to women everywhere. Unger posits that,

> The term [sex] has been used interchangeably as both an independent and a dependent variable (Unger and Denmark, 1975). As the former, it is implied that sex is built into the organism by chromosomes, genes, and hormones. As the latter [gender], it is assumed that sex is derived (except for the physical structure) from the individual's postnatal experiences as defined by the sociocultural matrix...the term *gender* may be used to describe those nonphysiological components of sex that are culturally regarded as appropriate to males or to females (1979:1085-86).

As scientific research reveals that there are fewer physiological differences between men and women than once thought, researchers must take into account the effects of gender within interactions. Without accounting for this, researchers fail to consider important power and social dynamics at play.

Socioeconomic status is another very important variable with regard to health care. Though it has been defined many different ways in the past, most researchers agree that the term encompasses income, education, and occupational status. Hence all three

demographic variables are conceptualized in this work as primarily socially constructed. While the origins of specific diseases are biologically based, many if not most are products of the relationship between biology and the environment.

Understanding the Roots of Racial Distrust

Throughout history, there have been major medical breakthroughs, from the realization of germs and diseases to medical immunizations to organ transplants. There have been new developments occurring every year that have the potential to increase quality of life and life expectancy. Unfortunately, these new developments have not been equally accessible to everyone. Early scientific research claimed that there were immense differences between racial groups that would require alternative treatment methods for many diseases. As early as the 1800s a physician, Cartwright (1851), explained how slaves were prone to diseases such as "drapetomania" and "dysaethesia aethiopica." Cartwright argued that these diseases caused a desire to run away and general "rascality" in slaves. However, as research has expanded, scientists have come to realize that the "difference" between racial groups is quite miniscule. The history of prejudicial treatment in health care and the problems that African Americans in the United States have faced in the past and continue to face today helps to explain why doctor-patient trust among African Americans is low relative to whites. From the denial of adequate medical treatment of African hostages during the Middle Passages, the misuse of medical experimentation, and the inaccessibility of health care, trust has been a major issue for African Americans.

According to Sawh and Scales (2006), between 1650 and 1850, around 12 million Africans were brought to the United States against their will to be forced into slavery. For

these Africans, conditions on the slave ships meant death for many. The era of slavery in the United States has proven to be one of the lowest points in history. With the plantation economy in the south where “cotton was king,” there was a huge influx of slaves needed to work. Typically, the slaves were not provided with enough food, water, or adequate living conditions. In these conditions, slaves often fell ill and received little, if any, medical treatment. Many would argue that medical treatment during this time was limited for everyone and that whites, along with blacks, had little choice for medical treatment. However, while the medical treatments available were primitive, they were seen as something available and deserving only to the upper, white, and educated classes. Whites often legitimated keeping blacks from modern medicine, rationalizing that whites and blacks required completely different treatment. There was a general understanding that there was no need to waste important medical resources on non-human subjects. Typically, the rhetoric about keeping blacks from modern medicine for their own well-being was in complete opposition to the medical experimentation that was occurring during this same time period. According to Savitt:

> Southern white medical educators and researchers relied greatly on the availability of Negro patients for various purposes. Black bodies often found their way to dissecting tables, operating amphitheaters, classroom or bedside demonstrations, and experimental facilities. This is not to deny that white bodies were similarly used. In northern cities and in southern port towns such as New Orleans, Louisville, Memphis, Charleston, and Mobile, where poor, transient whites were abundant, seamen, European immigrants, and white indigents undoubtedly joined blacks in fulfilling the "clinical material" needs of the medical profession. But blacks were particularly easy targets, given their positions as voiceless slaves or "free persons of color" in a society sensitive to and separated by race. This open and deliberate use of blacks for medical research and demonstration well illustrates the racial attitudes of antebellum white southerners (2002:189).

It is likely that African Americans' distrust of the medical establishment has roots in slavery. Slaves were often used to fulfill the need for "guinea pigs" for training and research in many southern medical schools and hospitals, contributing to a legacy of distrust between African Americans and their medical providers. Many years after slavery ended, African Americans were still being used in medical experimentation. One of the major reasons for mistrust of physicians among African Americans is the Tuskegee Syphilis case, which showed that blacks were still receiving unequal medical treatment (Jones 2003). In 1932 the Public Health Service began recruitment for the Tuskegee Syphilis study, recruiting 399 African American men with syphilis for study along with 201 men without syphilis used for controls. In an apparent cover-up, the United States Public Health Service (PHS) claimed the intention of the study was to provide treatment for these men. However with the effects of the Great Depression, funds allocated for treatment quickly vanished. In an attempt to "salvage" part of the study, Dr. Taliaferro Clark suggested that the research be changed to monitor different racial variations through the course of the disease. This meant that of the almost 400 African-American subjects that were found to have syphilis, not one was to receive any type of treatment. In fact, they were not even informed that they had the disease. According to Jones, "the fact that only men who had late, so-called tertiary, syphilis were selected for the study indicated that the investigators were eager to learn more about the serious complications that result during the final phase of the disease" (2003:1). Not only did the researchers refuse to provide the subjects with treatment, they actively made sure that the subjects did not receive treatment from any other facility. It was not until 1972, 40 years after the project had begun, and after the deaths of many of the subjects, that it was finally brought

to a halt. This was particularly troublesome as new antibiotics that were known to be effective treatments for syphilis were withheld and the men involved were uninformed participants.

With all of the health care problems initially faced by African Americans, one would hope that things have improved significantly in the 21st century. Nonetheless, African Americans still face disadvantages when seeking medical treatment and are plagued by many issues, foremost being affordable access to adequate health care. Racial disparity has been substantially reduced in the United States,

> attributable to enforcement of provisions of the Civil Rights Act of 1964, which prohibited discrimination in institutions receiving federal funds, and the enactment of Medicare and Medicaid in 1965, which reduced financial barriers to care for minority and nonminority elderly and low-income Americans. Despite these advances, there is mounting evidence that racial and ethnic disparities persist in the use of preventive and life-saving medical technologies (Lillie-Blanton, Brodie, Rowland, Altman, and McIntosh. 2000:218-219).

Of the 46 million Americans that currently do not have health care, a disproportionate number are African American. According to the Kaiser Commission on Medicaid and the Uninsured,

> The uninsured rate for African-Americans is more than one and a half times the rate for white Americans, largely because of gaps in employer-based coverage. Although over 8 in 10 African-Americans are in working families, employee sponsored health insurance among African-Americans remains substantially lower than that of whites (53% vs. 73%), even in a strong economy that has helped to improve access to job-based health benefits to some (www.kff.org 2000).

