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Digging Below the Demographic Level: Examining the Effects of Internalized Racial and Social Attitudes on White Physicians-In-Training Self-Reported Cross Cultural Competency

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LOYOLA UNIVERSITY CHICAGO

DIGGING BELOW THE DEMOGRAPHIC LEVEL: EXAMINING THE EFFECTS OF
INTERNALIZED RACIAL AND SOCIAL ATTITUDES ON WHITE PHYSICIANS-
IN-TRAINING SELF-REPORTED CROSS CULTURAL COMPETENCY

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN COUNSELING PSYCHOLOGY

BY

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For social justice

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ABSTRACT

The racial and social attitudes of White physicians-in-training were explored in relation to aspects of self-perceived cross cultural competence. Specifically, internal motivation to respond without prejudice, ethnocultural empathy, color-blind racial attitudes, and general just world beliefs were examined as possible predictors of patient centered attitudes toward patients of color and skillfulness in providing cross cultural care. Multivariate multiple regression analyses found that internal motivation to respond without prejudice was significantly associated with patient centeredness toward patients of color. Global ethnocultural empathy was significantly associated with patient centeredness and skillfulness in providing cross cultural care. General just world beliefs attitudes had no significant relationship to criterion variables in contrast to the proposed hypothesis. Unawareness of blatant racial issues was significantly and positively associated with patient centeredness. Implications, future directions, and limitations of the study are provided.

CHAPTER ONE

INTRODUCTION

...the health care system and its providers do not operate in a cultural vacuum, but rather are susceptible to biases and norms that exist in the larger societal and environmental context.

Johnson, Saha, Arbelaez, Beach, & Cooper

Despite many social and cultural changes in American society, racial and ethnic health care disparities continue to persist (Smedley, Stith, & Nelson, 2003). The Committee on Understanding Health Care Disparities defines health care disparities as “ racial or ethnic differences in the quality of health care that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention” (pp. 3-4). Health care disparities exist across a wide variety of sub-disciplines of medicine, suggesting a need for change. The importance of change is further highlighted by an analysis of mortality data that suggests nearly one million lives could be saved by eliminating health care disparities (Woolf, Johnson, Fryer, Rust, & Satcher, 2004).

Health Care Disparities and Subtle Bias

According to Ferguson and Candib (2002), “Minority patients, especially those not proficient in English, are less likely to engender empathic response from physicians, establish rapport with physicians, receive sufficient information, and be encouraged to participate in medical decision making” (p. 353). Physicians filter their professional encounters with minority patients through stereotyped and biased lenses. Social psychologist John F. Dovidio and his colleagues (2008) propose that health care

disparities may occur partially as a function of subtle bias on the part of well-meaning White physicians who consciously embrace egalitarian values while harboring negative, often unconscious attitudes toward minorities. This is referred to as aversive racism (Gaertner & Dovidio, 2005). In particular, health care disparities can occur as a function of faint social norms and unclear situational expectations (Dovidio et al., 2008). This conceptualization is relevant to the process of the clinical encounter, which often involves physicians experiencing high pressure and potentially anxiety producing situations (i.e., time pressure and clinical uncertainty) on a daily basis (Smedley et al., 2003). Related meta-analytic research on aversive racism indicates that Blacks receive help less quickly than Whites in emergency (i.e., high pressure) situations from White helpers (Kunstman & Plant, 2008; Saucier, Miller, & Doucet, 2005). In other research, lay White individuals interpreted situations as being less of an emergency than they actually were when victims were Black (Kunstman & Plant, 2008). Taken together, the phenomenon of aversive racism and significant professional and cognitive demands placed upon physicians facilitate a perfect storm which creates health care disparities related attitudes and possible behaviors. Thus, daily medical hassles + unintentional bias = potential health care disparities.

Specifically, health care disparities may occur as a function of physicians providing less information to patients, withholding diagnostic or clinical procedures, as well as misdiagnosing illnesses (Elster, Jarosik, VanGeest, & Fleming, 2003; Green et al., 2007; Kogan, Kotelchuck, Alexander, & Johnson, 1994; Murdoch, Hodges, Cowper, Fortier, & van Ryn, 2003); beneath the above-mentioned outcomes may be a process of

subtle bias. One of the sources of subtle bias in the health care process is negative stereotypes and racial attitudes, which physicians may consciously and unconsciously apply to minority patients (Burgess, van Ryn, Dovidio, & Saha, 2007; Dovidio et al., 2008; Smedley et al., 2003; van Ryn & Burke, 2000; van Ryn & Fu, 2003). To a degree the reduction and elimination of health care disparities, may be facilitated partially by assessing the racial and social attitudes of physicians.

Health Care Disparities: The Process and Provider Factors

Health care disparities occur at multiple levels and have multiple causes (Smedley et al., 2003). The goal of this study is to focus on disparities that occur at the “care level” (i.e., the interaction between the physician and patient during the clinical encounter). The Institute of Medicine (2003) highlights clinical uncertainty, time pressure, stereotypes, and provider bias as most relevant to disparities at the care level.

Recently, a useful model was proposed describing how practitioners’ attitudes influences patient attitudes, the clinical encounter, and perpetuates health care disparities. The model suggests that patient demographic variables have an effect on physician attitudes. Physicians’ attitudes then influence medical case conceptualization, which then influences clinical decision-making, and physician interpersonal behavior. The overall effect of physicians’ attitudes and related processes then affect patient behavior, satisfaction, and the clinical encounter in general (van Ryn & Fu, 2003). What is most notable about the model is that it delineates how powerful and central physicians’ attitudes are in the health care process. Consequently, although physicians and patients are partners in the health care process, physicians have the greatest influence in the dyad

because of their social position. Due to this power differential, the Committee on Understanding Health Care Disparities asserted that although both patients and physicians need to be educated about the health care process, the “greater burden” of education (i.e., awareness about health disparities and related issues) is on physicians and other health care providers (Smedley et al., 2003).

Implicit biased attitudes have been suggested to shape outcomes relevant to the clinical encounter. Implicit attitudes as measured by the Implicit Association Test (Greenwald, Nosek, & Banaji, 2003), reveal that physicians perceive Blacks as less cooperative during the clinical encounter (Green et al., 2007). Among mental health professionals the priming of unconscious stereotypes about Blacks affected diagnostic ratings and impressions (Abreau, 1999). Research using virtual humans has shown that implicit bias is related to empathy for virtual patients; lighter complexion virtual patients received more empathy than dark complexion virtual patients (Rossen, Johnsen, & Deladisma, 2008). More recently, research has shown that health care trainees endorse biases in favoring Whites and light skin tones; higher implicit bias was associated with less self-reported cultural competence (White-Means, Dong, Hufstader, & Brown, 2009). Thus, a physician’s unconscious and internalized racial attitudes have the potential to affect professional behavior and attitudes relevant to developing rapport.

Saha (2006) suggests that there is a “cultural distance” between physicians and patients of color. This cultural distance inhibits optimal and effective physician-patient interactions during the medical encounter; distance is created by the interaction of providers and patients. This social distance may develop, as a function of provider

behavior, due to biased attitudes. As a result, physicians' exploration of the clinician-self relationship (Cooper, Beach, Johnson, & Inui, 2006) is important to be examined.

White Physicians, Self-Awareness, and Socialization

According to the Minority Affairs Consortium of the American Medical Association, Whites represent the largest singular racial group among physicians in the United States, accounting for 55.8% of nearly one million physicians (American Medical Association, 2005). Whites, as a unique social group, currently represent both a numerical and social majority in the United States. Being a member of a social majority frequently includes group-specific privileges that are not shared by individuals who are not a part of the majority group; such privileges result in a unique set of life experiences and, in particular, a distinctive world view that physicians carry into the clinical encounter. Specifically, Whites often adopt a color blind view of race in the U.S. (Judd, Park, Ryan, Brauer, & Kraus, 1995). A color-blind world view suggests that race and racism are unimportant (Neville, Lilly, Duran, Lee, & Browne, 2000); such a world view perpetuates bias because not acknowledging the role of race in our society often leads to subtle forms of racism (Neville et al., 2000). The way in which many Whites are socialized may be the source of the color-blind world view. Many White parents often avoid discussions of race, relying on their children's schools to address such issues; this is in contrast to African American parents who tend to have more direct discussions with their children about race (Hamm, 2001).

The challenge of a color-blind world view is that it is an obstacle to racial self-awareness (Gushue & Constantine, 2007) and one's ability to effectively work with

members of stigmatized groups (Gushue, 2004). Lack of self-knowledge may also lead to health-disparities-blindness. Specifically, individuals may not be able to see how their attitudes and behavior contribute to inequitable health care; they may not recognize that health disparities exist at all (Wilson, Grumbach, Huebner, Agrawal, & Bindman, 2004). Such blindness likely contributes to poor physician-patient interactions as well as health care disparities at the care level. Overall, many White physicians would benefit from developing improved rapport and communication with patients of color (Ferguson & Candib, 2002). Thus, White physician self-awareness and self-reflection is of the utmost importance to be explored in research and addressed in training settings.

Physician Attitudes

The assertion that self-knowledge is an important factor in practitioner development is consistent with a recently delineated model which theorizes that internal motivation to be nonbiased, consideration of “psychological bias”, understanding of historical racism, and perspective-taking are all relevant to reducing bias in the health care process (Burgess et al., 2007). Betancourt (2003), a scholar of cross cultural medical care argues,

Certain attitudes are particularly important if one is to effectively engage in cross cultural care. These include, among others, humility, empathy, curiosity, respect, sensitivity, and awareness to one’s own internal predisposition to racial, cultural, gender, and class bias and categorization, in addition to awareness of the myriad of outside influences that affect the individual patient. (p. 564)

He further suggests such attitudes are important to “effective communication” during the clinical encounter (Betancourt, 2003). Thus, genuine cross cultural competence begins inside one’s head. Accordingly, understanding physicians’ internalized racial and social

beliefs are key to understanding their self-perceived cultural competence. Although such research is important, little research is available regarding physicians' racial and social attitudes (Smedley et al., 2003).

A dearth of research suggests that attitudes, characteristics, and identity matter for physicians similar to counselors and lay individuals. Physician characteristics such as being liberal, older, Black, and a family practitioner, have been found to predict varying aspects of self-perceived physician cultural competence (Paez, Allen, Beach, Carson, & Cooper, 2009). In addition, research co-examining physician and patient perceptions finds that differences in White identity (Garrouette, Sarkistan, Arguelles, Goldberg, & Buchwald, 2006) as well as personal and ethnic similarity relate to positive outcomes relevant to the clinical encounter (Street, O'Malley, Cooper, & Haidet, 2008). Although research solely examining White training physicians' attitudes is no substitute for patient report or observation, understanding the physicians' perspective is important. Furthermore, the attitudes of White physicians are important because people of color monitor their providers' verbal and non-verbal behavior (Ward, 2005) are better able to recognize nonverbal racial bias (Richeson & Shelton, 2005), and in some cases have mistrust toward Whites, which affects their trust in health care providers (Benkert, Peters, Clarke, & Keves-Foster, 2006).

The purpose of this dissertation is to dig below the demographic level by excavating racial and social attitudes that are relevant to White training physicians' self-perceived cross cultural competence. It is expected that the findings of this study will provide information relevant to the clinical encounter, cross cultural medical education,

and health care disparities. This dissertation explores the social attitudes of White physicians-in-training through the combined application of counseling and social psychology as well as medical constructs. The following section will briefly explore the key constructs in this project: ethnocultural empathy, internal motivation to respond without prejudice, color-blind racial attitudes, just world beliefs, and aspects of cultural competence (i.e., patient centeredness and skillfulness in providing cross cultural care).

Ethnocultural empathy was chosen because empathy, in general, is a professional expectation for physicians. Ethnocultural empathy is described as empathic feelings toward members of a different cultural group than one's own (Wang et al., 2003). Ethnocultural empathy is not only an extension of general empathy but may also be an important component of how physicians view patients and interact with them. Internal motivation to respond without prejudice was selected for the purpose of accounting for physicians self-reported attitudes around interacting with patients in an egalitarian manner. Internal motivation to respond without prejudice reflects an individual's internalized value of not wanting to appear prejudiced to oneself (Plant & Devine, 1998). Individuals who strongly endorse internal motivation to respond without prejudice want to overcome their internalized feelings of bias toward minorities. Both ethnocultural empathy and internal motivation to respond without prejudice represent forms of positive racial attitudes.

General just world beliefs is defined as the belief that the world is fair toward others (Dalbert, 1999). Such attitudes have relevance for working with members of oppressed social groups. The construct of color-blind racial attitudes was selected

because it represents a contemporary attitude toward issues of race individuals may endorse. Color-blind racial attitudes are the belief that race is not relevant to current milieu of American society (Neville et al., 2000).

The dependent variables for this study represent cross cultural competence (i.e., patient centeredness and skillfulness in providing cross cultural care). Cross cultural competence has been broadly defined as being able to develop successful working relationships in spite of cultural differences that may exist (Cooper & Rotter, 2003).

Patient centeredness is defined as the physician engaging in perspective taking in relation to the patient and providing care based on what the patient may prefer (Beach, Saha, & Cooper, 2006); this is in contrast to a physician-centered style of providing health care. The overall goal of patient centeredness is to balance the relationship between doctors and patients in the hope that health care disparities can be reduced by encouraging patients to be more involved in their own care (Beach, Rosner, Cooper, Duggan, & Shatzer, 2007; Beach, Saha, & Cooper, 2006). Endorsing patient centeredness also has relevance to cross cultural competence and feeling self-efficacious in working with patients of color. Patient centeredness was selected because of its proposed theoretical relationship to cross cultural competence. Skillfulness in providing cross cultural care was selected because the perceived ability to work with individuals cross culturally is a key element in developing cross cultural physician-patient relationships (Weissman et al., 2005). Skillfulness is also likely an important component in helping physicians to feel self-efficacious in working with patients of color (Beach et al., 2007).

In summary, this study will examine the social attitudes of White physicians-in-training (i.e., medical students and residents) with the intended purpose of adding to the empirical literature on health care disparities by exploring social attitudes potentially relevant to the clinical encounter.

Research Questions and Hypotheses

Research Question 1) Will positive (i.e., internal motivation to respond without prejudice and ethnocultural empathy) and negative (i.e., general just world beliefs and color blind racial attitudes) racial and social attitudes have a significant association to patient centeredness and skillfulness in providing cross cultural care?

