HHS Public Access

Author manuscript

Soc Issues Policy Rev. Author manuscript; available in PMC 2024 October 02.

Published in final edited form as:

Soc Issues Policy Rev. 2017 January ; 11(1): 124–158. doi:10.1111/sipr.12029.

Color-Blind and Multicultural Strategies in Medical Settings

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Abstract

Recently, scholars have called for research that systematically examines the role of race and culture in shaping communication during racially discordant practitioner–patient interactions (i.e., patient and physician from different racial ethnic groups). In this review, we focus on two conceptual frameworks that influence the way people think about race, and subsequently, how they interact with others of a different race: *color blindness* and *multiculturalism*. We integrate basic social psychological research on interracial laboratory interactions with research on the markers of successful practitioner–patient communication to discuss how these two strategies shape interactions between Black patients and non-Black practitioners. Given that racial discrimination is often addressed within medical education and training contexts, we also discuss how these two strategies influence how practitioners are trained to talk about race. We conclude by offering practical suggestions as to how medical interactions can be improved by taking into consideration how color-blind and multicultural strategies shape behaviors within medical settings.

As the United States has become more racially and ethnically diverse, explicit attitudes about racial minorities and beliefs about racial integration have become increasingly more positive. Yet, according to a survey by PRRI (Cox, Navarro-Rivera, & Jones, 2016), individuals interact primarily with people of the same race as themselves. For White Americans, 91% of their social network is comprised of other Whites, and for Black Americans, 83% of their social network is comprised of other Blacks. Given these statistics, it is not surprising that even the most well-intentioned individuals—those who hold positive explicit attitudes about individuals of other races and who are motivated to be unprejudiced—not only experience anxiety and uncertainty during interracial interactions, but also express racial bias in subtle ways through their automatic (i.e., nonverbal) behaviors. In interactions in which race is "on the table" for both partners—that is, when race is a salient social category and people view their partners as representative members of their racial groups—the strategies people use to regulate race-related thoughts can dramatically shape how they behave toward and perceive their interaction partners.

In response to the difficulties that Whites and minorities face in forming relationships across the racial divide, scholars in social psychology have attempted to develop interventions

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to improve interactions between minorities and Whites in a variety of interpersonal settings. In this review, we focus on two strategies related to how people think about race, and subsequently, how they interact with others of a different race: *color blindness* and *multiculturalism*. The goal of this article is to provide a theoretical and empirical overview of these two strategies as they have been studied in the social psychological literature, and then discuss how they influence interactions within the medical context. We start by defining color blindness and multiculturalism and provide historical context as to how they emerged as strategies for reducing race-based discrimination. Second, we discuss how color blindness and multiculturalism have been studied by social psychologists using experimental approaches in the laboratory. Third, we integrate social psychological research on laboratory-based interactions with research on the markers of successful practitioner–patient communication to theorize about how color blindness and multiculturalism might influence medical interactions between Black patients and non-Black practitioners. In this third section, we first discuss the role of race in medical encounters, before providing an overview of how these two strategies operate within racially discordant medical encounters.

Given that racial discrimination in healthcare is often addressed within medical education and training contexts, we also discuss how these two strategies influence how practitioners are trained to talk about race (i.e., “cultural competency training”). We focus on how color-blind and multicultural strategies may help or hinder practitioners in becoming more culturally aware. Finally, we offer practical suggestions as to how medical interactions, and subsequently, patient outcomes, can be improved by taking into consideration how color-blind and multicultural strategies shape behaviors within medical settings. Throughout the article, we take a dyadic approach by discussing how these two approaches to handling race simultaneously affect the perspectives of practitioners and patients.

It is well-documented that Black patients experience a lower quality of care and exhibit poorer outcomes when receiving care from non-Black practitioners as compared to interactions involving White patients (Cooper et al., 2003; Hagiwara et al., 2013). In addition, much of the literature on the effects of color-blind and multicultural strategies within interracial interactions focus on the Black–White interaction context. As such, the focus of this article is on how color-blind and multicultural strategies influence interactions between Black patients and non-Black physicians. We do, however, acknowledge that these effects may generalize to other racial minority members and other interracial interaction contexts.

Color Blindness and Multiculturalism: History and Definitions

In the United States, negative explicit beliefs about racial minority groups have declined over the past 60 years (Bobo, 2001; Dovidio & Gaertner, 2004; Pearson, Dovidio, & Gaertner, 2009). It is no longer socially acceptable to express overt forms of racial discrimination in most regions in the United States (Dovidio, Gaertner, & Pearson, 2016). Not only have norms shifted in the United States against harboring and expressing negative racial attitudes, but also, law and policy makers have made important headway in instituting structural changes that aim to protect minorities against overt discrimination (i.e., Fair Housing Act, 2015). Yet, despite these advances, negative racial attitudes still exist and exert

a powerful influence on behavior. Racial disparities still occur in multiple settings, including health (National Center for Health Statistics, 2016), income and wealth (Shapiro, Meschede, & Osoro, 2013), and opportunities for social advancement (Reeves, 2013). For example, in an analysis of data from Project Implicit, Blacks were 8% less likely than Whites to report access to affordable healthcare in counties where Whites showed higher explicit bias. Moreover, racial disparities in mortality from circulatory diseases (i.e., myocardial infarction) was stronger in counties where Whites showed greater explicit bias against Blacks (Leitner, Hehman, Ayduk, & Mendoza-Denton, 2016).