These statistics were gathered more than ten years ago in 2000 when the economy was relatively stable. Today, the economy is seeing many ups and downs even as the federal government is making an attempt to implement a new and inclusive health care law. According to the U.S. Census Bureau and DeNavas-Walt, Proctor, and Smith (2012),

"The uninsured rate and the number of uninsured for blacks also decreased in 2011 to 19.5 percent and 7.7 million, from 20.8 percent and 8.2 million in 2010" (2012:23). Hopefully, there will be a continuation of this decrease, as federal mandates require citizens to be covered under some type of insurance. Many ask, with 8 in 10 African Americans working, how can there still be such a lack of employee-sponsored health care? There are, of course, inequalities that still exist in the types of jobs generally available to African Americans who still face both individual and institutional racism in hiring practices and are more likely found in the secondary labor market in jobs with no benefits.

Civil rights activist Stokely Carmichael differentiated two types of racism decades ago and argued that institutional racism was the more dangerous because it is subtle and difficult to detect while having the most severe impact on the daily lives and well-being of African Americans. He offered two common claims made by the white majority to support his argument. First, Carmichael quoted the well-known psychiatrist Freud.

> The individual factor must be taken into account through psychoanalysis. It will be seen the black man's alienation is not an individual question. It is a question of socio-diagnostics. The Negro problem does not resolve itself into the problem of Negroes living among white men, but rather of Negroes exploited, enslaved, despised by the colonialist, capitalist society that is only accidentally white (1969:161).

While Freud did recognize the racism experienced by African Americans, his claim of it's being simply an accident places the blame on the capitalist society, not whites. Carmichael also pointed out that many white Americans claim that, on an individual level, they themselves have no problems with African Americans -- if they were the ones "in charge," they certainly would see them as equal with other groups.

Unfortunately, history has shown that this is not the case. Whites have found many ways to justify individual racism so as to make the problem invisible. Claims that the United States is a meritocracy help this ideology as well. If the United States is believed to be a meritocracy—the American Dream of being rewarded according to your hard work—then it can be claimed that African Americans are simply lazy, and that it is their laziness, not discrimination, that keeps them from decent jobs. The main problem, as seen by Carmichael, is institutional racism. By definition, according to Feagin and Feagin, institutional racism is "institutional practices that differentially and negatively affect members of a subordinate racial group" (2008:356). Well-known and respected companies in the United States, such as Abercrombie and Fitch in 2005 and Lockheed in 2008, are frequently fighting discrimination lawsuits brought on by African Americans and other minority groups. Abercrombie and Fitch was found to be discriminating in their hiring practices, while Lockheed was charged with allowing covert racism to continue within the work place by concentrating minorities in low-paying jobs with no repercussions for the perpetrators. Lower incomes often leave little for health care payments even if there is health care "available" to every employee. While some African Americans have been able to obtain jobs in larger companies with decent health care benefits, many African Americans are still being forced into low paying seasonal or part-time jobs that do not offer any health care or other benefits. Even worse, a disproportionate number of African Americans still have trouble acquiring these jobs. Many are forced into illegitimate activities in order to find ways to support themselves and their families, such as dealing drugs or selling stolen merchandise. Obviously, there are no health care benefits associated with these "jobs" either. African Americans are

forced into these types of activities for more reasons than just unfair hiring practices. Looking at incarceration rates, blacks are being barred from employment based on criminal records as well. Liptak wrote in the *New York Times* that "more than one in 100 American adults is behind bars…one in 15 black adults," this mainly being black males (2008:1). Black males are frequently stopped, harassed, and arrested for small offenses; sometimes the offense is merely being black, and subjected to unfair prison sentences. With prison records, it becomes increasingly difficult for these men to find legitimate work. All of these factors form the tower of disadvantage being faced by African Americans today. Access to health care is not simply an issue that all Americans are facing right now. African Americans are feeling the pain more than some.

Finding affordable medical treatment can be a major problem even when health care is available, forcing many African Americans to find alternative sources for medical treatments. When health care coverage is not an option, the majority of United States hospitals cannot openly refuse patients that come in seeking emergency medical attention. Hospitals will not, however, cover preventative care or doctor's appointments for routine checkups. The Kaiser Commission notes "uninsured African Americans are much less likely to have seen a physician over the course of a year compared to those with private or Medicaid coverage" (2000:1). Even if uninsured African Americans do seek out preventative care, typically the best physicians and medical facilities are not available to them. Often local health clinics that provide reduced-cost services do not employ top quality nurses and physicians.

When there is a limited selection of doctors providing low-cost health care, many African Americans are forced to choose from just a few doctors, assuming there is a

choice at all. Often there is no option for seeking out a physician who will be aware of both language differences and cultural barriers. African-American patients often have no choice but to deal with racist doctors and nurses. Even if the doctors and nurses are not racist, general cultural barriers can make communication about serious medical conditions near impossible. When this occurs, patients are generally less trusting of their physician and less likely to continue seeking out treatment.

Distrust among non-white patients can be attributed to several other factors. According to Stephanikova et al. one of the first factors to consider is "personal experience with racial/ethnic discrimination in health care" (2006:391). When patients feel they have been discriminated against, they are less likely to trust their medical providers. Prior research indicates that over two-thirds of black HIV patients reported racial discrimination at some point during their treatment. According to Morin et al. "in African-American communities, there may be relatively high rates of distrust of government and traditional medicine, lack of information or active misinformation, and intense HIV-related stigma" (2002:369). A second factor that needs to be considered is that "the legacy of racial discrimination in medicine may contribute to mistrust among some minority patients" (Stephanikova et al. 2006:391). As mentioned earlier, studies such as the Tuskegee Syphilis case and medical research done during slavery have led to a fear of experimentation and further discrimination. According to Boulware et al. (2003), this lack of trust has also affected African Americans' willingness to participate in new research experiments. This has led to a gap in new treatments and cures for diseases that disproportionately affect African Americans such as HIV and diabetes. Boulware et al. further claim that,

> [d]ifferences in trust of health care providers have been implicated in racial disparities in health and access to health care and in lower rates of satisfaction with physician visits…trust is considered to be a vital element of the therapeutic alliance and may be closely related to the degree to which patients seek routine care, adhere to prescribed medications, and maintain long-term relationships with medical providers and health insurers (2003:360).