Hypothesis 1) Positive and negative racial and social attitudes will have a significant association with patient centeredness and skillfulness in providing cross cultural care.

Research Question 2) Will ethnocultural empathy have an association with patient centeredness and skillfulness in providing cross cultural care?

Hypothesis 2) Ethnocultural empathy will have a significant association with patient centeredness and skillfulness in providing cross cultural care.

Research Question 3) Will internal motivation to respond without prejudice have an association with patient centeredness and skillfulness in providing cross cultural care?

Hypothesis 3) Internal motivation to respond without prejudice will have a significant association with patient centeredness and skillfulness in providing cross cultural care.

Research Question 4) Will general just world beliefs have an association with patient centeredness and skillfulness in providing cross cultural care?

Hypothesis 4) General just world beliefs will have a significant association with patient centeredness and skillfulness in providing cross cultural care.

Research Question 5) Will color-blind racial attitudes have a significant association with patient centeredness and skillfulness in providing cross cultural care?

Hypothesis 5) Color-blind racial attitudes will have a significant association with patient centeredness and skillfulness in providing cross cultural care.

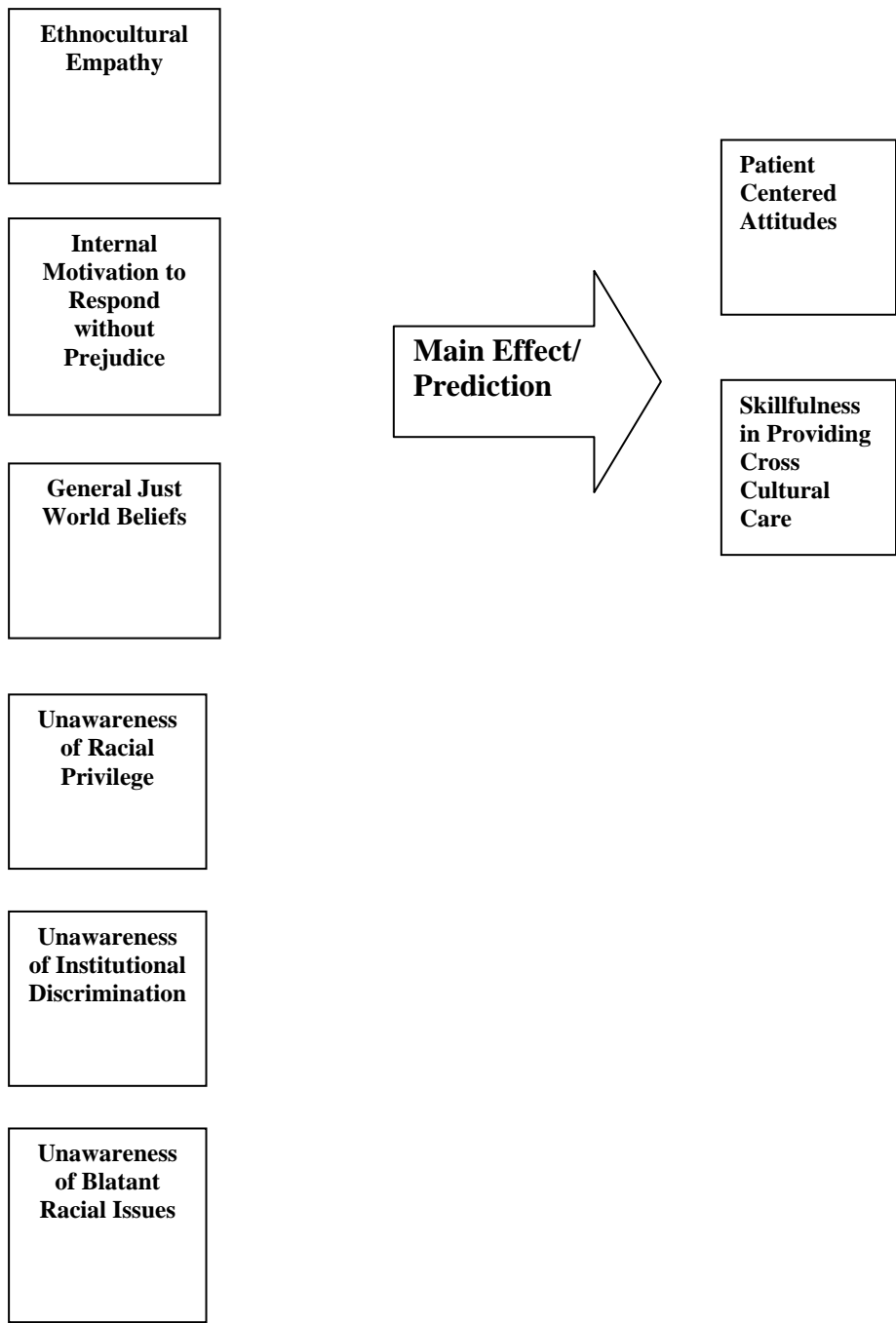


Figure 1. Overall Model

CHAPTER TWO

LITERATURE REVIEW

The following literature review will present ethnocultural empathy, internal motivation to respond without prejudice, general just world beliefs, color-blind racial attitudes, skillfulness in providing cross cultural care, and patient centeredness.

Ethnocultural Empathy

Cultural empathy is the acquired ability to understand the experience of individuals of other cultures; this includes the capacity to understand culturally laden information and to effectively communicate this to individuals (Ridley, 1996).

Ethnocultural empathy as defined by Wang, Davidson, Yakushko, Savoy, Tan and Bleir (2003) is a “personality trait or learned behavior” which includes intellectual, emotional, and communicative components. Wang and colleagues further define ethnocultural empathy as 1) the ability to see the world through someone else’s eyes 2) feeling from the perspective of another racial or ethnic culture, 3) emotional response to a member of another racial or ethnic group than one’s own, and 4) communicating one’s feelings of ethnocultural empathy through words and actions. Ethnocultural empathy is important because it is likely an intermediate step between general empathy and other outcomes relevant to working with members of minority groups. Ethnocultural empathy is likely an important factor in a variety of interracial interactions. For instance, ethnocultural

empathy may have significant relevance for how physicians-in-training think about working with patients of color.

It has been suggested that minorities may experience less empathy in encounters with physicians (Ferguson & Candib, 2002), due to minority status being viewed as a stigmatizing trait (cf. Goffman). This may be suggestive not only of a lack of empathy on the part of some physicians toward patients of color but also a lack of ethnocultural empathy. Many Whites may have an inaccurate view of minorities, stereotypes, or biased attitudes that may affect the clinical encounter. Researchers have suggested that, “attitudes toward an individual are linked with nonverbal behavior emitted toward that individual and positive attitudes lead to more nonverbal behaviors” (Neville et al., 2000, p. 226). Physicians’ attitudes may in part drive their interactions with patients of color. It may be that the clinical encounter is vulnerable to negative nonverbal behaviors as a function of attitudes physicians may possess.

Many physicians-in-training may not appreciate the difficulty of empathizing with individuals who are members of a different cultural group than their own (Burgess et al., 2007). Empathizing with a member of another racial or cultural group may be difficult because of the conscious and unconscious stereotypes that physicians may carry with them into interactions with patients. High endorsement of general empathy has been shown to predict lower endorsement of prejudice (Backstrom & Bjorklund, 2007). Bias, similar to prejudice is known to play a role in health care disparities (Backstrom & Bjorklund, 2007; Burgess, van Ryn, Crowley-Matoka, & Malat, 2006; Burgess et al., 2007). Similar to the relationship general empathy can have to general prejudice; it

seems plausible that ethnocultural empathy might have relevance to bias in the context of the clinical encounter, thus contributing potentially to health care disparities.

Empathy is an important relational factor in how doctors and patients of color interact during the clinical encounter. Practicing physicians are at least sometimes less satisfied in their interactions with patients of color in comparison to White patients during the clinical encounter (Kamath, O'Fallon, Offord, Yawn, & Bowen, 2003) and feel less affiliated and friendly toward patients of color (van Ryn & Burke, 2000). Reduced satisfaction is in part related to physicians' perceived difficulties in communication as well as cultural practices and beliefs. Reduced feeling of affiliation and friendliness is related to physicians' perceptions of patients' demographic characteristics (i.e., race). Therefore, if one considers that doctors are sometimes dissatisfied in their interactions with patients, do not like their patients, and view their patients as unintelligent, this can contribute to poor experiences for physician and patient. The result of such difficult interactional patterns may be reduced empathic responding. Hooper, Comstock, Goodwin, and Goodwin (1982) found that physicians responded more empathically, asked open ended questions, and allowed patients to ask more questions when patients were White than when they were Hispanic. African American patients are also known to experience less quality interpersonal interactions with their physicians (Johnson, Rotter, Powe, & Cooper, 2004). During medical visits, physicians were found to be more talkative and less patient-centered. These four studies suggest negative interpersonal dynamics can occur between some physicians and patients of color; the quality of these relationships may contribute to difficulties in the clinical encounter. Negative

interpersonal interactions between physicians and patients can contribute to less empathic care.

Ethnocultural empathy has been explored primarily among undergraduates and counseling trainees. Ethnocultural empathy has been found to be associated with aspects of White racial identity, multicultural counseling competence (Karuppaswamy, 2006), gender authority (Cundiff & Komarraju, 2008), a multicultural training intervention (Nganga, 2006), sympathy for victims of domestic violence (Jones, 2005), and education and training after accounting for diversity experiences (Briggs, 2006). It has been negatively correlated with social dominance orientation, right-wing authoritarianism, hypersensitivity, and narcissism (DiMeo, 2007). The patterns of these studies suggest ethnocultural empathy has important implications general interpersonal interactions as well as situations relevant to helping professionals, including physicians.

Although research is limited, there is one notable study that links ethnocultural empathy with counselor interactions with clients. Garran (2008) found that ethnocultural empathy, racial identity, and cultural competence attitudes among White counselors were significantly associated with “therapeutic engagement” with youth of color. Overall ethnocultural empathy and empathic feeling and expression were correlated with therapeutic engagement. Thus, ethnocultural empathy could be a necessary and important attribute to exhibit in cross cultural encounters. The challenge of physicians interacting with patients of color seems to rest partly in physicians’ difficulty in working effectively with some patients of color (van Ryn & Burke, 2000).

Ethnocultural empathy has also been found to be related to negative social attitudes. Specifically, social dominance orientation, and right wing authoritarianism are negatively predictive of ethnocultural empathy (DiMeo, 2007). Both social dominance orientation and right wing authoritarianism are attitudes that relate to believing in hierarchy among groups within society; both constructs are relevant to maintaining the current social order as it currently exists. The negative relationship social dominance and right wing authoritarianism have with ethnocultural empathy suggests that maintaining the status quo cannot coexist well with empathy toward other groups. Research suggests that many doctors are paternalistic (Falkum & Forde, 2001) and authoritarian to varying degrees (Tsimtsiou et al., 2007). These studies are relevant because individuals who are paternalistic and authoritarian may not be well responded to by some patients. White physicians with predominant attitudinal patterns of authoritarianism and paternalism may not have empathic mind-sets necessary to engage well with patients of color. Consequently, ethnocultural empathy may be an important attitude to develop among physicians-in-training in an effort to optimize care for patients of color. To date there is no research on ethnocultural empathy and its relation to the social attitudes of physicians'-in-training. Though little research is available on ethnocultural empathy research examining general empathy can be informative.

Social psychology research has found that undergraduates who were provided with vignettes of culturally dissimilar target individuals demonstrated less empathic concern and perspective taking. Participants blamed culturally dissimilar targets for problems stemming from situation-specific events, while demonstrating more positive

affect toward culturally similar individuals (Nelson & Baumgarte, 2004). Conversely, individuals who were encouraged to take the perspective of members of oppressed groups better understood the experiences of such individuals, made situational attributions, and verbalized more positive attitudes (Vescio, Sechrist, & Paloucci, 2003).

Other research finds that general empathy is positively related to motivation to respond without prejudice (Buswell, 2006). Hence, individuals who are more empathic toward others may be more likely to be motivated to respond in non-prejudiced ways toward those they perceive as being culturally different from themselves. This may be a function of empathy's relationship to conscientiousness (Del Barrio, Aluja, & Garcia, 2004). It could be that individuals who are more empathic provide more quality care to patients of color and are more cross culturally competent. Finally, research has found that general empathy predicts helping behavior when the recipient of the help is a member of the helper's in-group (Strurmer, Snyder, & Omoto, 2005). Considering that in-group bias is a factor in providing help to others then ethnocultural empathy is all the more important to consider in the context of cross cultural clinical encounters. It is possible that development of ethnocultural empathy is an intermediate step between general empathy and the cross cultural attitudes and interactions which contribute positively to the interracial clinical encounter. Ethnocultural empathy may be a means of reducing in-group bias and encouraging more culturally competent care with patients of color. Specifically, ethnocultural empathy may be useful to include in interventions with health care providers.

Counseling research has examined general empathy finding an empirical link to self-perceived multicultural competence. For example, empathic concern alone has been found to relate to multicultural knowledge and awareness (Constantine, 2000). Multicultural training along with empathic concern were predictive of self-reported multicultural counseling competence (Constantine, 2001b). These studies suggest counselors who are more empathic self-report higher multiculturally competent attitudes when working with racially and ethnically diverse clientele. Moreover, empathic perspective taking and empathic concern were both predictive of multicultural case conceptualization (Constantine, 2001a), the ability to integrate multicultural information into the conceptualization of diverse clients' presenting problems (Ladany, Inman, Constantine, & Hofheinz, 1997). Thus, counselors who report multicultural training and empathy are more likely to integrate multicultural information (e.g., social and cultural context) into their understanding of cases. All together, these studies strongly suggest that empathy is relevant to multicultural processes in clinical settings. This literature is also consistent with a recent model suggesting that empathic perspective taking is relevant to decreasing bias in the health care process (Burgess et al., 2007); it may be that the cognitive and affective components of empathy are useful in helping physicians to better connect with patients especially patients who are of a different sociocultural group. Because a similar set of skills, knowledge, and attitudes are necessary for productive cross-cultural medical clinical encounters ethnocultural empathy may also be relevant to training physicians. Ethnocultural empathy appears to be an important factor in helping

to better understand how to reduce health care disparities and bias that occurs at the “care level”.

In summary, ethnocultural empathy has been found to have significant relationships with social constructs that have relevance to cross cultural competence and health care disparities. Although, there is only a small body of literature on the topic of ethnocultural empathy, general empathy has been found to be related to a variety of multicultural counseling constructs. Taken together, ethnocultural empathy may be an important but unexplored variable relevant to cross cultural competence and ultimately health care disparities.

Motivation to Respond Without Prejudice

The internal and external attitudes related to race-related impression management have been described as motivation to respond without prejudice (Plant & Devine, 1998). Internal motivation to respond without prejudice is specifically defined as being internally motivated to be non-prejudiced because of an internalized set of values; external motivation to respond without prejudice is a set of attitudes whereby an individual responds in a non-prejudiced way based on how they expect to be evaluated by others (Plant & Devine, 1998). Individuals who are externally motivated are most interested in hiding prejudice; in contrast, individuals who are internally motivated intend to be prejudice free (Plant & Devine, 2009). Motivation to respond without prejudice is a useful construct in that it acknowledges individuals’ cognitive control and choice in how they choose to respond to members of minority groups.

Research suggests that motivation to respond without prejudice is related to a variety of positive and negative social attitudes (Plant & Devine, 1998). Specifically, internal motivation to respond without prejudice was negatively related to modern racism, right wing authoritarianism, and protestant work ethic; it is positively related to positive attitudes toward Blacks and egalitarianism. In contrast, external motivation to respond without prejudice was found to be associated with higher endorsement of modern racism and right wing authoritarianism, and less positive attitudes toward Blacks. Furthermore, individuals high in internal motivation to respond without prejudice endorsed fewer stereotypes in both public and private research conditions than individuals low in internal motivation to respond without prejudice.

Although internal motivation to respond without prejudice is an intentional set of attitudes, it has been found to have effects on unconscious cognitive processes. One study found that internal motivation to respond without prejudice was negatively predictive of implicit bias (Hausmann & Ryan, 2004). That is, as individuals increasingly endorsed internal motivation to respond without prejudice, unconscious bias was less frequently endorsed. Similar research suggests that a combination of high internal and low external motivation to respond without prejudice resulted in less implicit bias (Devine, Plant, Amodio, Harmon-Jones, & Vance, 2002). Consequently, the advantage of being internally motivated is a self-regulation process that can shape unconscious biased thoughts. Accordingly, a physician may be able to control unconscious thoughts through a process of internal motivation.

Internal motivation to respond without prejudice has further been found to be related to increased egalitarian goal activation and decreased stereotype activation following exposure to African American faces (Johns, Cullum, Smith, & Freng, 2008). This suggests that there may be two benefits to the development of internal motivation to respond without prejudice; specifically, the reduction of stereotypes, and the activation of egalitarian goals. Taken together, the encouragement of internal motivation to respond without prejudice among training physicians may contribute positive attitudes toward patients of color. Positive attitudes have the potential to encourage constructive interactions that contribute to more satisfying clinical encounters.

Using a longitudinal research design with non-Black college students, Plant (2004) found that internal motivation to respond without prejudice had an association to positive outcome expectations, less interracial anxiety, and less reports of avoidance of interracial interaction with Blacks. Individuals who avoid interracial interactions both materially and psychologically limit their ability to become culturally competent with diverse clients. Lessened interracial anxieties as a function of internal motivation may prevent ineffective physician-patient interactions during the medical encounter.

Both survey and longitudinal research suggest internal motivation to respond without prejudice is important for cross cultural interactions. Internal motivation to respond without prejudice may be important because physicians who are more internally motivated are more likely to be invested in having positive cross cultural interactions with patients. Consequently, physicians endorsing such attitudes may have more willingness to do the personal and professional work that will enable them to become

cross culturally competent. In particular, internal motivation to respond without prejudice may be important for health care providers to possess (Burgess et al., 2007) due to an increasingly diverse patient population. It has been found to influence a variety of attitudes relevant to the process of cross cultural care.

It may be that better patient-physician interactions and reduction of health care disparities are likely to be facilitated by internal motivation to respond without prejudice (Burgess et al., 2007). Thus, internal motivation to respond without prejudice is a desirable mind-set for health care professionals. Given the pattern of existing research, internal motivation to respond without prejudice is an important construct to be explored among physicians-in-training.

Just World Beliefs

Just world beliefs are defined as the belief that the world, in general, is a fair place (Lipkus, Dalber, & Siegler, 1996). Just world beliefs can be a form of system justification in which individuals seek to rationalize the status quo (Jost & Hunyady, 2002, as cited in Jost & Hunyady, 2005). It is an important construct in that it relates to how varying social groups are viewed (Jost & Hunyady, 2005) and possibly treated. For example, Sutton and Douglas (2005) suggest just world beliefs may be an “active ingredient” in a variety social outcomes, such as insensitive attitudes toward the poor.

Just world beliefs also have two-fold implications in that a just world belief for one’s self has a different meaning than a just world belief toward others (Sutton & Douglas, 2005). Just world beliefs for the self has been associated with a variety of positive outcomes (Jost & Hunyady, 2005), whereas just world beliefs toward others has

been significantly related to unsympathetic attitudes toward the poor (Sutton & Douglas, 2005), negative attitudes toward the elderly, attitudes toward the punishment of criminals (Beague & Bastounis, 2003), and the blaming of rape victims (Murray, Spadafore, & McIntosh, 2005). In addition, individuals high in general just world beliefs perceive that age discrimination is non-existent in the U.S., and are less likely to endorse the provision of special programming for the elderly (Lipkus & Siegler, 1993). The primary focus of this review is general just world beliefs toward others because as a construct it has the most relevance to the attitudes of physicians-in-training.

Believing the world is inherently a fair place may allow a person to accept the social structure of society, not questioning inequities that exist. Just world beliefs can serve the psychological purpose of moderating the relationship between stress and coping (Tomaka & Blacovich, 1994). Acknowledging that the world is less fair for some than for others may intensify the experience of stress. For instance, being able to reduce subjective stress and anxiety in interracial situations by believing in the minimizing of inequity can have implications for how physicians-in-training interact with members of oppressed groups in many settings.

Physicians who enter into clinical encounters with high general just world belief attitudes may be less prepared to effectively work with patients of color. Recent research suggests that individuals endorsing high general just world beliefs endorse lower other group orientation (i.e., interest in interaction with individuals outside of one's cultural groups) (Wright & Littleford, 2002); therefore, endorsing that the world unfair is related to more openness to diverse experiences. Just world beliefs among White physicians-in-

training may be important to explore because one's ability to see the world as fair or unfair to others may be related to one's ability to understand racial injustice (Wright & Littleford, 2002). Understanding inequity and injustice and other social justice related issues may be a key component to working cross culturally. General just world beliefs may help to explain findings among White physicians who believe that demographic characteristics like race "rarely" or "never" contribute to health care disparities (Kaiser, 2002) and believe that unfair treatment does not occur in the healthcare system (Wilson, Grumbach, Huebner, Agrawal, & Bindman, 2004).

An individual's just world belief attitudes may mirror the social status a person holds in the context of a given society (Wright & Littleford, 2002). For instance, research comparing the general just world beliefs, of Blacks to Whites finds that both groups have differing levels of just world beliefs with Whites having higher general just world beliefs (Calhoun & Cann, 2001; Hunt, 2000). Among advantaged racial groups (i.e., Whites), Jost and Hunyady (2005) theorize that system justifying beliefs (i.e., just world beliefs) result in in-group preference, perceived legitimacy of social systems, and reduced support for social change. Overall, greater endorsement of general just world beliefs is likely counterproductive to attitudes necessary for working effectively with diverse individuals and in particular to individuals who are members of oppressed groups. Finally, general just world beliefs have been found to be negatively associated with altruistic behavior toward beggars on the street (Beague, Charmoillaux, Cochet, Curry, & De Suremain, 2008). It is possible that general just world beliefs could affect attitudes relevant to cross clinical encounters with members of disadvantaged groups.

In summary, general just world beliefs are known to be predictive of a variety of attitudes relevant to cross cultural competence and perhaps the cross cultural care process. To date, no research on general just world beliefs has been conducted with physicians-in-training. General just world beliefs may be an important relevant construct in understanding the attitudes of physicians-in-training. Considering that general just world beliefs are relevant to helping behavior and interest in interacting with people from other cultural groups then it is plausible that just world beliefs have relevance for cross cultural competence among physicians-in-training.

Color-Blind Racial Attitudes

Color-blind racial attitudes as conceptualized by Neville, Lily, Duran, Lee and Browne (2000) consist of three factors: unawareness of racial privilege, unawareness of institutional discrimination, and unawareness of blatant racial issues. Unawareness of racial privilege connotes a lack of knowledge of White privilege. Unawareness of institutional discrimination is described as unawareness of institutional discrimination and exclusion. Unawareness of blatant racial issues represents a lack of knowledge of racial discrimination in society. The theory of color-blind racial attitudes suggests that some individuals may view race as unimportant, ignoring the role of racism as a sociopolitical reality in peoples' experiences, yielding a distorted perception of race relations (Neville et al., 2000). Color-blind racial ideology may help some Whites reduce conflicting and uncomfortable feelings about racial inequality (Unzetta & Lowery, 2008). Color-blind attitudes are seen by many Whites as socially acceptable. Multicultural counseling scholars have suggested that not considering race as a relevant factor is a form

of rationalizing which maintains a privileged status by denying the importance of racial and cultural issues (Gushue & Constantine, 2007).

On the surface color-blind racial attitudes may seem a reasonable solution to overcoming racial bias; however, in actuality color-blind racial attitudes may work to perpetuate bias (Neville et al., 2000). Social psychology research has found that when color-blind racial strategies are compared to multicultural strategies (i.e., acknowledging racial differences as a reality) individuals under color-blind conditions tend to display increased stereotyped attitudes, whereas individuals who engage in multicultural strategies demonstrate less ethnocentric attitudes (Ryan, Hunt, Weible, Peterson, & Casas, 2007). Correll, Park, and Smith (2008) found that engaging in color-blind racial strategies initially decreased explicit prejudice but, the researchers hypothesized that participants may have been engaging in socially desirable responding. When prejudice was measured at the unconscious level, color-blind participants actually endorsed the same amount of bias as participants in multicultural conditions. Additionally after time elapsed, the color-blind participants demonstrated a rebound effect which resulted in greater endorsement of prejudice than participants who utilized a multicultural ideology in the same study (Correll, Park, & Smith, 2008). Thus, color-blind racial strategies ultimately resulted in negative outcomes.

The findings of the two studies are consistent with attitudinal research on affirmative action. Awad, Cokely and Ravitch (2005) found that color-blind racial attitudes were predictive of endorsing unfavorable attitudes toward affirmative action. Specifically, color-blind racial attitudes were more predictive of negative attitudes toward

affirmative action, over and above modern racism attitudes. Taken together, these three studies suggest endorsing color-blind attitudes are not an effective strategy in the context of interracial interactions.

Color-blind racial attitudes represent important internal cognitive processes that have implications for physicians-in-training. Research focusing on internal processes with regard to color-blind racial attitudes among counseling and clinical psychology trainees found that those lower in color-blind racial attitudes endorsed more developed White racial identity schemas (Gushue & Constantine, 2007); the researchers suggest practitioners' racial identity is important because it may affect the working relationship between practitioners and their clients (Gushue & Constantine, 2007). Color-blind racial attitudes have been positively associated with endorsement of fear of individuals of other races and negatively associated with White empathic attitudes toward racism, and lower White guilt (Spanierman & Heppner, 2004).

Therapists' color-blind racial attitudes have been negatively related to self-reported empathy after controlling for social desirability (Burkard & Knox, 2004). That is, the more self-reported color-blindness (i.e., higher lack of awareness of racism) the less empathic the counselor toward the target individual. Counselors who were less color-blind demonstrated more empathy. Color-blind racial attitudes are important with regard to predicting self-reported multicultural counseling competencies. Color-blind racial attitudes uniquely accounted for 29% of the variance in self-reported multicultural counseling competencies over and above other demographic and attitudinal characteristics such as, social desirability, race, multicultural training, and ethnic identity

(Chao, 2006). Endorsing unawareness predicted trainees feeling less competent with regard to working with diverse clients. Using a global version of the COBRAS, Neville, Spanierman and Doan (2006) also found that color-blind racial attitudes were significantly negatively predictive of multicultural awareness and knowledge as well as multicultural case conceptualization in relation to etiology of illness and treatment. Case conceptualization is important because it is the initiation of the diagnoses and treatment process. Taken together, these studies suggest that a practitioner's internal racial attitudes can affect their professional attitudes, behaviors, and judgments. Because physicians-in-training are also expected to develop an empathic and culturally competent approach to patients it is possible that physicians-in-training are also susceptible to biases that would influence attitudes toward patients of color.

Overall, literature suggests that color-blind racial attitudes are relevant to self-perceived multicultural competence for some health care professionals. It may be that individuals who endorse color-blind racial attitudes may provide less competent care because of their lack of awareness. Given that color-blind racial attitudes have been found to be important among counselors, it may also be the case that color-blind racial attitudes are relevant to the self-perceived cross cultural competence of White physicians-in-training.

Cross Cultural Competence

Effective cross cultural care, the goal of cultural competence training, is based on the providers' knowledge, attitudes, and skills (Betancourt, 2003). Specifically, cultural competence is a matter of self-awareness, understanding diversity issues, valuing and

having positive attitudes toward such issues and combining one's knowledge and attitudes into meaningful skills when working with patients (Betancourt, 2003). It has been suggested that cultural competence and patient centeredness share similar features essential to improving health care and reducing health care disparities (Beach, Saha, & Cooper, 2006).

Surveys indicate some physicians-in-training lack adequate levels of cultural competence (i.e., knowledge, preparedness, and skills) (Bussey-Jones, Genao, St. George, & Corbie-Smith, 2005; Weissman et al., 2005). For instance, among third year medical students, the average score was 55% on a test of cultural competence. Qualitative research with medical residents found that they did not receive adequate support to become culturally competent; and consequently, resorted to developing their own informal methods of developing cultural competence, such as observing their trainers, drawing upon personal experiences from their racial/ethnic background, and through experiences traveling abroad (Park et al., 2005). Related research using a nationally representative sample of patients reported that many patients of color view the health care system as not being culturally competent and see the health care system as biased (Johnson, Saha et al., 2004). Taking into account the observations of medical students and patients, the health care system may not be well prepared to meet the needs of diverse patients. As a result, patient centered care may be compromised.