Finally, the third factor that needs to be considered is the amount of social distance between minority patients and their medical providers. Although racial-matching among patients and doctors is often present in health care, it is still likely that a doctor of a different race will see minority patients. Stephanikova et al. reports "less than 22 percent of African-American patients reported having an African-American physician" (2006:391). And, of course, a still higher percentage will be seen by a physician of a different socioeconomic class.

With all of these factors potentially contributing to lower levels of trust among African-American patients, I predict that blacks will be less likely to report trust in physicians and to be less likely to question medical authority due to the feelings of intimidation and lack of trust. Given the past and present state of health care for African Americans, it seems as though subpar medical care is the norm rather than a rare occurrence. However, it is less clear whether blacks will be more likely to assume the sick role and fail to question medical authority because of their lack of power or vulnerability in society in general. I predict higher levels of trust will allow a patient to ask whether his or her physician is refraining from using certain medical tests that are deemed expensive.

Understanding the Roots of Gender Distrust

For women, the intersectionality of race, class, gender, and sexuality plays an important role in health care and health research. According to Rogers and Kelly, an

> intersectionality approach explains the multiple complex dimensions of inequality and power structures that create roles of domination and subordination under the rubric of race, class, gender, and sexuality. The multiplicative effect of discrimination certainly influences a person's health…this multiplicative effect of oppression directly affects one's internal sense of self, one's external material resources, and participation in and regard for one's health (2011:399).

Women's exclusions from past health research or, as with the history of African Americans, their history of abuse as participants included in research explains much of the distrust women often feel in relation to their physicians. Murphy et al. surveyed over 2,000 insured adults, 55 percent women, to assess "how patients of primary care physicians are responding to a changing health care environment" (2001:123). Using the Primary Care Assessment Survey, they concluded that three of the four scales (communication, interpersonal treatment, and trust) showed statistically significant declines in patient satisfaction over the three-year period. Considering the intersectionality of race and gender, women have been mistreated on both fronts in health care research. Looking at human experimentation, Lederer reveals how female black slaves were used in experimentation. Although many slaves shared these same types of experiences, it was black women who were exploited in the reproductive health field. Lederer explains that:

> In the 1840s, James Marion Sims, a young Alabama physician, encountered women who had suffered injuries during childbirth. These women survived, but they experienced chronic pain, irritation, and offensive odors from ruptures in the bladder and rectum. When Sims was

> asked by a local slave-owner to see a young woman suffering with this condition, his initial response was disgust (he had not planned to treat women's diseases)…. He made bargains with several owners to accept female slaves as "patients;" in exchange for room and board, Sims was allowed to try new tools and procedures on the women…. Sims praised the courage and stoicism of three slave women—Lucy, Betsy, and Anarcha—whose endurance allowed him to make a breakthrough that would aid all women (2005:21).

These women were treated without anesthesia, used for experimental purposes, and their "participation" was traded in exchange for physician's room and board. From the treatments that Sims perfected during this time, Lederer explains that Sims is now known as the "father of American gynecology," and "the statue of Sims erected in Bryant Park in New York City in 1894 continues to celebrate him as "a doctor to slave and empress alike" (2005: 20). It is ironic that the serial injustices experienced by minority women have remained invisible in the public eye, when male doctors are valorized for "helping" their victims of medical research.

Researchers and organizations advocating for women's health have also documented ethical abuses in medical research. For instance, early experimentation on "the Pill" in the 1970s for its effectiveness and safe use drew samples from minority female populations in Puerto Rico. These women were not aware that they were participating in a clinical study, but were under the impression that they were receiving birth control from a legitimate medical provider. A number of these women experienced serious side effects, including death (MacLean and Ross 2009). Similarly, Roberts in *Killing the Black Body* documents the reproductive abuses and eugenics practices against minority women who were subjected to sterilization against their knowledge or will,

practices which peaked in the 1970s, particularly in the southern states. Describing these abuses Roberts writes,

> The violence was committed by doctors paid by the government to provide health care for these women. During the 1970s sterilization became the most rapidly growing form of birth control in the United States, rising from 200,000 cases in 1970 to over 700,000 in 1980. It was a common belief among Blacks in the South that Black women were routinely sterilized without their informed consent and for no valid medical reason. Teaching hospitals performed unnecessary hysterectomies on poor Black women as practice for their medical residents. This sort of abuse was so wide-spread in the South that these operations came to be known as "Mississippi appendectomies." In 1975, a hysterectomy cost $800 compared to $250 for a tubal ligation, giving surgeons, who were reimbursed by Medicaid, a financial incentive to perform the more extensive operation--despite its twenty times greater risk of killing the patient (1997:90).

While the historical medical abuses of poor and black women with little education have been particularly egregious, Scully (1994) in *Men Who Control Women's Health* and Block (2007) in *Pushed: The Painful Truth about Childbirth and Modern Maternity Care* make convincing arguments that the medicalization of women's reproductive health among all races and classes has created very real health risks in the customary practice of obstetrics-gynecology today. The numbers of induced births, caesarean sections, and other standard technical practices that make childbirth more routinized for medicine have subjected women to unnecessary medical risks by treating childbirth as pathology rather than a natural process. A national women's movement emerged in the 1970s and 1980s to advocate against the unnecessary medical intervention in women's reproductive health (Morgen 2002).

Despite this legacy of abuse, existing research has not consistently documented a relationship between gender and physician trust. This may be because of variations in

education as more educated women have greater awareness of historical abuses than less educated ones. Also many women are still socialized to conform to traditional gender roles that dictate that women submit to male authority (which physicians typically represent) while other women will no doubt be more critical of unnecessary medical procedures and question authority concerning financial incentive plans. A related issue is the nature of gendered interaction styles. According to Street, "a number of studies have found that, as health care providers, women and men differ in the way that they communicate with their patients. While differences between male and female patients are less clear-cut, some research does show that patients, regardless of sex, often vary their responses depending on the clinician's gender" (2002:201). Looking at the situational context of the medical encounter, many factors play a role in patient-provider interaction, for example, type of health care organization, political and legal issues, use of and exposure to media, economic factors, social class, and culture. Street (2002) claims that though these things are important, the interpersonal context is the most important, especially in reference to gender. There are different communication styles for many based on this interpersonal context. Doctors can be assertive or reserved and friendly or unfriendly. A doctor's bedside manner can make or break a relationship with his or her patient. A patient will respond to this bedside manner in either a positive or negative way and one would assume that the level of trust would either increase or decrease accordingly. Street asserts "to have a coherent and successful interaction, communicators must cooperate and coordinate their responses. Thus, any one interactant has the potential to exert considerable influence over the other" (2002:204).