Beach, Saha, and Cooper (2006) aptly summarize the relationship between patient centeredness and cross cultural competence by stating the following:

The primary goal of patient-centeredness has been to provide individualized care and restore an emphasis on personal relationships. It

aims to elevate quality for all patients. Alternatively, the primary aim of the cultural competence movement has been to increase health equity and reduce disparities by concentrating on people of color and other disadvantaged populations. Nevertheless, there is significant common ground between the two. To deliver individualized care, a provider must take into account the diversity of patients' perspectives, and so to the extent that patient-centered care is delivered universally-care should become more equitable. Likewise, to the extent cultural competence enhances the ability of health care systems and providers to address individual patients' preferences and goals, care should also become more patient-centered. (p. viii)

Patient centeredness and cultural competence go hand and hand; one cannot exist without the other.

Patients of color have suggested that beyond technical skill and individualized treatment, positive interpersonal qualities and "people skills" are important for health care providers (Tucker et al., 2007). Thus, patients place a high value on interpersonal interactions with their physicians. Patient centeredness is related to a variety of service outcomes relevant to patients. Exploring a patient's perspective of their own disease or illness is seen as an important aspect of patient centeredness. For instance, in one study exploring aspects of patient centeredness observed during an unannounced visit was found to be related to patient trust (Fiscella et al., 2004). In an observational study of patients' perceptions of patient centeredness, aspects of patient centeredness were found to predict satisfaction, ability to cope with medical problems, and reduction of symptom severity one month after the clinical encounter. In contrast, receiving a prescription was not significantly associated with patient satisfaction or enablement (i.e., patients feeling that he or she can cope with their medical problem) (Little et al., 2001). This suggests that the interpersonal skills that doctors possess in the context of the medical encounter

are critical to patient outcomes. Patient centeredness, as perceived by patients, has been associated with “finding common ground”, reduced diagnostic tests, as well as better health outcomes (Stewart et al., 2000). Patient centeredness appears to be a key component of the health care process that is important to be cultivated.

In an intriguing study on race concordance (i.e., the physician and the patient are of the same race) researchers found that patient centered communication was predictive of perceptions of personal similarity between physicians and patients (Laveist & Carrol, 2002). Patient centered communication was also predictive of patient involvement, trust, satisfaction, and adherence. Although race concordance was a main feature of this study, it was not predictive of any of the main study outcomes, suggesting that race concordance was not as important as patient centeredness (Street et al., 2008). If health care disparities are to be reduced the development of patient centered attitudes among future physicians may be important, over and above race concordance.

When comparing medical student experiences with White versus African American standardized patients, students who more greatly endorsed patient centered attitudes were more effective with African American patients. Specifically, interpersonal skills, history taking, and counseling were more effective among patient centered students. Patient centeredness however, did not have a significant effect when examining interactions with White standardized patients (Beach et al., 2007). Taken together, patient centeredness may be very important when working with patients of color because it enhances the quality of the relationship.

Although many of the above mentioned studies have used patient centeredness as a predictor of outcomes, few have examined patient centeredness as a potential criterion variable. In a unique study exploring language and cultural competence, self-reported language ability, and cultural competence were associated with patient reports of a variety of aspects of patient centeredness, such as eliciting of problems and concerns responsiveness, empowerment, and explanation of process of care (Fernandez et al., 2004). Thus, patients' perceptions of patient centeredness was an important outcome that was facilitated by physicians self perceived cultural competence and language ability.

Though some physicians-in-training believe they are not well supported in developing cross cultural skills (Park et al., 2005), research suggests that intentional efforts at developing the cross cultural skills of health care providers have positive outcomes. Skills acquired and improved through cultural competence training relate not only to improving providers' competence, but also patient outcomes. Majumdar, Brown, Roberts, and Carpino (2004) found that providers receiving a cross cultural competence intervention improved their competence over the course of one year in the areas of understanding of multiculturalism, cultural awareness, appreciation of cultural differences, cultural beliefs, taking into account social context, and perceiving culture as important whereas control group participants attitudes remained the same. In addition, patients who worked with providers who received the intervention reported improved functioning (Majumdar et al., 2004). This indicates that providers' internalized cross cultural competence can affect both helping attitudes and behaviors with patients, and ultimately patients' improved functioning.

Conclusion

In summary, traditional research on race-related issues has focused on members oppressed groups while paying little attention individuals from the dominant group who may engage in or prevent social injustices as a function of their social position. This study seeks to understand the racial and social attitudes of White physicians-in-training that may have a direct and indirect bearing on the quality of the clinical encounter with racial and ethnic minority patients. Key constructs from the fields of social psychology and counseling psychology relevant to the medical context include: ethnocultural empathy, motivation to respond without prejudice, general just world beliefs, and color-blind racial attitudes. These constructs represent viable predictor variables that may help to better understand the attitudes of White physicians-in-training. The criterion variables for this study include skillfulness in providing cross cultural care and patient centeredness. Both represent aspects of cross cultural competence.

Overall, this study is important because it aims to contribute to the current body of literature with regard to understanding how internalized social attitudes of physicians can facilitate or hinder physician-patient relationships. This study is also important because it is the first to employ a multidimensional and interdisciplinary approach to understanding the social attitudes of physicians-in-training. It may also have further relevance for theory-building, in relation to health care disparities that occur at the physician-patient level as a function of physicians' internalized attitudes and patients' reactions to physicians' attitudes.

CHAPTER THREE

RESEARCH METHODOLOGY

Participants

Data were collected over the course of nine months through web-based data collection. Three hundred and fifty-two individuals visited the web page to read the informed consent; a total of 203 individuals completed surveys and 133 self identified as White. The mean age of the sample was 27.6 years; the standard deviation for age was 5.9. The median age was 26; the modal age for participants was 24 years. The majority of participants were female (78.2%) and 92% were first through fourth year medical students. Eighty-seven percent of participants also indicated that they had an interest in working with diverse patients, 76.7% reported that their schools had diversity courses; the average number of multicultural/diversity courses for the sample was 1.6 with a range of 0 to 7. Seventy-nine percent of participants either “strongly agreed” or “agreed” that experiences outside their training had best prepared them to work with diverse groups. Nearly 68% percent of participants reported that they had seen either “some” or “a lot” of minority patients at the time they completed the survey.

Instruments

Demographic Questionnaire

A demographic questionnaire was included in the survey packet to assess for general information such as age, race, socioeconomic status, year in school, diversity experiences, etc.

Scale of Ethnocultural Empathy

Ethnocultural empathy was measured with the Scale of Ethnocultural Empathy (SEE) (Wang et al., 2003). It consists of 31 items which include global and area specific scales of ethnocultural empathy; the main analysis for this study used the global scale of ethnocultural empathy. The overall scale reliability estimate obtained during validation was .91. The scale employs a likert format that ranges from “1” to “6” (i.e., “strongly agree” to “strongly disagree”). The subscales of the SEE are: Empathic Feeling and Expression, Empathic Perspective Taking, Acceptance of Cultural Differences, and Empathic Awareness. Empathic Feeling and Expression refers to measuring attitudes about communication about discrimination and prejudice; it also refers to emotional expression in relation to discriminatory issues. Sample items for the subscale include: “I share the anger of those who face injustice because of their racial and ethnic backgrounds,” and “I express my concern about discrimination to people from other racial and ethnic groups.” Empathic perspective taking refers to an individual’s interest in gaining insight into the feelings and experiences of people from different racial and ethnic backgrounds. Sample items for this subscale include: “I can relate to the frustration that some people feel about having fewer opportunities due to their racial or

ethnic backgrounds,” and “I know what it feels like to be the only person of a certain race or ethnicity in a group of people.” Acceptance of cultural differences relates to recognizing and accepting cultural differences of individuals from different racial and ethnic groups. Sample items for this subscale include: “I feel annoyed when people do not speak Standard English,” and “I don’t understand why people of different racial and ethnic backgrounds enjoy wearing traditional clothing.” Empathic awareness refers to knowledge about individuals from racial and ethnic groups. “I am aware of how society treats racial or ethnic groups other than my own,” and “I can see how racial and ethnic groups are systematically oppressed in our society.” The reliability estimates for each of the subscales found at the time of validation were .89, .75, .73, and .76, respectively. The reliability estimate for this sample was .88. The SEE was validated in relation to social desirability, general empathy, and universal-diverse orientation. The SEE was found to have a low correlation with social desirability and had adequate test-retest reliability over short periods of time.

Motivation to Respond without Prejudice Scale

The Internal Motivation to Respond without Prejudice Scale (Plant & Devine, 1998) was used to measure participants’ internal motivation to respond without prejudice. The scale is five items in length. Four of five of the original items were used in this study due to an error. It utilizes a likert format of “strongly disagree” to “strongly agree” ranging from 1 to 9. The Internal Motivation to Respond without Prejudice Scale was modified to ask participants about their attitudes toward minority patients. Original sample items include: “Being non-prejudiced toward Black people is important to my

self-concept,” and “I am personally motivated by my beliefs to be non-prejudiced toward black people.” Modified items included: “Being non-prejudiced toward minority patients is important to my self-concept,” and “Because of my personal values, I believe that using stereotypes about minority patients is wrong.” The reliability estimate for the Internal Motivation to Respond without Prejudice Scale was found to be .76 when developed (Plant & Devine, 1998). The reliability estimate for this sample was .75.

Color-Blind Racial Attitudes Scale

The Color-Blind Racial Attitudes Scale (COBRAS) (Neville et al., 2000) was used to measure the construct of color-blindness. The COBRAS is 20 items in length and uses a likert format which ranges from “1” to “6” (i.e., strongly agree to strongly disagree) and consists of three separate subscales, which include: Unawareness of Racial Privilege, Unawareness of Institutional Discrimination and Unawareness of Blatant Racial Issues. Unawareness of racial privilege is defined as the inability to perceive White privilege. Sample items for this subscale include: “Everyone who works hard, no matter what race they are, has an equal chance to become rich,” and “Race plays a major role in the type of social services (such as type of health care or day care) that people receive in the U.S.” Unawareness of blatant racial issues refers to limited insight into various forms of racial discrimination. Sample items for this subscale include: “Racism is a major problem in the U.S.,” and “Racism may have been a problem in the past, but it is not an important problem today.” Unawareness of institutional discrimination is defined as the inability to understand institutional discrimination.” Sample items for this subscale include: “It is important that people begin to think of themselves as American

and not African American, Mexican American or Italian American,” and “Due to racial discrimination, programs such as affirmative action are necessary to help create equality.” The reliability estimates established at validation were .83, .81, and .76, respectively. The reliability estimates for this sample were .87, .78, and .79, respectively. The scales can be combined to produce a global score; however, the most optimal factor structure suggested by the developers is the three factor model (Neville et al., 2000). The overall Cronbach’s alpha coefficient estimate established at validation was .91. The COBRAS was validated with college students and community members. Validity evidence suggested the COBRAS was convergent with measures of Just World Beliefs, Quick Discrimination Index, and the Modern Racism Scale. It has been shown to be divergent with social desirability.

General Just World Beliefs (i.e., Just World Beliefs toward Others Subscale)

The General Belief in a Just World scale was used to measure the construct of just world beliefs toward others. The subscale scale is six items in length (Dalbert, 1999). Sample items include: “I think basically the world is a just place,” and “I am confident that justice always prevails over injustice.” Validity evidence suggests it has a relationship with measures of mood, life satisfaction, and self esteem. It has an estimated mean reliability estimate of .68 across several studies. It has also been found to correlate with color-blind racial attitudes (Neville et al., 2000).

Cultural Competence Measures

Patient Centeredness (i.e., a measure of attitudinal cultural competence).

The Patient Centered Attitudes Measure (PCAM) measures attitudes of curiosity, respect, empathy, bio-psychosocial perspectives, the patient and doctor as a person, the sharing of power, and the therapeutic alliance (Beach et al., 2007). The PCAM is based on previous literature on patient centeredness as well as suggestions from the report Unequal Treatment (Smedley et al., 2003). Several of the above mentioned dimensions have also been cited as important by Betancourt (2003), a well-known scholar of cross cultural care in medicine. It utilizes a 5-point likert response set ranging from “strongly agree” to “strongly disagree”. Sample items for the original measure include: “I have a strong interest in patients as people, apart from their disease.” and, “Patients cannot get good care from a physician who does not entirely respect them.” Rather than modifying individual questions, instructions for the PCAM were modified to encourage participants to think about questions specifically in relation to patients for color. The instructions were as follow: “Thinking about the patients of color you have provided care to in the past or will provide care to in the future, please respond to the following questions. Please give your response by clicking on the response that best represents your point of view.” Although the goal of this study was not to validate the PCAM, it was correlated with the internal motivation to respond without prejudice scale, the scale of ethnocultural empathy, and aspects of color-blind racial attitudes. The reliability estimate for this sample was .59 suggesting an underestimated measurement of the patient centered construct. The developers of the PCAM found a reliability estimate of .73 for their

sample of 177 medical students. No validity evidence was reported in the original study citing the PCAM.

Skillfulness in Providing Cross Cultural Care. The Skillfulness subscale of the Cross Cultural Care scale is eight items in length and assesses several domains of self perceived skill in providing cross cultural care (Park, Betancourt, & Weissman, 2006; Park, Chun, Betancourt, Green, & Weissman, 2009; Weissman et al., 2005). It was originally developed for use with a national sample of residents. Items on the scale were drawn from focus group interviews with medical students. The goal of the developers was to fill the existing vacuum of validated measures of cross cultural competence in medicine. It was validated in relation to a measure of perceptions of preparedness to provide cross cultural care. The questions were also reviewed by experts in the field of cross cultural medical care. Sample items included: “Determining how a patient (or pediatric patient’s family) wants to be addressed,” and “Identifying whether a patient’s (or pediatric patient’s family) is mistrustful of the health care system or the physician.” In this study, the scale was found to be correlated with measures of internal motivation to respond without prejudice and ethnocultural empathy. Its reliability estimate was found to be .87 in the present study.

Procedures

Once Loyola University Chicago Institutional Review Board approval was obtained, participants were recruited through two university medical schools and through a professional organization for medical students. Approval was obtained from Deans of both medical schools and the board of the medical student association to recruit

participants. Both Deans agreed to send out a letter by email introducing students to the opportunity to participate in the study. A separate email was sent by this researcher to the student association's various list serves to recruit for the study.

The data were collected through the Opinio on-line survey program over several months. Participants were presented with a hyper text link in an email which took them to the survey's web-page. At the initial web-page, participants were presented with a more detailed introduction and informed consent for the study. As part of the informed consent, participants were informed that they would have the opportunity to win one of three \$50 prizes as part of a random raffle. Participants were required to respond to the informed consent document, all other questions were unlocked so that they could skip items if they chose to. After responses were entered and completed participants were directed to debriefing and thank you pages (see Appendix B) that allowed them to provide their email if they wanted to participate in the raffle offered in the introduction letter and informed consent document at the start of the survey. If participants chose not to participate in the study, they were directed to a thank you page.