Differences in how men and women communicate may shape how male and female patients experience trust and compliance with medical authority. Street focuses on how communication differences among physicians can change the dynamics of doctor-patient relationships. Such interactions can be applied to the patients as well. He claims that "in many ways, gender-linked communication differences in medical care parallel gender differences in other contexts" (2002:203). Women tend to talk to build "community and rapport" whereas men seem to talk to establish their status and independence. Women's speech is typically more aesthetically pleasing though less strong and active. This is consistent with prior evidence that shows that female physicians are often more patient-centered and concerned about psychosocial health issues—more so than their male counterparts (Street 2002). We can also expect that patients will take on these gendered styles of communication. If doctors interact more with patients, asking questions and expressing concerns, and male patients are assertive and ask more questions, I predict that males will be more trusting and willing to ask challenging questions of their physicians.

Similar to other minorities, historically women have had problems accessing proper and necessary medical treatment. Women have been denied medical treatment, especially with regard to reproductive health, and left out of important research involving threatening diseases. Gijsbers Van Wijk et al. claims, "although women are major health care users as well as providers, they are underrepresented in decision-making in health care… health care for women should be adequate and not depart from a male model of health and illness" (1996:712). Yet women have been given many reasons in the past to distrust physicians and medical authority.

For centuries, religious leaders, policy makers, and the medical community have scrutinized women's reproductive rights. In the US, representatives of the dominant Christian religion, along with many activist groups, have fought long and hard, since *Roe v. Wade,* to again make abortions illegal. Women are constantly being told how and what they can do with their bodies and their reproductive systems. Not only has abortion been a major topic of public debate, birth control has been highly regulated as well. According to Bone, "at the beginning of the twentieth century, the federal Comstock Act prohibited information on contraception from the public domain" (2010:17). In addition to this, mail carriers could open mail and confiscate birth control (prophylactic or information) being sent to homes. According to the *Columbia Electronic Encyclopedia*, Margaret Sanger was "indicted in 1915 for sending birth control information through the mails and arrested the next year for conducting a birth control clinic in Brooklyn" (2011). In 1916, Margaret Sanger opened the first birth control clinic in the United States. It was not until 1937 that the ban on birth control was lifted, and women were allowed to decide when they wanted to get pregnant. It is easy to see why women may not trust the medical establishment. For a period of 43 years, the government made it legal for a *mail carrier* to make medical decisions for women. When they overtly removed birth control from the mail, they were covertly removing women's reproductive rights. This was all done due to "moral" control with little medical backing. Even though birth control gave women the ability to control their own reproductive health and life, the medical field has done little to intervene in the religious and political debates on this topic. Based on the history of medical abuses and growing awareness among women about the "over-medicalization" of women's bodies, I expect women will be less trusting of their physicians than men.

However, women may be less likely to actually openly question medical authority for fear of reprisal, given their lack of power and legitimacy as advocates for their own health relative to medical professionals.

Understanding the Roots of Socioeconomic Distrust

Education and income are important determinants of a patient's socioeconomic position that, in turn, is expected to influence levels of trust in medical authority. Patients with more education are expected to have higher levels of trust in their physicians since they are more likely to have been privy to the benefits of health care. Similarly, sharing a common socioeconomic status with doctors may make it easier for patients to ask challenging questions about financial incentive plans that may impact their quality of treatment. In one study seven physicians were observed with 115 patients, and it was found that "doctors gave more information and offered more support and encouragement to patients who asked questions and expressed concerns…. More educated patients asked more questions and offered more opinions" (Street 2002:206). Also, since higher education levels are associated with higher incomes, it is likely that better health care options afford patients a greater choice in their physician. Musick and Worthen found knowledge to be an important aspect of predicting trust in doctor-patient relationships. They defined knowledge as "intelligence or the ability to employ knowledge in a specific setting or interaction [which they thought to be] important for the generation of trust in general" (2008:4). They also claim that:

> Greater intelligence and social intelligence in particular, allows individuals to correctly interpret situational cues and evidence. These more accurate appraisals in turn bolster trust . . . .those with little situational knowledge or intelligence are less able to discern important cues and so make reasonable appraisals of

> trustworthiness of others. When in a vulnerable situation, those low on knowledge and intelligence will be unwilling to provide as much trust due to the extra vulnerability it imposes (2008:4).

Those patients with higher education levels will also be more privy to research and findings on medical options and treatments. With more knowledge going in, they may have a better idea of whether their doctors are offering the best in health care tests. Although Anderson and Dedrick found that "patients who had less formal education tended to express more trust in physicians" this relationship has possibly changed due to an increase in the level of formal education and the level of access to information due to technological advances (1990:1095).

A final factor in examining socioeconomic status is that those in higher income classes tend to have greater access to health resources. Higher income and status levels also, as mentioned earlier, give patients more access to information due to technological advances. Technology access, such as personal computers and Internet services, are relatively expensive and are more likely available in higher income brackets. I expect persons with low socioeconomic status will have significantly more distrust in medical authority than patients with higher socioeconomic status, and that they will be less likely to openly question medical authority. I predict that due to unparalleled access to both information and better health care, patients with higher socioeconomic status will be more likely to question medical authority because they believe they have the right to question a physician and are typically in more trusting relationships. There is a sense of entitlement for this group that I believe is absent among the lower economic classes.

METHODOLOGY

Research Hypotheses

Past research suggest the following hypotheses related to patients' trust in their physicians.

Hypothesis 1: White patients are more likely than black patients to trust their doctor to put their health above costs.

Hypothesis 2: Male patients are more likely than female patients to trust their doctor to put their health above costs.

Hypothesis 3: Higher socioeconomic patients are more likely than lower socioeconomic patients to trust their doctor to put their health above costs.

The second series of hypotheses concerns patients' willingness to inquire about their doctor's participation in financial incentive plans to limit costly use of labs and technology.

Hypothesis 4: White patients are more likely than black patients to ask their regular doctor whether he/she participates in financial incentive plans that limit the use of expensive tests.

Hypothesis 5: Male patients are more likely than female patients to ask their regular doctor whether he/she participates in financial incentive plans that limit the use of expensive tests.

Hypothesis 6: Higher socioeconomic patients are more likely than lower socioeconomic patients to ask their regular doctor whether he/she participates in financial incentive plans that limit the use of expensive tests.