Data Analysis Plan

Power analysis suggests that at .80 power with an alpha level of .05 and an expected medium effect size a minimum of 97 participants is recommended to conduct a multiple regression analysis (Cohen, 1992). This study consisted of 133 participants.

Beyond descriptive and frequency analysis, correlation analysis was conducted to examine the basic relationships between the variables. The presence of multicollinearity was also assessed. Demographic variables were also examined to determine if they had

any association with criterion variables. Multivariate multiple regression analysis and analysis of variance were used for continuous and non-continuous variables respectively.

Main analyses were conducted by way of multivariate multiple regression analysis for main and post-hoc analysis. Multivariate regression analysis is a function of SPSS General Linear Models whereby continuous predictor variables are entered into SPSS as a covariate; this indicates to SPSS that a regression is to be conducted. Overall, a multivariate regression analysis is a cross between a multiple regression and a multivariate analysis of variance; in essence, it provides information relevant to predication and main effect. The benefit of a multivariate multiple regression analysis is that it allows for the simultaneous analysis of multiple criterion variables. A further advantage of this procedure is that it accounts for intercorrelations between variables and protects against Type I and II error (Haase & Ellis, 1987). Furthermore it provides discriminant analysis to separate out the linear combination created by the SPSS (Lutz & Eckert, 1994). Multivariate multiple regression is also robust to data that is not normally distributed (SPSS, 2007). SPSS provides three pieces of analysis: a table of the overall multivariate statistics, a between subjects analysis of variance table that separately discriminates the relationships between independent and dependent variables, and a table of parameter estimates indicating the direction of the relationships between variables. Follow-up analysis can be conducted to determine the unique relationship between variables that are established as significant in the main analysis (Bray & Maxwell, 1982). Effect size is determined at each step of analysis by way of examining partial η^2 .

CHAPTER FOUR

RESULTS

Preliminary Analyses

Means, standard deviations, ranges, skewness, kurtosis, and reliability estimates were analyzed for the variables under study (see Table 1). Intercorrelations among the variables were also calculated (see Table 2). All data were examined to determine the normality of distribution. Scores for the Patient Centeredness Attitudes Measure (PCAM) were slightly abnormal with a kurtosis score of 2.58, suggesting the scores were mesokurtic. Kurtosis values of 2 or less are considered most appropriate (Heppner & Heppner, 2004). Due to the robustness of multivariate multiple regression analysis to deviations from normality, the scores for the PCAM were not transformed.

Table 1

Scale Summaries

| Variable | Reliability Estimate | n | M | SD | Observed Range | Potential Range |
|----------|----------------------|-----|--------|-------|----------------|-----------------|
| INTERMOT | .75 | 132 | 31.85 | 4.61 | 15-36 | 4-36 |
| SEETOT | .88 | 122 | 142.29 | 18.03 | 85-182 | 31-186 |
| GENERJWB | .86 | 130 | 18.84 | 5.53 | 6-32 | 6-36 |
| URP | .87 | 128 | 25.29 | 5.37 | 10-37 | 7-42 |
| UID | .78 | 133 | 23.03 | 5.21 | 12-38 | 7-42 |
| UBRI | .79 | 133 | 21.30 | 1.89 | 17-27 | 6-36 |
| PC | .59 | 129 | 37.15 | 3.77 | 21-44 | 9-45 |
| SPCCC | .90 | 130 | 33 | 6.98 | 15-49 | 10-50 |

| Variable | Potential Range | Skewness | Kurtosis |
|----------|-----------------|----------|----------|
| INTERMOT | 4-36 | -1.401 | 1.73 |
| SEETOT | 31-186 | -.459 | .037 |
| GENERJWB | 6-36 | -.021 | -.469 |
| URP | 7-42 | -.227 | .127 |
| UID | 7-42 | .289 | -.118 |
| UBRI | 6-36 | .012 | -.148 |
| PC | 9-45 | -1.14 | 2.58 |
| SPCCC | 10-50 | .021 | .111 |

Note: INTERMOT=Internal Motivation to Respond without Prejudice, SEETOT=Scale of Ethnocultural Empathy Total; GENERJWB=General Just World Beliefs; URP=Unawareness of Racial Privilege; UID=Unawareness of Institutional Discrimination; UBRI=Unawareness of Blatant Racial Issues; PC=Patient Centeredness; SPCC=Skillfulness in Providing Cross Cultural Care.

Correlations

Correlation analyses for the variables of interest are included in Table 2.

Table 2

Scale Intercorrelations

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|-------------|---------|---------|---------|---------|-------|--------|------|----|
| 1. INTERMOT | -- | | | | | | | |
| 2. SEETOT | .514** | -- | | | | | | |
| 3. GENERJWB | -.119 | -.317** | -- | | | | | |
| 4. URP | .183* | .423** | -.242** | -- | | | | |
| 5. UID | -.416** | -.475** | .299** | -.343** | -- | | | |
| 6. UBRI | -.059 | .106 | .151 | .004 | .169 | -- | | |
| 7. PC | .322** | .344** | .028 | .189* | -.105 | .224** | -- | |
| 8. SPCCC | .173* | .288** | .059 | .111 | -.084 | .110 | .165 | -- |

Note: INTERMOT=Internal Motivation to Respond without Prejudice, SEETOT=Scale of Ethnocultural Empathy Total; GENERJWB=General Just World Beliefs; URP=Unawareness of Racial Privilege; UID=Unawareness of Institutional Discrimination; UBRI=Unawareness of Blatant Racial Issues; PC=Patient Centeredness; SPCCC=Skillfulness in Providing Cross Cultural Care.

**p<.01 and *p<.05 two tailed

Research Questions

The results of the multivariate multiple regression analysis conducted are presented below. Main effects are presented first for the entire model; univariate effects and follow-up tests are presented afterward. Multivariate effects provide information about the significance of the overall model. Univariate effects provide information about individual relationships between independent and dependent variables. Parameter estimates provide information about the direction of significant relationships. Univariate effects tables and parameter estimate tables are presented in Appendix A.

Pillai's Trace will be the test statistic used for interpretation of the results for main and univariate effects. Partial eta squared (i.e., η^2) will be the measure of effect size used

to understand the results. Partial eta squared measures the degree to which the independent variable relates to the criterion variable; it specifically explains the variance accounted for by the dependent variable in relation to the independent variable (Weinfurt, 2000). Partial eta squared is similar to R^2 , though partial eta squared is not cumulative; partial eta squared is interpreted from small to large (Weinfurt, 1995). Thus, the larger the partial eta squared the more variance accounted for. In the field of social science a partial eta squared of .01 is considered a small effect, .09 is a medium effect and .25 is a large effect (Cohen, 1988, as cited in Tabachnick & Fidell, 2007).

Research Question 1

Research question one examines the relationship between global ethnocultural empathy, internal and external motivation to respond without prejudice, general just world beliefs, aspects of color-blind racial attitudes, and cross cultural competence (i.e., patient centeredness and skillfulness in providing cross cultural care) (see Figure 1). It was hypothesized that global ethnocultural empathy, internal and external motivation to respond without prejudice, general just world beliefs, and aspects of color-blind racial attitudes would have a significant association to patient centeredness and skillfulness in providing cross cultural care. External motivation to respond without prejudice was dropped from analysis as a result of non-significant correlations with the criterion variables.

Initial results of multivariate tests suggest significance (η^2_m represent main effects) for internal motivation to respond without prejudice, Pillai's Trace=.049,

$F(6, 132)=3.199, p<.05$, partial $\eta^2_m=.049$, and global ethnocultural empathy, Pillai's trace=.084, $F(6, 132)=5.767, p<.05$, partial $\eta^2_m=.084$, in relation to the linear combination of skillfulness in providing cross cultural care and patient centered attitudes. All other predictor variables were non-significant at this level of analysis. Thus, for the overall model, ethnocultural empathy and internal motivation to respond without prejudice were significant in relation to the linear combination of patient centeredness and skillfulness in providing cross cultural care. The following sections will present univariate effects highlighting the relationships between the separate constructs under study.

Table 3

Main Model - Multivariate Effects

| Effect | Value | F | Hypothesis df | Error df | Sig. | Partial Eta Squared |
|-------------|-------|-------|---------------|----------|------|---------------------|
| Intercept * | .044 | 2.848 | 2.000 | 125.000 | .062 | .044 |
| SEETOT * | .084 | 5.767 | 2.000 | 125.000 | .004 | .084 |
| INTERMOT * | .049 | 3.199 | 2.000 | 125.000 | .044 | .049 |
| GenerJWB * | .030 | 1.957 | 2.000 | 125.000 | .146 | .030 |
| URP * | .010 | .630 | 2.000 | 125.000 | .534 | .010 |
| UID * | .006 | .354 | 2.000 | 125.000 | .703 | .006 |
| UBRI * | .040 | 2.581 | 2.000 | 125.000 | .080 | .040 |

*Pillai's Trace

Research Question 2

Research question 2 examines the relationship between global ethnocultural empathy, patient centeredness and skillfulness in providing cross cultural care. It was hypothesized that ethnocultural empathy would have a significant association with patient centeredness and skillfulness in providing cross cultural care. Global ethnocultural empathy had a significant univariate association to patient centeredness, $F(1, 133)=4.324, p<.05, \eta^2=.033$, and skillfulness in providing cross cultural care, $F(1,133)=7.657,$

$p < .05$, $\eta^2 = .057$. This suggests that global ethnocultural empathy was independently associated with patient centeredness and skillfulness in providing cross cultural care.

Research Question 3

Research question 3 examines the relationship between internal motivation to respond without prejudice, patient centeredness, and skillfulness in providing cross cultural care. It was hypothesized that internal motivation to respond without prejudice would have a significant association with patient centeredness and skillfulness in providing cross cultural care. Hypothesis three was partially supported; internal motivation to respond without prejudice had a significant association with patient centeredness, $F(1,133) = 6.337$, $p < .05$, $\eta^2 = .048$. This suggests internal motivation to respond without prejudice was specifically associated with patient centeredness and had no significant association to skillfulness in providing cross cultural care.

Research Question 4

Research question 4 examines the relationship between general just world beliefs, patient centeredness, and skillfulness in providing cross cultural care. It was hypothesized that general just world beliefs would have a significant association with patient centeredness and skillfulness in providing cross cultural care. General just world beliefs did not have a significant association to patient centeredness or skillfulness in providing cross cultural care.

Research Question 5

Research question 5 examines the relationship between aspects of color-blind racial attitudes, patient centeredness and skillfulness in providing cross cultural care. It

was hypothesized that color-blind racial attitudes would have a significant association with patient centeredness and skillfulness in providing cross cultural care. It should be noted that although unawareness of blatant racial issues was not significant at the multivariate level of analysis, it was significant at the univariate level of analysis.

Unawareness of blatant racial issues, $F(1, 133)=4.971, p<.05, \eta^2=.038$, had a significant univariate association to patient centeredness. Unawareness of racial privilege and unawareness of institutional discrimination were not significant.

Protected F Test

As noted in the data analysis plan section of Chapter Three (see page 42) it is customary to conduct follow-up tests (i.e., Protected F) of significant independent variables when using multivariate analysis of variance related statistical procedures (Bray & Maxwell, 1982). This additional step helps to provide further understanding of the unique individual relationships between the significant predictor and criterion variables. This statistic represents the final and perhaps most meaningful effect size. The results of the follow-up tests indicated higher endorsement of internal motivation to respond without prejudice significantly predicted increased patient centeredness, $F(1,132)=15.1, p<.01, \text{partial } \eta^2=.104$. Higher endorsement of global ethnocultural empathy, $F(1,132)=17.63, p<.01, \eta^2= .119$, significantly predicted higher endorsement of patient centeredness. Greater endorsement of global ethnocultural empathy, $F(1,132)=11.838, p<.01, \text{partial } \eta^2=.083$, was significantly predictive of higher levels of skillfulness in providing cross cultural care.

Summary

Correlations were examined for all predictor and criterion variables; in some cases the directions of the relationships were unexpected. For instance, unawareness of racial privilege had a positive relationship with internal motivation to respond without prejudice, ethnocultural empathy, and patient centeredness.

Multivariate multiple regression analyses indicated that internal motivation to respond without prejudice significantly accounted for the variance in patient centeredness. Similarly, global ethnocultural empathy significantly accounted for the variance in patient centeredness and skillfulness in providing cross cultural care. The relationships of the above mentioned variables remained significant after follow-up tests were conducted. The unique variance accounted for resulted in small to medium effect sizes.

CHAPTER FIVE

DISCUSSION

The purpose of this dissertation was to determine if any statistical relationships existed between White physicians-in-training self-reported racial and social attitudes and two measures of cross cultural competence. In general, it was presumed that the psychology of White physicians-in-training were important for feeling competent when working with patients of color. The independent variables under study included: ethnocultural empathy, internal motivation to respond without prejudice, general just world beliefs, and color-blind racial attitudes. The criterion variables included: patient centeredness and skillfulness in providing cross cultural care. It was hypothesized that ethnocultural empathy, internal motivation to respond without prejudice, general just world beliefs, and color-blind racial attitudes would significantly contribute to the variance in patient centeredness and skillfulness in providing cross cultural care.

The following main research questions were analyzed by way of quantitative data analysis:

- ◆ Will positive (i.e., internal motivation to respond without prejudice and ethnocultural empathy) and negative (i.e., general just world beliefs and color blind racial attitudes) racial and social attitudes have a significant association to patient centeredness and skillfulness in providing cross cultural care?

- ◆ Will ethnocultural empathy have an association with patient centeredness and skillfulness in providing cross cultural care?
- ◆ Will internal motivation to respond without prejudice have an association with patient centeredness and skillfulness in providing cross cultural care?
- ◆ Will general just world beliefs have an association with patient centeredness and skillfulness in providing cross cultural care?
- ◆ Will color-blind racial attitudes have a significant association with patient centeredness and skillfulness in providing cross cultural care?

This chapter will focus on elucidating the statistical results outlined in Chapter Four. The discussion will begin by addressing preliminary analyses followed by main analyses. The chapter will close with a discussion of future directions, implications, limitations, and a brief summary.

Main Analyses

Ethnocultural Empathy

Ethnocultural empathy was found to have a significant association with patient centeredness and skillfulness in providing cross cultural care. Ethnocultural empathy accounted for an 11% unique contribution to patient centeredness and an 8% unique contribution to skillfulness in providing cross cultural care, suggesting a medium and small effect, respectively. The findings infer ethnocultural empathy is a meaningful part of developing cross cultural competence among White physicians-in-training. It stands to reason that a White physician-in-training who enters into interracial clinical encounters with ethnoculturally empathic attitudes may have a greater ability to communicate such

attitudes to patients. Research suggests attitudes in part predict intentions and intentions predict behaviors (Ajzen, Czasch, & Flood, 2009). As a result, training physicians' attitudes are likely to have some association to intentions and actual behaviors when interacting with patients of color. Consequently, it is plausible that White physicians-in-training may have a greater chance of engaging patients in ways that decrease negative interpersonal interactions because they are more self-aware and more empathic than their peers who do not highly endorse such attitudes.

That ethnocultural empathy is positively associated with patient centeredness and skillfulness in providing cross cultural care is quite a meaningful and unique finding. To date no other study has examined these variables collectively. However, parallel research suggests ethnocultural empathy has been associated with the multicultural counseling competence (Karuppaswamy, 2006) and therapeutic engagement with clients of color (Garran, 2008).

Ethnocultural empathy is additionally important because of its cognitive and affective components. Thus, thinking and feeling in a culturally accepting and empathic manner is important for working with diverse patients. Accordingly, it may be important to develop interventions for training physicians that are both cognitively and emotionally oriented. For instance, taking the perspective of a minority group member is associated with arousal of empathy, better situational attributions, and intergroup attitudes (Vescio, Sechrist, & Paloucci, 2003). Having White physicians-in-training engage in case-based discussions (Green, Betancourt, Greer, Donahue, & Weissman, 2008) from a perspective

taking viewpoint may contribute to improving patient centeredness and skillfulness in providing cross cultural care.

Although the current findings on ethnocultural empathy are valuable researchers have documented a problem with empathy among training physicians (Hojat et al., 2009). Research suggests that training physicians maintain reasonable levels of medical empathy in their first and second years of medical school. In their third and fourth years as they have more contact with patients average empathy scores tend to drop off sharply. This is likely due to the increased pressure to provide services in a fast paced environment. If one considers that ethnocultural empathy is at least theoretically related to medical empathy the ability of the average training physician to maintain both kinds empathy may be compromised. It has been suggested that interventions regarding empathy be repeated over time along with guided imagery and behavioral rehearsal (Burgess et al., 2007).

Though ethnocultural empathy was shown to have an association with skillfulness in providing cross cultural care and patient centeredness, it may also be that the improvement of skillfulness and patient centeredness could be associated with greater ethnocultural empathy. That is, the bidirectional nature of the analyses used for this study indicates that positive attitudes may be encouraged in either direction. This is important given that training physicians may be at different places in regard to cross cultural competence when they enter medical school. Considering this, different interventions may be appropriate for different levels of cross cultural competence upon entering medical training programs. Assessment of cross cultural competence at various

points in the training process may be further useful in developing interventions for physicians in training.

Internal Motivation to Respond Without Prejudice

Will internal motivation to respond without prejudice have an association with patient centeredness and skillfulness in providing cross cultural care?

Although internal motivation to respond without prejudice was not associated with skillfulness in providing cross cultural care, it was associated with patient centeredness. In the context of the omnibus model, internal motivation to respond without prejudice accounted for 4% of the variance in the combined dependent variables. At the univariate level of analysis, internal motivation to respond without prejudice uniquely accounted for 10% of the variance in patient centeredness. This represents a medium effect size based on Cohen's (1988) suggestions for effect sizes in the social sciences.

Overall, this finding suggests internal motivation to respond without prejudice is associated with patient centeredness, a world view salient for working with diverse patients. This finding is meaningful given that it is the first study to empirically associate internal motivation to respond without prejudice with patient centeredness. Internal motivation to respond without prejudice is important because internally motivated individuals are more likely to critically think about their behavior when interacting with patients of color (Fehr & Sassenberg, 2009). Consequently, internal motivation might also be a catalyst for engaging in cross culturally competent behavior when interacting with diverse patients. Accordingly, the development of internal motivation to respond

without prejudice is consistent with the Association of American Medical Colleges' (2009) report that suggests physicians' cross cultural competency is consequential to reducing health care disparities, increasing patient trust and communication, reducing treatment bias, and better addressing disease management.

Interventions that address building awareness of unconscious bias for training physicians during pre-medical, medical school, and residency training may be highly useful (Burgess et al., 2007). In particular, courses which are the medical equivalent to "multicultural counseling" style courses may be most useful. Such courses focus on knowledge, awareness, and exploration of one's own identity, promoting conscious awareness of how one might interact with individuals different from themselves (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006). Beyond coursework students would be greatly aided by having trainers who could help physicians-in-training reinforce what they learn when working with actual patients.

Scholars have suggested that patient centeredness and cross cultural competence have a theoretically mutual relationship (Beach, Saha, & Cooper, 2006). One way of approaching such a course might be by way of using patient centeredness as a vehicle for encouraging internal motivation to respond without prejudice. Patient centeredness may be a means for helping White physicians-in-training understand that diverse patients may require differing approaches. Patient centeredness should be presented as an important part of ethics and the Hippocratic Oath; internal motivation to respond without prejudice could be presented as an extension of patient centeredness. Helping students understand the pros and cons of the medical model (i.e., a doctor centered world view) in comparison

to a more patient centered model (i.e., taking the perspective of the patient into consideration) might also be useful. Understanding and critiquing both models in the context of health care disparities may be important for helping students to become internally motivated to respond without prejudice. The overall goal of such a curriculum would be to promote critical thinking about how one's world view is important for working with diverse patients.

General Just World Beliefs

General just world beliefs were not associated with either criterion variable for this particular portion of the sample. It may be that general just world beliefs may be too distal a variable to significantly contribute to the variance in the criterion variables. Thus, the scale may have not been specific enough to obtain significant findings. Null findings may also be an artifact of the sample being predominantly White and female. Past research has found that different racial groups have differing levels of just world beliefs (Calhoun & Cann, 2001; Hunt, 2000). Differing levels of just world beliefs are likely associated with differing experiences in social status, possibly contributing to a non-significant result for this sample.

It may be that White physicians-in-training's general just world beliefs attitudes are in some way separate from cross cultural competence, in part because White physicians-in-training may not view their just world beliefs attitudes as problematic. As a result, general just world beliefs may not be related to either criterion variable because of a lack of awareness regarding just world beliefs and the role they may play in providing care to diverse patients. If one considers that awareness is crucial factor in

being cross culturally competent then it is possible that being unaware could result in non-significant findings.

Finally, social desirability may have been a factor in the non-significant findings for the general just world beliefs variable. Participants being presented with a survey about racial issues may have brought up uncomfortable feelings. Participants may have responded in a socially desirable manner rather than responding in a forthright manner that truly reflects their attitudes.

Color-Blind Racial Attitudes

The three types of color-blind racial attitudes had non-significant relationships with patient centeredness or skillfulness in providing cross cultural care at the multivariate level of analysis. At the univariate level of analysis there was a positive relationship between unawareness of blatant racial issues and patient centeredness. This finding is consistent with bivariate correlations that found unexpected positive relationships between the subscales of the Color-Blind Racial Attitudes Scale and the criterion variables. This finding may be reflective of social desirability and a suppression effect, which cannot be fully understood using a paper and pencil measure of racial color-blindness. Participants may have wanted to present themselves in a favorable manner relevant to being cross culturally competent, thus effecting the association between variables. Additionally similar to Correl, Park, and Smith's (2008) findings participants attitudes in relation to unawareness of blatant racial issues may have shown a positive association because color blind racial attitudes can initially look like positive racial attitudes but over the long-term contribute to more prejudiced attitudes.

Similar to general just world beliefs, unawareness of racial privilege and unawareness of institutional discrimination were not related to patient centeredness and skillfulness in providing cross cultural care in contrast to the original hypothesis. Due to the nature of medical work a physician could believe she is skillful in spite of endorsed social attitudes compartmentalizing one's social attitudes from professional attitudes. Considering medicine is focused on technical skills and not social attitudes, it is conceivable that unawareness of racial privilege and unawareness of institutional discrimination may not have relationships to the criterion variables in this study. Previous research suggests that counselors' color-blind racial attitudes were negatively predictive of self-reported multicultural competence (Chao, 2006; Neville, Spanierman, & Doan, 2006). This difference in findings among physicians-in-training in comparison to counselors highlights differences in professional activities as well as possible differences in professional socialization. That is, doctors are expected to use their technical skills to treat patients whereas counselors use self-awareness and emotional intelligence to treat clients. In particular, counselors are expected to pay attention to how their personal feelings and reactions influence the counseling relationship. Physicians are not expected to account for their personal feelings; they are expected to divorce their personal feelings from their work with patients.

Self Efficacy Theory and Cross Cultural Competence

One means of understanding the findings for this study may be to conceptualize skillfulness in providing cross cultural care and patient centeredness as forms of cultural competence that reflect efficacy expectations for working with diverse patients. In the

context of medicine, efficacy expectations contribute to whether a physician believes she can engage in cross culturally competent behavior (see Bandura, 1977). Efficacy expectations contribute to self efficacy; self efficacy in the context of physician cross cultural competence, is the degree to which a physician believes engaging in cross culturally competent behavior will result in better health care outcomes (see Bandura, 1977). Efficacy expectations for cross cultural competence is further important for encouraging positive outcome expectations when actually providing services to diverse patients. Outcome expectations are the extent to which a physician believes engaging in cross culturally competent behaviors will result in a better medical encounter (i.e., better physician-patient communication, cross cultural understanding, and possibly the reduction of health care disparities).

Taken together, the psychological attitudes of White physicians-in-training, matter for feeling efficacious when providing services to diverse patients. Specific to this study, cross cultural competence (i.e., efficacy expectations) can in part be encouraged through the development of internal motivation to respond without prejudice and ethnocultural empathy.

Limitations

Threats to Statistical Conclusion Validity

In this study there are several possible threats to statistical conclusion validity. Statistical conclusion validity is defined as the extent to which a researcher makes a correct conclusion about the relationship between variables (Heppner, Wampold, & Kivlighan, 2008). One threat to statistical conclusion validity may be due to the reduced

reliability of the Patient Centeredness Attitudes Measure (PCAM). The PCAM had only a .59 reliability estimate, suggesting 41% error. Thus the PCAM was likely an underestimate of the construct of patient centeredness. It is possible that the reliability of the measure was affected by the altering of the instructions to ask specifically about patients of color. In addition, restriction of range of the PCAM scores is a factor to be considered. Many of the participants endorsed higher scores on this scale. This likely occurred because most of the participants in the sample were female. Restriction of range not only affects the correlations between each of the variables but also reliability estimates. Restriction of range may result in more attenuated relationships than might actually occur if range restriction were not present.

An additional threat to statistical conclusion validity may have been the use of the internet as a survey tool. Although convenient, the use of the internet may have introduced extraneous variance due to distractions in the environment in which participants responded. Participants had the option of saving and pausing the survey returning to the survey later. Participants could have provided responses when they were in different frames of mind.

Threats to Internal Validity

The concern of having confidence about the relationships between the variables under study refers to internal validity (Heppner et al., 2008). History is considered an important factor in any research investigation. This study was conducted over the course of nine months; it is possible that participants were sensitive to any variety of historical events relevant to this research project. For instance, the election of the first African

American president of the U.S. was in its final stages during the data collection process for this study. Much of the data was collected in the months before November 2008. It is possible that participants may have been more or less willing to participate in the study as a function of the racial climate present at the time.

Obviously individuals willing to participate in a web-based survey are a self-selected group of volunteers. It is possible that interest in multicultural research or activities played a role in participants electing to participate. Considering that 87% of participants reported having a significant interest in working with diverse patients it is likely that those who had less of an interest in diversity issues were less likely to respond. A total of 352 individuals reviewed the initial web page but only 203 actually completed the survey.

Threats to Construct Validity

Given the taboo nature of multicultural research (Sadowski, Kuo-Jackson, Richardson, & Corey, 1998) participants may have responded in a socially desirable manner because the study asked about race and their professional attitudes. It is possible some participants responded in a favorable manner in an effort to seem more cross culturally competent. The topic of race for some can be anxiety provoking.

A challenge in the development of this study was the lack of availability of well validated measures of cultural competence for physicians. For instance, while the PCAM (Beach et al., 2007) was face valid and was developed based on literature, it did not go through a thorough validation process. The instrument had only been used once prior to its use in this study. The construct of patient centeredness may have been “inadequately

explicated” (Heppner et al., 2008) to be fully confident of the findings. The reliability estimate for the PCAM was moderate (i.e., .59) for this study whereas the reliability estimate for the original study was .73.

An additional threat to construct validity may have been mono method bias. Mono method bias refers to using one measure to assess a construct (Heppner et al., 2008). Using only self-report may have introduced bias into this study. Not all White physicians-in-training may be able to accurately assess their cross cultural competence due to varying levels of self-awareness.

Threats to External Validity

External validity refers to research findings being generalizable to groups beyond the current sample under study (Heppner et al., 2008). The generalizability and the portability of the findings beyond this sample should be done with caution. This is particularly important given that this sample is not representative of most medical students. This particular sample consisted of mostly White female participants.

Implications

The findings of this study highlight the applicability of multicultural counseling competence research in the field of medicine. Numerous studies in the field of counseling psychology have focused on how the personal characteristics and attitudes of counselors are related to self-reported multicultural competence. The grafting of this paradigm into a medical context may be helpful in more clearly understanding physicians’ attitudes and their potential association to the perpetuation or reduction of health care disparities.

This study is significant in that it is consistent with recommendations of major policy reports by the Institute of Medicine (2003) and the American Association of Medical Colleges (2005), that recommend increased awareness of health disparities among providers, conducting research relevant to the topic, improving the condition of the clinical encounter, and exploring biases that exist among health care providers. A notable step beyond previous recommendations and current literature is the inclusion of positive and negative racial attitudes in the current investigation. Including both positive and negative racial and social attitudes allows for a more complex understanding of physicians as social and racial beings with a variety of different kinds of attitudes. Consequently, the findings of this study and other future similar studies may contribute to research-based practice within medical education as was suggested by the report *Unequal Treatment* (Smedley et al., 2003).