Hypothesis 7: As trust increases, patients will be more likely to question medical authority by asking their regular doctor whether he/she participates in financial incentive plans that limit the use of expensive tests.

Data and Procedures

The data used for this research come from the 2002 General Social Survey (GSS) collected by National Opinion Research Center (NORC). In 2002, a total of 2765 respondents completed the survey. These surveys were completed mostly through face-to-face interviews. However, in 2002, the addition of computer-assisted personal interviews added to the number of completed surveys. Telephone interviews were conducted on an "as needed" basis for respondents in remote areas. The data for this research were extracted from the *2002 Topical Module: Doctors and Patients*. The data were managed and analyzed using SPSS (Statistical Program for the Social Sciences).

Data yielded by the following survey questions were utilized. Table 1 summarizes specific variables and measurements.

Question 1: *Do you have a regular doctor or clinic?*

Question 2: *Have you been a patient with this doctor or clinic for more than one year?*

Question 3: *Do you have any health insurance, including Medicare or Medicaid?*

Question 4: *Do you feel that you had enough choices among different doctors in your health insurance plan when you chose your current doctor?*

Question 5: *I prefer that my doctor offers me choices and asks my opinion.*

Question 6: *I prefer to leave decisions about my medical care up to my doctor.*

Question 7: *I prefer to rely on my doctor's knowledge and not try to find out about my condition on my own.*

Question 8: *How much would you trust the doctor to put your health above costs?*

Question 9: *How likely would you be to ask your regular doctor whether he or she has financial incentive plans that limit the use of expensive tests?*

Table 1. Survey Questions and Variables

Survey Question [Variable Name]	Response Choices
Do you have a regular doctor or clinic? [Regdoc]	0=No 1=Yes
Have you been a patient with this doctor or clinic for more than one year? [Regdocyr]	0=No 1=Yes
Do you have health insurance, including Medicare or Medicaid? [Hlthplan]	0=No 1=Yes
Do you feel that you had enough choices among different doctors in your health insurance plan when you chose your current doctor? [Chosedoc]	0=No 1=Yes
I prefer that my doctor offers me choices and asks my opinion. [Docaskme]	1=Strongly Disagree 2=Moderately Disagree 3=Slightly Disagree 4=Slightly Agree 5=Moderately Agree 6=Strongly Agree
I prefer to leave decisions about my medical care up to the doctor. [Docdecid]	1=Strongly Disagree 2=Moderately Disagree 3=Slightly Disagree 4=Slightly Agree 5=Moderately Agree 6=Strongly Agree
I prefer to rely on my doctor's knowledge and not try to find out about my condition on my own. [Docrely]	1=Strongly Disagree 2=Moderately Disagree 3=Slightly Disagree 4=Slightly Agree 5=Moderately Agree 6=Strongly Agree
How much would you trust the doctor to put your health above costs? [Doccosts]	1=Not at all 2=A Little 3=Somewhat 4=Mostly 5=Completely
How likely would you be to ask your regular doctor whether he or she has financial incentive plans that limit the use of expensive tests? [Fininc4]	1=Very Unlikely 2=Somewhat Unlikely 3=Neither Likely or Unlikely 4=Somewhat Likely 5=Very Likely

The analysis reported below utilizes multivariate regression analysis to determine whether race, gender, or socioeconomic status predicts patient trust and willingness to question medical authority. The hypotheses are rejected or supported based on a 95 percent level of confidence. As noted above, questions measuring the dependent variables focus on financial incentive plans specifically, using two survey questions from the 2002 GSS. The first question measuring Trust asks respondents "How much would you trust the doctor to put your health above costs?" The second question measuring Questions Medical Authority asks the respondents "How likely would you be to ask your regular doctor whether he or she has financial incentive plans?"

Independent variables include race, gender, and socioeconomic status. In order to account for the qualitative information in the data, dummy variables were created to incorporate them into regression analysis. Race was recoded as a dummy variable where black=1 and white=0. Other race groups were omitted from the analysis. Gender was recoded where female=1 and male=0. Socioeconomic status was measured with the variable "SEI" or Socioeconomic Index. This index was created as an ordinal measure (scale 0-100) to quantify respondent's socioeconomic status. According to Davis and Smith, this variable "converts a respondent's job category into a number representing a rough estimate of their general socioeconomic status at the time of the interview (2008). The scale includes measure of both employment and education.[1]

In addition to these variables I include five control variables in the analysis that based on the literature reviewed are likely to be important in shaping the doctor-patient

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[1] More information on how the measure SEI was constructed can be found online at http://publicdata.norc.org:41000/gss/DOCUMENTS/REPORTS/Methodological_Reports/MR074.pdf.

relationship: age, insurance, regular doctor, knowledge. With an aging population, I believe that age is important because of the different ways of thinking between generations. Older generations may be more likely to follow the traditional model of paternalistic health care where there is little room to question the doctor. Older respondents may also have more health problems that cause them to seek care more often than younger respondents. This increase in doctor-patient interactions may influence the level of trust between older patients and their doctors. Younger patients may be more likely to question as they are becoming more open to the idea of advocating for their own health care. Having insurance may influence whether a patient would question the doctor based on concern for expensive tests that may need to be paid out-of-pocket. As reviewed earlier, the length of time established within the doctor-patient relationship is an important variable when measuring patient trust. Thus the current research includes having a regular doctor or clinic. With regard to knowledge, some patients still follow the traditional model and prefer to rely on the doctor's knowledge and expectations. These patients do not want to search for information about their condition on their own. It would seem that these patients would be less likely to question their doctor about anything concerning tests or costs. Finally, some patients do advocate for their own health care and prefer that the doctor offers them choices and asks their opinion. These patients are expected to be more likely to question their doctors about many things, including testing and costs. These control variables are listed in Table 2.

Table 2. Control Variables

Survey Question [Variable Name]	Response Choices
Respondent's Age [Age]	Number of years old
Do you have any health insurance, including Medicare or Medicaid? [Hlthplan]	0=No 1=Yes
Do you have a regular doctor or clinic? [Regdoc]	0=No 1=Yes
I prefer to rely on my doctor's knowledge and not try to find out about my condition on my own. [Docrely]	1=Strongly Disagree 2=Moderately Disagree 3=Slightly Disagree 4=Slightly Agree 5=Moderately Agree 6=Strongly Agree
I prefer that my doctor offers me choices and asks my opinion. [Docaskme]	1=Strongly Disagree 2=Moderately Disagree 3=Slightly Disagree 4=Slightly Agree 5=Moderately Agree 6=Strongly Agree

Prior research conducted concerning doctor-patient relationships reveals that the demographics of the medical provider such as gender, race, and age play a role in the levels of trust between patient and physician. One limitation of this research is that the demographics of the medical providers are unknown. Without knowing the sociodemographics of the physicians, such phenomena as racial-matching and doctor-patient concordance cannot be tested. Other limitations include not knowing the past medical histories of the respondents, as this could be important as well.

RESULTS

Descriptive Statistics

Table 3 provides descriptive statistics for the sociodemographic groups used in the analysis. The total sample of respondents included 84.2 percent whites (n=2188) and 15.8 percent blacks (n=410). Other races were excluded from the analysis due to the small numbers. About 44 percent (n=1228) of the sampled respondents are men and 55 percent women (n=1537). Table 4 shows that 2637 participants were assigned an SEI score based on their response to questions concerning employment and education. The SEI scale ranges from 0-100. The respondent with the lowest score was 17.1 and the highest SEI score was 97.2. The mean was 49.2 with a standard deviation of 19.2.

Table 3. Descriptive Statistics for Independent Variables

Variable		Percent %	Frequency (n)
Race	White	84.2	2188
	Black	15.8	410
Gender	Male	44.4	1228
	Female	55.6	1537

Table 4. Statistics for Socioeconomic Status [SEI]

Variable	Minimum	Maximum	Mean	Std. Deviation	Frequency (n)
Socioeconomic Status	17.1	97.2	49.213	19.2424	2637

Information about the use of financial incentive plans is not well disseminated throughout the health care industry. Therefore, it is important to note that survey

respondents were told about financial incentive plans before answering these questions on the survey. As seen in Table 5, just under half or about 48.8 percent of respondents indicated that they had heard about doctors limiting the use of expensive tests before reading questions abut financial incentives on this survey. About 51.2 percent had never heard of them before.

Table 5. Respondents' Knowledge about Financial Incentive Plans

Survey Question [Variable Name]	Yes %	No %	Frequency Total (n)
Some doctors or groups may be paid more if they limit the use of expensive tests of the use of specialists. Such arrangements are known as financial incentives. Have you heard of such arrangements before now? [Fininc]	48.8 (1340)	51.2 (1406)	2746

As shown in Table 6, 83 percent of the respondents reported having a primary care physician or clinic and among those 88 percent indicated that they had been a patient with their doctor or clinic for over a year. Eighty-six percent reported having health insurance. About 18 percent of respondents felt they did not have enough choice among doctors when they chose their current doctor.

Table 6. Descriptive Statistics for Health Care

Survey Question [variable name]	Yes %	No %	Frequency (n)
Do you have a regular doctor or clinic? [Regdoc]	83.3	16.7	2754
Have you been a patient with this doctor or clinic for more than one year? [Regdocyr]	88.3	11.7	2294
Do you have any health insurance, including Medicare or Medicaid? [Hlthplan]	86.6	13.4	2755
Do you feel that you had enough choices among different doctors in your health insurance plan when you chose your current doctor? [Chosedoc]	81.8	18.2	2355

Table 7 provides a summary for respondents' preferences on the level of involvement in their own care. The first item suggests that respondents want to be involved in decision-making regarding their health care. This supports the idea that patients are becoming more aware of the importance of self-advocacy in health care. However, responses on the other items are somewhat contradictory with about a third agreeing (strongly or moderately) to leave health-care decisions in the hands of their physicians. This could be typical of the traditional medicine model in which the doctor has final say and authority to all health care decisions. This paternalistic model has been the dominant model for many centuries and can be seen within many health care settings.

Table 7. Descriptive Statistics for Doctor's Decision-Making Authority

Survey Question [Variable Name]	Moderately and Strongly Disagree %	Slightly Disagree %	Slightly Agree %	Strongly and Moderately Agree %	Frequency (n)
I prefer that my doctor offers me choices and asks my opinion. [Docaskme]	1.8	1.6	5.3	91.3	2745
I prefer to leave decisions about my medical care up to the doctor. [Docdecid]	34.2	13.2	15.0	37.6	2745
I prefer to rely on my doctor's knowledge and not try to find out about my condition on my own. [Docrely]	41.1	14.5	12.6	31.8	2746

Table 8 and Table 9 provide a summary of the descriptive data concerning trust and willingness to question medical authority. About 13 percent of respondents would completely trust their doctor to put health above costs. However, over 20 percent of respondents claimed they would trust their doctor “not at all” to put their health above costs. About 26 percent of respondents indicated that they would be "very unlikely" or "unlikely" to question medical authority. About sixty-three percent indicate they are "likely or very likely" to question medical authority about participation in financial incentive plans. In general, it seems then that patients indicate a willingness to question their physicians about financial incentives.

Table 8. Descriptive Statistics for Trust

Survey Question [Variable Name]	Not at All %	A Little %	Somewhat %	Mostly %	Completely %	Frequency (n)
How much would you trust the doctor to put your health above costs? [Doccosts]	21.5	13.9	27.5	23.8	13.3	2719

Table 9. Descriptive Statistics for Questioning Medical Authority

Survey Question [Variable Name]	Very Unlikely %	Somewhat Unlikely %	Neither Likely or Unlikely %	Somewhat Likely %	Very Likely %	Frequency (n)
How likely would you be to ask your regular doctor whether he or she has financial incentives that limit the use of expensive tests? [Fininc4]	12.9	13.5	10.5	25.1	38.0	2713

Predicting Trust and Questioning Medical Authority

Table 10 provides a summary of the results from the multiple regression analysis predicting Trust and Questioning Medical Authority. As shown in Model 1 among the predictive variables of race, gender, and socioeconomic status, only race significantly predicted levels of trust. As expected, black respondents are significantly less likely to trust their doctors than white respondents ($b = -.093$, $p \leq .001$).

After adding the control variables, as shown in Model 2, the relationship between race and trust remains ($b = -.072$, $p \leq .001$). Other important predictors include age ($b = .156$, $p \leq .001$) with older respondents reporting higher levels of trust than younger respondents. A patient who prefers the doctor's knowledge ($b = .124$, $p \leq .001$) is significantly more likely to report higher levels of trust. This finding makes sense as those patients who prefer a doctor's knowledge to their own are going to be very likely to believe and trust what the doctor is telling them.