This study further supports the notion that moving beyond the study of race as a demographic variable is important for obtaining a deeper understanding of physicians as social beings. It moves beyond the work of van Ryn and Burke's (2000) landmark study on physician's perceptions of patients and their perceptions of patients by addressing deeper relevant social attitudes. Cokely and Awad (2008) stated it best, "As ethnic minority research starts to mature, it begins to move away from ... reliance on distal explanations to more theoretically driven research with proximal explanations" (p. 373). To better understand provider-level phenomenon, it is key to continue to investigate attitudes of training physicians that reflect the deeper social attitudes they endorse.

The findings of this study are significant in that they build on prior research and theory, that suggests that internal motivation to respond without prejudice and empathy are salient factors in reducing bias among health care providers (Burgess et al., 2007). Recent empirical research also indicates that multicultural competence on the part of doctors is important to patients. That is, physician multicultural competence as reported by patients predicts patient satisfaction, patient physician working alliance, and adherence to treatment (Fuertes, Boylan, & Fontanella, 2009). These parallel findings support the importance of continued study of physicians' attitudes.

The findings of this study have crucial implications for medical education, highlighting the significance of addressing internalized social attitudes. Internalized attitudes may be just as important as the practical medical skills physicians-in-training learn during their educational experiences. Internalized racial and social attitudes are important because cross-cultural skills are unlikely to be effective if they are not being driven by genuinely positive cross cultural attitudes such as a healthy motivation to respond without prejudice and ethnocultural empathy. Perhaps a requirement for being a culturally competent physician in the 21st century is based on a combination of positive racial and social attitudes. Counseling psychologists can play a key role in designing courses relevant to improving the cross cultural attitudes and skills of physicians-in-training because of the field's commitment to diversity and social justice (Tucker et al., 2007). A key feature of addressing training physicians' cross cultural competency educational needs may be to require self-reflective style cross cultural education as an adjunct to already existing cross cultural communication and technical medical courses.

Given that ethnocultural empathy was found to be a significant factor in cross cultural competence, policies should be put in place to address the trend of declining empathy that has been documented to occur among medical students (e.g., Hojat et al., 2009). If a decline occurs in relation to medical empathy it also likely that ethnocultural empathy may suffer as well. Special attention should be given to third year medical students, in relation to, the maintenance of empathy.

Future Directions

This is possibly the first study to examine training physicians' internalized racial and social attitudes using constructs from multiple disciplines. There are many possible future directions. First and foremost, this study should be replicated and extended. Cooper, Beach, Johnson, and Inui (2006) propose that it is important to look under the "social iceberg" and examine the clinician-self relationship (i.e., the extent to which healthcare providers understand that their attitudes and other background factors affect the healthcare process when working with patients.

Empathy, in particular, should also be explored more deeply. Empathy is an important variable to be considered because of the potential positive interpersonal experience it can create for patients. A positive interpersonal experience may be a gateway whereby both patients and physicians feel positively engaged in the health care process. Empathy and engagement may set the tone for how treatment will be experienced and accepted by patients. Empathy may have a tripartite role in the development of physicians-in-training. Specifically, general empathy, medical empathy,

and ethnocultural empathy should be examined as predictors to better understand their individual and combined relationship to cross cultural competence.

Mixed methodology, using a combination of paper and pencil as well as experimental research methods, may be useful in better understanding these relationships. Research should also continue to examine the relationship between color-blind racial attitudes and other relevant criterion variables. In vivo research methods with standardized patients and physicians-in-training are necessary to move beyond the limitations of paper and pencil research methods. Such research could allow for observations of real time interactions rather than simply depending on self-report.

Though internal motivation as a predictor seems to play an important role in relation to a variety of criterion variables, it may also be useful to determine what the antecedents are to internal motivation to respond without prejudice. Knowing this can be informative for future interventions. It may be that the large number of females in the sample may play a role in this sample's significant internal motivation. Women, a minority group unto themselves are likely to have their own experiences of oppression and discrimination, thus making them more likely to be internally motivated. Thus, experiences of sexism may have sensitized them to be more internally motivated. Moreover, racial identity constructs (Helms, 1990), universal-diverse orientation (Miville et al., 1999), and the theory of planned behavior (Ajzen, Czasch, & Flood, 2009) may all be important to understanding the antecedents to internal motivation to respond without prejudice.

Finally, it will also be important to explore the climate and multicultural curriculum in various medical training programs. The institutional curriculum represents “those dimensions.....that may enhance or obstruct trainees’ optimal learning and behavior change regarding issues of multiculturalism in medicine” (Murray-Garcia & Garcia, 2008, p. 651). The institutional curriculum likely represents the conscious and unconscious individual and organizational maintenance of the status quo relevant to diversity issues in medicine (Murray-Garcia & Garcia, 2008). Knowing the institutional curriculum present in medical schools may aid administrators in making changes that may result in more cross culturally competent physicians. Students suggest that cross cultural care is not supported as a function of daily and institutional processes (Park et al., 2005). When physicians-in-training try to engage in cross cultural care activities they report being discouraged to do so. Qualitative or mixed methods research designs could be very informative in determining the relationship of educational experiences to endorsed attitudes.

Conclusion

In general, this study represents an important preliminary step in the medical education, health care disparities, and cross cultural competence literature. The goal of this study was to conduct an exploratory investigation of the self-reported racial and social attitudes of White physicians-in-training, and to determine their relationship to self perceived cross cultural competence.

There were several expected correlational findings with regard to positive social attitudes. Internal motivation to respond without prejudice, ethnocultural empathy,

patient centeredness, and skillfulness in providing cross cultural care reflected positive correlations with each of the criterion variables. Surprisingly unawareness of blatant racial issues and unawareness of racial privilege were positively correlated with patient centeredness, likely suggesting an effect of social desirability.

The main findings of this study suggest that internal motivation to respond without prejudice significantly contributed to the variance in patient centeredness. Ethnocultural empathy also significantly contributed to the variance in patient centeredness and skillfulness in providing cross cultural care.

In closing, “Digging below the Demographic Level” is an important next step in advancing the medical education, cross cultural competence, and health care disparities literature. Racial and social attitudes are highly meaningful for addressing health care disparities that may potentially occur at the provider level. Understanding such factors may help to address the educational needs of future physicians-in-training. Addressing such attitudes is important for the practice of medicine and the development of interpersonal rapport with diverse patients. Though the findings of this study are potentially promising, the findings should be interpreted with caution making no assumption of generalizability beyond this particular sample. In the future it will be important to conduct replication and follow-up studies.

APPENDIX A
STATISTICAL TABLES

Univariate Statistic

| Source | Dependent Variable | Type III Sum of Squares | df | Mean Square | F | Sig. | Partial Eta Squared |
|-----------------|--------------------|-------------------------|-----|-------------|-------|------|---------------------|
| Corrected Model | PC | 396.629 ^a | 6 | 66.105 | 5.626 | .000 | .211 |
| | SPCCC | 722.242 ^b | 6 | 120.374 | 2.656 | .018 | .112 |
| Intercept | PC | 66.046 | 1 | 66.046 | 5.621 | .019 | .043 |
| | SPCCC | 8.120 | 1 | 8.120 | .179 | .673 | .001 |
| SEETOT | PC | 50.808 | 1 | 50.808 | 4.324 | .040 | .033 |
| | SPCCC | 346.992 | 1 | 346.992 | 7.657 | .007 | .057 |
| INTERMOT | PC | 74.449 | 1 | 74.449 | 6.337 | .013 | .048 |
| | SPCCC | 7.805 | 1 | 7.805 | .172 | .679 | .001 |
| GenerJWB | PC | 16.292 | 1 | 16.292 | 1.387 | .241 | .011 |
| | SPCCC | 121.337 | 1 | 121.337 | 2.678 | .104 | .021 |
| URP | PC | 14.665 | 1 | 14.665 | 1.248 | .266 | .010 |
| | SPCCC | 1.547 | 1 | 1.547 | .034 | .854 | .000 |
| UID | PC | 6.962 | 1 | 6.962 | .593 | .443 | .005 |
| | SPCCC | 6.246 | 1 | 6.246 | .138 | .711 | .001 |
| UBRI | PC | 58.403 | 1 | 58.403 | 4.971 | .028 | .038 |
| | SPCC | 13.896 | 1 | 13.896 | .307 | .581 | .002 |
| Error | PC | 1480.363 | 126 | 11.749 | | | |
| | SPCCC | 5709.758 | 126 | 45.316 | | | |
| Total | PC | 185437.000 | 133 | | | | |
| | SPCCC | 151269.000 | 133 | | | | |
| Corrected Total | PC | 1876.992 | 132 | | | | |
| | SPCCC | 6432.000 | 132 | | | | |

a. R Squared = .211 (Adjusted R Squared = .174)

b. R Squared = .112 (Adjusted R Squared = .070)

Main Analysis Parameter Estimates

Parameter Estimates

| Dependent Variable Parameter | | B | Std. Error | t | Sig. | 95% Confidence Interval | | Partial Eta Squared |
|------------------------------|-----------|--------|------------|-------|------|-------------------------|-------------|---------------------|
| | | | | | | Lower Bound | Upper Bound | |
| PC | Intercept | 11.902 | 5.020 | 2.371 | .019 | 1.968 | 21.836 | .043 |
| | SEETOT | .047 | .023 | 2.080 | .040 | .002 | .092 | .033 |
| | INTERMOT | .197 | .078 | 2.517 | .013 | .042 | .353 | .048 |
| | GenerJWB | .070 | .059 | 1.178 | .241 | -.047 | .187 | .011 |
| | URP | .070 | .063 | 1.117 | .266 | -.054 | .194 | .010 |
| | UID | .054 | .071 | .770 | .443 | -.085 | .194 | .005 |
| | UBRI | .370 | .166 | 2.230 | .028 | .042 | .699 | .038 |
| SPCC | Intercept | 4.173 | 9.859 | .423 | .673 | -15.337 | 23.683 | .001 |
| | SEETOT | .124 | .045 | 2.767 | .007 | .035 | .212 | .057 |
| | INTERMOT | .064 | .154 | .415 | .679 | -.241 | .369 | .001 |
| | GenerJWB | .190 | .116 | 1.636 | .104 | -.040 | .420 | .021 |
| | URP | .023 | .123 | .185 | .854 | -.221 | .266 | .000 |
| | UID | .051 | .138 | .371 | .711 | -.223 | .325 | .001 |
| | UBRI | .181 | .326 | .554 | .581 | -.465 | .826 | .002 |

APPENDIX B
ON LINE SURVEY

Social Attitudes Survey

Informed Consent

1. Dear Participant,

My name is Sha'kema Blackmon. I am a doctoral student at Loyola University Chicago.

You are being asked to participate in a research study on the social attitudes of physicians in training; this study is being conducted for the purpose of obtaining data for my dissertation.

If you choose to participate in this study you will be asked to complete a survey and demographic questionnaire. The survey should take 30 minutes or less to complete.

Before participating in this study it is essential that you read and understand the following statements:

Your participation in this research study is Completely Voluntary; you may refuse to participate in any part of this study without penalty or loss of privilege except for the benefits related to taking part in this study.

Your participation in the study is also Confidential and Anonymous. Confidentiality will be maintained to the degree permitted by the technology used. No absolute guarantees can be made regarding the confidentiality of electronic data. To ensure anonymity please do not put your name on any part of the survey.

Please be advised that your information may be viewed by others if you fail to close your internet browser as soon as you complete the survey. Taking this step will ensure that your information is kept as confidential and anonymous as possible.

To further ensure confidentiality all responses from participants will be presented in an aggregated form; no identifying information will be used in the presentation of the data obtained for this study. All information which you provide will be kept on the Loyola University Chicago web server which has a secured firewall.

There are no immediate risks associated with this study other than would be expected when engaging in any normal daily activities. The benefit of participating in this study is that you may develop an increased interest in exploring social issues as they relate to the practice of medicine. I hope that the knowledge gained from the aggregated (i.e. grouped) responses will contribute to future curriculum improvements within medical schools.

If you choose to participate in this survey I ask that you participate in the survey one

time only. To ensure that duplicate submissions are not given from the same participant I will record and later retrieve the IP addresses from each computer used to participate in this study. The IP address with a time and date stamp will serve the purpose of identifying multiple submissions. This will be done only for the purpose of preventing multiple submissions and ensuring the quality of the data set.

If you should participate in this study you will be eligible to participate in a random raffle. You will have the opportunity to win one of three \$50 prizes. You will be asked to provide your email which will be separately stored from your individual response to ensure confidentiality. I am the only person that will have access to this data.

If you should have any concerns or questions I can be reached at 973-652-6791 or sblackm@luc.edu. Please feel free to contact me any time before or after completing the survey with any questions or concerns you may have. My dissertation supervisor, Suzette Speight can be reached at 330- 972-7956. You can also contact the Loyola University Compliance Manager at 773-508-2689 if you should have questions about your rights as a research participant.

By completing the survey you are agreeing to participate in the research.

Please click the button below to indicate that you have read and understood the purpose of this study and the activities associated with it.

I agree to participate in this survey.



I do not agree to participate in this survey.



Demographic Questionnaire

Please respond to all the following demographic questions. Answering all or as many of the questions as possible will help me to have a better understanding of the characteristics of the respondents of this survey.

2. **What is your gender?**
- Female
- Male

3. **What is your sexual orientation?**

4. **What is your age?**

List age here

5. **What is your race/ethnicity?**

6. **If your race or ethnicity was not listed above please specify in the blank space provided**

7. **Are you an international student?**
- Yes
- No

8. **What is your primary spoken language?**

9. Do you speak a second language? Yes
No

10. How many years have you lived in the United States?

11. Do you have disability? Yes
 No

12. What is your religion?

13. What is your current income?

14. What year are you in medical school?

1st year medical student

2nd year medical student

3rd year medical student

4th year medical student

Other

15. **What year are you in your residency program?**

- 1st year resident
- 2nd year resident
- 3rd year resident
- 4th year resident
- Other

16. **What is your area of focus in medical school? (Please specify)**

17. **What is your area of focus in your residency program?**

18. **If you are still in medical school what degree are you seeking?**



19. **If your degree is not listed above please specify below.**

20. If you have already completed your degree please indicate below

21. If your degree is not listed please specify below

22. Does your medical school have a course(s) which address diversity issues in medicine? Yes No

23. Is this course(s) a requirement or elective? Requirement Elective

24. To date how many courses have you taken which specifically address working with diverse patients while in medical school?

Indicate number of courses here

25. I feel that my medical school has done a good job of integrating diversity issues into the classes I have taken so far. Yes No Neither agree nor disagree

26. I feel that my experiences outside medical school have best prepared me to work with people who are different from me or who are members of racial/ethnic groups. Disagree Strongly Disagree Neither Agree or Disagree Agree

Strongly Agree

27. I am interested in working with diverse (i.e. a variety of racial ethnic as well as other underrepresented groups) patients in the future? Yes
 No
 Not sure

28. I would say that the faculty at my medical school are diverse (i.e. mix of women, ethnic minorities and members of other minority groups)? Yes
 No
 Not sure

29. I have have completed ___#___ clinical rotations to date.
 Enter number of rotations here

30. I have seen _____ ethnic-minority patients to date.

- None
- Only a few
- Some
- Alot

31. How did you hear about this survey?

- School/Program List Serve
- Student Association
- Other

Instructions: Thinking about the patients of color you have provided care to in the past or will provide care to in the future please respond to the following questions. Please give your response by clicking on the response that best represents your point of view.

32. Physicians need to “know where their patients are coming from” in order to treat their medical problems.

3=Neither Agree Nor Disagree

1 2 3 4 5

Strongly Disagree Strongly Agree

33. A patients background and culture, while worth noting, are not critical issues to explore in treating illness.

3=Neither Agree Nor Disagree

1 2 3 4 5

Strongly Disagree Strongly Agree

34. I have genuine interest in patients as people, apart from their disease.

3=Neither Agree Nor Disagree

1 2 3 4 5

Strongly Disagree Strongly Agree

35. Patients usually know what is wrong with them.

3=Neither Agree Nor Disagree

1 2 3 4 5
 Strongly Disagree Strongly Agree

36. Patients should always be given a choice between medical treatments.

3=Neither Agree Nor Disagree

1 2 3 4 5
 Strongly Disagree Strongly Agree

37. Patients should always be given information about their medical conditions.

3=Neither Agree Nor Disagree

1 2 3 4 5
 Strongly Disagree Strongly Agree

38. Patients cannot get good care from a physician who does not entirely respect them.

3=Neither Agree Nor Disagree

1 2 3 4 5
 Strongly Disagree Strongly Agree

39. An important part of my role as a future physician is to provide emotional acceptance and empathy to patients.

3=Neither Agree Nor Disagree

1 2 3 4 5
 Strongly Disagree Strongly Agree

40. Physicians should not allow patients to see their emotions.

3=Neither Agree Nor Disagree

1 2 3 4 5
 Strongly Disagree Strongly Agree

Social
Attitudes
Survey

Please rate how skillful you are at each of the following with regard to delivering cross cultural care to ethnic minority patients. Please give your response by clicking on the response that best represents your point of view

41. Determining how a patient (or pediatric patient's family) wants to be addressed.

1 2 3 4 5

Not at all Skillful Very Skillful

42. Taking a social history.

1 2 3 4 5

Not at all skillful Very Skillful

43. Assessing the patient's (or pediatric patient's family's) understanding of the cause of his or her illness.

1 2 3 4 5

Not at all skillful Very Skillful

44. Identifying whether a patient's (or pediatric patient's family) is mistrustful of the health care system or the physician.

1 2 3 4 5

Not at all Skillful Very Skillful

45. Negotiating with the patient (or pediatric patient's family) about key

aspects of the treatment plan.

1 2 3 4 5

Not at all Skillful Very Skillful

46. Identifying how well a patient (or pediatric patient's family) can read or write English.

1 2 3 4 5

Not at all Skillful Very Skillful

47. Identifying cultural (non-religious) customs that might affect clinical care.

1 2 3 4 5

Not at all Skillful Very Skillful

48. Identifying religious beliefs that might affect clinical care.

1 2 3 4 5

Not at all Skillful Very Skillful

49. Identifying how a patient (or pediatric patient's family) makes decisions with other family members.

1 2 3 4 5

Not at all Skillful Very Skillful

50. Working effectively through a medical interpreter.

1 2 3 4 5

Not at all Skillful Very Skillful

Social
Attitudes
Survey

51. Thinking about your experiences to date, how prepared do you feel to care for patients (or pediatric patients' families)...

from cultures different from your own?

Somewhat Unprepared Somewhat Prepared Well Prepared
2 3 4

1 2 3 4 5

Very Unprepared Very Well Prepared

52. Thinking about your experiences to date, how prepared do you feel to care for patients (or pediatric patients' families)...

with health beliefs or practices at odds with Western medicine?

Somewhat Unprepared Somewhat Prepared Well Prepared
2 3 4

1 2 3 4 5

Very Unprepared Very Prepared

53. Thinking about your experiences to date, how prepared do you feel to care for patients (or pediatric patients' families)...

with a distrust of the U.S. health care system?

Somewhat Unprepared Somewhat Prepared Well Prepared
2 3 4

1 2 3 4 5

Very Unprepared Very Prepared

54. Thinking about your experiences to date, how prepared do you feel to care for patients (or pediatric patients' families)...

with limited English proficiency?

Somewhat Unprepared Somewhat Prepared Well Prepared

2 3 4

1 2 3 4 5

Very Unprepared Very Prepared

55. Thinking about your experiences to date, how prepared do you feel to care for patients (or pediatric patients' families)...

who are new immigrants?

Somewhat Unprepared Somewhat Prepared Well Prepared

2

3

4

1 2 3 4 5

Very Unprepared Very Prepared

56. Thinking about your experiences to date, how prepared do you feel to care for patients (or pediatric patients' families)...

whose religious beliefs affect treatment?

Somewhat Unprepared Somewhat Prepared Well Prepared

2

3

4

1 2 3 4 5

Very Unprepared Very Prepared

57. Thinking about your experiences to date, how prepared do you feel to care for patients (or pediatric patients' families)...

who use alternative or complementary medicines?

Somewhat Unprepared Somewhat Prepared Well Prepared

2

3

4

1 2 3 4 5

Very Unprepared Very Prepared

58. Thinking about your experiences to date, how prepared do you feel to care for patients (or pediatric patients' families)...

who are members of racial and ethnic minorities?

Somewhat Unprepared Somewhat Prepared Well Prepared

2

3

4

1 2 3 4 5

Very Unprepared Very Prepared

68. I think basically the world is a just place.

| Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Agree 5 | | | |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

69. I believe that, by and large, people get what they deserve.

| Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Agree 5 | | | |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

70. I am confident that justice always prevails over injustice.

| Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Agree 5 | | | |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

71. I am convinced that in the long run people will be compensated for injustices.

| Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Agree 5 | | | |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

72. I firmly believe that injustices in all areas of life (e.g. Professional, family, politics) are the exception rather than the rule.

| Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Agree 5 | | | |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

73. I think people try to be fair when making important decisions.

90. It is important for public schools to teach about the history and contributions of racial and ethnic minorities.

1 2 3 4 5 6
Strongly Disagree Strongly Agree

91. Racial and ethnic minorities in the U.S. have certain advantages because of the color of their skin.

1 2 3 4 5 6
Strongly Disagree Strongly Agree

92. Racial problems in the U.S. are rare, isolated situations.

1 2 3 4 5 6
Strongly Disagree Strongly Agree

93. Race plays an important role in who gets sent to prison.

1 2 3 4 5 6
Strongly Disagree Strongly Agree

Please respond to each item using the following scale. Please give your response by clicking on the response that best represents your point of view.

94. I feel annoyed when people do not speak standard English.

| | | | | | |
|-----------------------------|---------------------------|------------------------|--------------------------|---|-----|
| Moderately Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Moderately Agree 5 | | |
| | 1 | 2 | 3 | 4 | 5 6 |

Strongly Disagree Strongly Agree

95. I don't know a lot of information about important social and political events of racial and ethnic groups other than my own.

Moderately Slightly Slightly Moderately

Disagree 2 Disagree 3 Agree 4 Agree 5

1 2 3 4 5 6
Strongly Disagree Strongly Agree

96. I am touched by movies or books about discrimination issues faced by racial or ethnic groups other than my own.

Moderately Disagree 2 Slightly Disagree 3 Slightly Agree 4 Moderately Agree 5

1 2 3 4 5 6
Strongly Disagree Strongly Agree

97. I know what it feels like to be the only person of a certain race or ethnicity in a group of people.

Moderately Disagree 2 Slightly Disagree 3 Slightly Agree 4 Moderately Agree 5

1 2 3 4 5 6
Strongly Disagree Strongly Agree

98. I get impatient when communicating with people from other racial or ethnic backgrounds, regardless of how well they speak English.

Moderately Disagree 2 Slightly Disagree 3 Slightly Agree 4 Moderately Agree 5

1 2 3 4 5 6
Strongly Disagree Strongly Agree

99. I can relate to the frustration that some people feel about having fewer opportunities due to their racial or ethnic backgrounds.

Moderately Disagree 2 Slightly Disagree 3 Slightly Agree 4 Moderately Agree 5

1 2 3 4 5 6

104. When I know my friends are treated unfairly because of their racial or ethnic backgrounds, I speak up for them.

| | | | | | | |
|-----------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| Moderately Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Slightly Agree 5 | Moderately Agree 6 | | |
| 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

105. I share the anger of those who face injustice because of their racial and ethnic backgrounds.

| | | | | | | |
|-----------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| Moderately Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Slightly Agree 5 | Moderately Agree 6 | | |
| 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

106. When I interact with people from other racial or ethnic backgrounds, I show my appreciation of their cultural norms.

| | | | | | | |
|-----------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| Moderately Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Slightly Agree 5 | Moderately Agree 6 | | |
| 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

107. I feel supportive of people of other racial and ethnic groups, if I think they are being taken advantage of.

| | | | | | | |
|-----------------------------|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| Moderately Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Slightly Agree 5 | Moderately Agree 6 | | |
| 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

108. I get disturbed when other people experience misfortunes due to their racial or ethnic background.

| | | | | | |
|-----------------------------|---------------------------|------------------------|------------------------|--------------------------|---|
| Moderately Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Slightly Agree 5 | Moderately Agree 6 | |
| 1 | 2 | 3 | 4 | 5 | 6 |

113. I can see how other racial or ethnic groups are systematically oppressed in our society.

| | | | | | | | |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| Moderately Disagree | | Slightly Disagree | | Slightly Agree | | Moderately Agree | |
| 2 | | 3 | | 4 | | 5 | |
| | 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

114. I don't care if people make racists statements against other racial or ethnic groups.

| | | | | | | | |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| Moderately Disagree | | Slightly Disagree | | Slightly Agree | | Moderately Agree | |
| 2 | | 3 | | 4 | | 5 | |
| | 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

115. When I see people who come from a different racial or ethnic background succeed in the public arena, I share their pride.

| | | | | | | | |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| Moderately Disagree | | Slightly Disagree | | Slightly Agree | | Moderately Agree | |
| 2 | | 3 | | 4 | | 5 | |
| | 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

116. When other people struggle with racial or ethnic oppression, I share their frustration.

| | | | | | | | |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------|
| Moderately Disagree | | Slightly Disagree | | Slightly Agree | | Moderately Agree | |
| 2 | | 3 | | 4 | | 5 | |
| | 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree |

117. I recognize that the media often portrays people based on racial or ethnic stereotypes.

122. I feel uncomfortable when I am around a significant number of people who are racially/ethnically different than me.

| | | | | | | |
|--|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|
| Moderately Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Moderately Agree 5 | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree <input type="checkbox"/> |

123. When I hear people make racist jokes, I tell them I am offended even though they are not referring to my racial or ethnic group.

| | | | | | | |
|--|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|
| Moderately Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Moderately Agree 5 | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree <input type="checkbox"/> |

124. It is difficult for me to relate to stories in which people talk about racial or ethnic discrimination they experience in their day to day lives.

| | | | | | | |
|--|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|
| Moderately Disagree 2 | Slightly Disagree 3 | Slightly Agree 4 | Moderately Agree 5 | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | |
| Strongly Disagree <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Strongly Agree <input type="checkbox"/> |

Instructions: The following questions concern various reasons or motivations physicians in training might have for trying to respond in nonprejudiced ways toward ethnic minority patients (i.e. African-Americans, Latinos, Asian Americans, Asian Americans and Native Americans). Some of the reasons reflect internal-personal motivations whereas others reflect more external-social motivations. Of course, people may be motivated for both internal and external reasons; I want to emphasize that neither type of motivation is by definition better than the other. In addition, I want to be clear that I am not evaluating your individual responses. All your responses will be completely confidential. I am simply trying to get an idea of the types of motivations that individuals in general have for responding in nonprejudiced ways. If anything useful is to be learned it is important that you respond to each of the questions openly and honestly. Please give your response by clicking on the

130. I attempt to act in non-prejudiced ways toward minority patients because it is personally important to me.

1 2 3 4 5 6 7 8 9
Strongly Disagree Strongly Agree

131. According to my personal values, using stereotypes about minorities is OK.

1 2 3 4 5 6 7 8 9
Strongly Disagree Strongly Agree

132. Because of my personal values, I believe that using stereotypes about minority patients is wrong.

1 2 3 4 5 6 7 8 9
Strongly Disagree Strongly Agree

133. Being non-prejudiced toward minority patients is important to my self-concept.

1 2 3 4 5 6 7 8 9
Strongly Disagree Strongly Agree

134. Thank you for taking the time to participate in today's study. **If you wish to participate in the random raffle please enter your email in the space provided below. After you have voluntarily entered your email please click the finish button.**

All of your responses are confidential; please remember to close your browser once you have completed the survey. I am not interested in your individual responses but I am more interested in the trend of the responses provided by you and other participants in the study. Your participation in this study will help me to understand how a variety of diversity attitudes are related to mind-sets relevant to ways of thinking which relate to working with individuals who are members of minority groups. I ask that you do not discuss this study with anyone else who may in the future choose to participate in this survey; this could affect the quality of the data set. If you should have any questions please feel

free to contact me at sblackm@luc.edu I hope to publish the results of this study in an effort to contribute to knowledge on the diversity attitudes of physicians in training. If you are interested in knowing the results of the survey you may also contact me at the above email address. If you should have further interest in exploring diversity issues in medicine I would recommend reading *Multicultural Medicine and Health Disparities* by David Satcher and Rubens J. Pamies or *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* by the Institute of Medicine. I greatly appreciate your participation in this survey.

Contact Information:

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Please provide an email address below where you can be reached for the next 6 months; if you are randomly selected as a winner you will be contacted.

Social Attitudes Survey

Thank you for taking our survey.

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