Model 3 reveals the relationship between race, gender, and socioeconomic status and the likelihood to question medical authority without using the control variables. In this model, race was significant in predicting the likelihood of questioning medical authority ($b = .047$, $p \leq .05$) with blacks significantly more likely to question than whites. Socioeconomic status was also significant in predicting the likelihood to question medical authority ($b = -.048$, $p \leq .05$). As SEI increased the likelihood of questioning authority decreased. The variable measuring female is also very close to significant ($b = .039$, $p \leq .056$), suggesting a pattern in the data with women more likely to question medical authority than men.

Model 4 adds in the control variables to predict the likelihood of questioning medical authority. In this model, race is again significant ($b = .047$, $p \leq .05$) along with socioeconomic status ($b = -.048$, $p \leq .05$). Gender is more clearly not significant in predicting the likelihood to question medical authority when controlling for the other variables. Other control variables that are significant in predicting the likelihood of questioning medical authority include having insurance ($b = -.049$, $p \leq .05$) and patient preference for the doctor to offer choices and ask for patient opinion ($b = .135$, $p \leq .001$). This is the strongest predictor which is not surprising as a patient who is very involved in his or her own health care will be very likely to question medical authority about the use of financial incentive plans.

Turning to Model 5, the relationship between race, gender and socioeconomic status and willingness to question medical authority is tested controlling for trust and the other variables. In Model 5, race ($b = .047$, $p \leq .05$) and socioeconomic status ($b = -.054$, $p \leq .001$) are significant when predicting willingness of the respondent to question medical authority about participating in financial incentive plans. However, there are still no significant findings in relation to gender. Again, respondents who prefer to be included in decision-making and want doctors to ask their opinions are those most likely to question medical authority ($b = .135$, $p \leq .001$). The findings also reveal that Trust is a significant predictor of questioning medical authority ($b = -.037$, $p \leq .05$). However, Trust did not predict in the direction expected. In fact, respondents who indicated that they had high levels of trust in their physicians were less likely to report a willingness to question their physicians about financial incentive plans suggesting a greater adherence to a traditional model of medicine.

Table 10. Multiple Regression Models for Trust and Questions Medical Authority (Standardized Beta Coefficients)

Variable	Model 1	Model 2	Model 3[a]	Model 4	Model 5[a]
	Trust	*Trust*	*Questions Medical Authority*	*Questions Medical Authority*	*Questions Medical Authority*
Black	-.093***	-.072***	.047*	.047*	.047*
Female	-.011	-.009	.039	.027	.027
Socioeconomic Status	.028	.033	-.048*	-.048*	-.054**
Age	---	.156***	---	-.010	-.010
Health Plan	---	.038	---	-.049*	-.049*
Regular Doctor	---	.037	---	-.025	.022
Rely on Doctor	---	.128***	---	-.027	-.020
Prefer to be Asked	---	.001	---	.135***	.135***
Trust	---	---	---	---	-.037*
Adjusted R^2	.009	.062	.006	.026	.028

[a]Also controlled but not shown or significant is whether the patient is aware that such financial incentive plans exist.
* $p \leq .05$
** $p \leq .01$
***$p \leq .001$

DISCUSSION AND CONCLUSIONS

In this analysis I found that race continues to be an important factor in determining trust in doctor-patient relationships. Specifically, the legacy of racism that blacks have inherited in the US does appear to remain important in shaping the trust that African Americans have in their doctors. Whites who have historically benefited from the medical system are more likely to report trusting their physicians than blacks. This finding is important because a lack of trust may lead to higher levels of patient non-compliance with treatment plans or a complete lack of seeking care all together. Such a pattern of health seeking behavior likely deepens the racial gap in health for preventable diseases such as heart disease, diabetes, HIV/AIDS, cancer, and stroke. Race also

predicted the likelihood that a patient will question medical authority in Models 3, 4, and 5. This shows that race is an important factor in shaping levels of trust within the doctor-patient relationship overall. It also suggests that African Americans may be more equipped to advocate for themselves than their white counterparts when seeking medical care due to an awareness of the potential for differential treatment motivated by racist practices. Even after controlling for important contextual factors that shape the doctor-patient interaction such as having a regular doctor and preferences for relying on the doctor or participating in health decisions, the impact of race did not change. The robustness of this finding suggests that health care providers need to take this into account when attempting to improve health care outcomes. This may imply acknowledging a willingness to include patients of minority background in their decision-making and explicitly disclosing participation in financial incentive plans in that process. The other findings also support a self-advocacy model that suggests that those who take an active role in their own treatment are the most likely to question medical authority. On the other hand, contrary to expectations, greater levels of trust seem to indicate stronger acquiescence to traditional models of medical authority as promoted by the functionalist sick role model. Patients did not indicate they would question medical authority if they reported high levels of trust that doctors would put their health above costs. This makes sense given that patients who believe that their doctors put their health first may be less likely to suspect the presence or importance of financial incentive plans as a factor in patient care.

Regarding socioeconomic status, I did not find that it was significantly related to trust (see Model 1 and 2). However, contrary to expectations people with high

socioeconomic status were less likely to question medical authority (see Model 3, 4, and 5). It may be that patients sharing a similar background status with physicians believe that those physicians value their lives and will put their health interests above the cost of expensive health care. This interpretation is consistent with the idea that privilege shapes one's perception of entitlement and also offers a degree of security or sense of well-being, a lack of vulnerability. It may also indicate that those with high socioeconomic status feel less of a need to advocate for themselves because they assume that doctors are looking after their health interests. Even though this finding is opposite of what I expected it is nonetheless consistent with a power model, not because people with higher socioeconomic status demonstrate greater self-advocacy, but because they may not feel that they need to because of their greater access to quality care and their position of entitlement. Also consistent with the power model, patients with lower socioeconomic status may be more likely to question their doctor about expensive tests because they fear they will not be able to afford them. These patients may be hoping to discern which tests are truly medically necessary at that time and which tests can wait or are unnecessary.

In these data, there does not seem to be a direct relationship between gender and levels of trust within the doctor-patient relationship. Further research may reveal that there are other more important factors such as length of doctor-patient relationship, gendered styles of communication, and whether the doctor is of the same gender as the patient. It is also likely that gender was not significant given the diversity that exists among women. Clearly women are not a homogenous group but rather have diverse interests, including those related to class, race/ethnicity, age, and sexual orientation. While some women may continue to conform to the traditional medical model that

promotes adherence to the sick role and submission to medical authority, others with greater feminist consciousness and awareness of the medicalization and control of women's bodies may question power differentials between themselves and their doctors. A more refined analysis that tests for interactions with gender by race, class, and sexual orientation may show greater predictive power. Even then more proximate causes such as a heightened feminist awareness or greater traditionalism are likely to be stronger predictors than social statuses.

As noted, it appears that trust is a significant predictor in determining whether a patient will question medical authority. Specifically, this research reveals that there is a negative association between trust and questioning medical authority. As trust in the medical provider increases, the likelihood of questioning medical authority decreases. Much more research needs to be done to explore the factors that influence the doctor-patient relationship including the complex role of trust and the multifaceted nature of trust. The present data are relevant only to patients' trust that health interests will be put above costs. Obviously this is a limited dimension of trust and other forms of trust are important for understanding health-seeking behaviors. Other factors such as age, insurance, primary care, and preference or choice of physician also play an important part in whether a patient will trust his or her doctor. With regard to questioning medical authority, other contextual variables such as preferring self-knowledge about one's illness, doctors asking for patients' opinions, and levels of trust are all important in supporting the importance of self-advocacy in unequal relations of power in the pursuit of medical care. Hence the findings in this research provide some support for both a

functionalist perspective of traditional medical authority as well as a power paradigm emphasizing the importance of self-advocacy in relationships of unequal power.

The findings in this research shed light on a small portion of the overall problem that plagues the medical system. Race appears to remain important in shaping levels of trust between doctors and patients. When considering additional variables such as insurance and primary care, other significant factors are at play. There is no one factor that we can single out to "fix" the problems that exists within the health care system. Although this is a very complex issue, this research does reveal an obvious place to start. History exposes the pervasive issues of racism, sexism, and classism that have troubled our society for hundreds of years. Unfortunately, the health care industries has not yet fully escaped institutional forms of discrimination, which are likely to be less offensive than overt racism or sexism, but are also more likely to go undetected and uncorrected. Such institutional inequality is what Gilbert (2005) referred to as a lack of "impersonal trust" that emanates at the macro or systemic level of the medical system.

Traditionally, patients were likely to follow the doctor's orders following the guidance "doctor knows best." Doctors, and the medical system in general, were seen as the leading authority on medical interventions and practices. However, today patients are realizing that sometimes doctors can be wrong or misguided by insurance and managed care influences. Patients are beginning to understand the importance of advocating for their own health care and that sometimes they must seek out additional information or resources in order to receive the best care possible. It is also becoming harder to deny that race, gender, and socioeconomic status can play an important role in the care that patients receive. Therefore, patients must advocate for themselves and not entrust the

medical system to provide the best medical care possible. Becoming an advocate for personal health care is more involved than just asking questions about using financial incentive plans. It also involves having the knowledge to know what questions to ask. This becomes important when we are considering the education level of patients today. If patients are not adequately educated, they will not be informed enough to know which questions to ask. Currently, the health care system is in a state of major revision and it is not quite clear how all of the changes will affect everyone involved in health care, including patients. As things continue to change, patients must learn to advocate for their own health care to better ensure that the health care system is working for them. Unfortunately, it is clear that the health care system does not always have the best interests of the patient in mind when making decisions. Money and pressures to cost-savings all too often are important factors.

The implications from this research suggest the importance of holding the health care system accountable for ensuring that patients understand how financial incentive plans may be impacting their care. Only about half of the respondents from this survey were aware that financial incentive plans existed. Patients may be more likely to question their physicians if they are aware that cost savings incentives of this type are not uncommon. Unfortunately, the high costs of health care can be partially blamed on the consumer that often has no idea how much is being charged for individual items and tests. Perhaps more self-advocacy from patients in regards to their own health care could help get the health care system in check.

This research looks specifically at whether patients trust their doctors to put health above costs and the likelihood that patients would ask their regular doctors whether they

have financial incentive plans that limit the use of expensive tests. Although this analysis is very specific and somewhat limited in how trust and self-advocacy are being measured, costs and financial incentive plans play an important role in the health care field. The ways in which physician trust and cost-saving strategies intersect in shaping health outcomes deserves closer examination. It is particularly important for future research to delve further into certain relationships. The relationship between gender and patient trust has not yet been fully investigated. Variables such as gender of physician and communication styles could be included to ascertain how doctor-patient relationships may be different. Also, the ways in which socioeconomic status influences trust and self-advocacy deserves closer examination. Finally, and most importantly, the specific ways in which collective distrust shapes the interpersonal medical environment for African Americans and the quality of health care received needs much closer examination. This is particularly important for closing the racial gap in health care disparities. Future research will be enhanced by mixed method designs that provide information on both quantitative aggregate trends as well as more detailed understandings of the subjective and interpersonal dynamics involved in medical treatment, self-advocacy, and building trust among doctors and patients.

This research exposes both positive and negative sides of the health care industry. In particular, it is encouraging to realize that the industry as a whole is starting to come to terms with the reality that not everyone is treated fairly and equally. Both doctors and patients alike are starting to recognize that health care is a joint effort. Gone are the days when doctors had paternalistic, omniscient roles guiding every decision made about a

patient's health. Today patients must become advocates for their own care in order to ensure they are receiving the best care possible.

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MIDDLE TENNESSEE STATE UNIVERSITY

September 26, 2012

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Protocol Title: "Doctor-Patient Trust and Medical Authority: A Race, Class, and Gender Analysis"
Protocol Number: 13-073

Dear Investigator(s),

The exemption is pursuant to 45 CFR 46.101(b) (4). This is because the research being conducted involves the collection of or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

You will need to submit an end-of-project report to the Office of Compliance upon completion of your research. Complete research means that you have finished collecting data and you are ready to submit your thesis and/or publish your findings. Should you not finish your research within the three (3) year period, you must submit a Progress Report and request a continuation prior to the expiration date. Please allow time for review and requested revisions. Your study expires on September 26, 2015.

Any change to the protocol must be submitted to the IRB before implementing this change. According to MTSU Policy, a researcher is defined as anyone who works with data or has contact with participants. Anyone meeting this definition needs to be listed on the protocol and needs to provide a certificate of training to the Office of Compliance. **If you add researchers to an approved project, please forward an updated list of researchers and their certificates of training to the Office of Compliance before they begin to work on the project.** Once your research is completed, please send us a copy of the final report questionnaire to the Office of Compliance. This form can be located at www.mtsu.edu/irb on the forms page.

Also, all research materials must be retained by the PI or **faculty advisor (if the PI is a student)** for at least three (3) years after study completion. Should you have any questions or need additional information, please do not hesitate to contact me.

Sincerely,
Andrew W. Jones
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