Current research on intergroup relations has painted a clear picture of how contemporary forms of racism operate to influence behavior in cross-race settings, moving beyond the effects of explicit bias to understanding how implicit bias (i.e., bias that occurs outside of awareness) operates within these contexts (McConahay, 1986; Sears, Henry, & Kosterman, 2000). In particular, nonconscious racial attitudes often manifest as subtle behaviors that are difficult to control and in many contexts, difficult to label as expressions of bias. In everyday encounters, these behaviors include nonverbal displays of anxiety and discomfort, and, in some cases, exaggerated (disingenuous) positivity (Kawakami, 2014; Mendes & Koslov, 2013; Richeson, Trawalter, & Shelton, 2005; for a thorough review see (Dovidio, Gaertner, & Pearson, 2016)). Consistent with the literature on everyday encounters, the growing literature on the effects of nonconscious racial attitudes on health practitioners' behaviors has shown that although non-Black (i.e., White, Asian, Hispanic, Latino) providers generally exhibit relatively low levels of explicit bias, they display substantial implicit racial bias toward Blacks at levels comparable to the general public (Blair et al., 2013a; Godsil, Tropp, Goff, & Powell, 2014; Hall et al., 2015; Sabin, Nosek, Greenwald, & Rivara, 2009). Nonconscious bias can affect how physicians communicate critical medical information, as well as how they are perceived by Black patients. For example, non-Black practitioners' implicit bias is associated with Black patients feeling less satisfied and having more negative impressions of the interaction (Penner et al, 2010; see also Hausmann et al., 2015; Schaa, Roter, Biesecker, Cooper, & Erby, 2015). Lack of trust stemming from nonconscious bias is associated with patients' reduced medication adherence 16 weeks later (Hagiwara et al., 2013), suggesting that physician implicit bias affects patients long after the interaction is over. Recently, Penner et al. (2016) found that in the context of interactions between oncologists and patients, non-Black oncologists' who were more implicitly biased had significantly shorter interactions and less supportive communication than those who were less biased. Nonconscious bias also indirectly affected patients' own confidence in treatment, and was associated with lower perceived patient-centered communication. Further, Hagiwara, Dovidio, Eggly, & Penner, (2016) found patients' past experiences with discrimination interacted with physician bias to affect physician displays of positive and negative affect, and engagement. Specifically, when interacting with Black patients who reported any incidences of prior discrimination, the physicians who were low in explicit bias but high in implicit bias were rated by observers as displaying less positive affect and more negative affect than the other physicians, and appeared less engaged.

Although a full review of effects of implicit bias on interactions is beyond the scope of this article (see Dovidio & Gaertner, 2004; Dovidio, Gaertner, & Pearson, 2016 for thorough reviews), there is considerable evidence documenting the effects of nonconscious bias on

non-Blacks' behaviors toward Blacks in a variety of settings, from everyday encounters to medical interactions. Scholars and lawmakers have devised strategies to help combat bias in cross-race encounters and racial discrimination more broadly. Importantly, because individuals are often well-intentioned in their treatment of Blacks, many of these strategies aim to harness the good intentions that non-Blacks have by providing guidelines as to how members of different racial groups can communicate better within interpersonal settings, as well as how institutional changes can be implemented to reduce racial disparities by targeting how people think about race and respond to race-related issues.

In this review, we focus on two strategies that have been examined in many interaction contexts: *color blindness* and *multiculturalism*. Both strategies were conceived with the same ultimate goal of facilitating positive interracial experiences, yet color-blind and multicultural strategies are quite different in how they propose individuals think about race and racial diversity within interracial contexts. The color-blind strategy emphasizes the importance of not incorporating race into judgments and decision making. Proponents of the color-blind strategy argue that in order to reduce prejudice and discrimination, people must act as if they are "blind" to race (see Gotanda, 1991; Neville, Lilly, Duran, Lee, & Browne, 2000; Parents Involved in Community Schools v Seattle School District No. 1, 2007). Historically, the color-blind strategy emerged during a time in which explicit racial discrimination was still common, and so proponents of it argued that being color blind meant embracing a world in which race cannot be used as a foundation for inequality. As the plaintiff's argued in Brown v. Board of Education (1954), "That the constitution is color-blind is our dedicated belief." In other words, by not acknowledging race, prejudice and discrimination will not have the opportunity to emerge.

The color-blind strategy has been a popular method for reducing prejudice and discrimination in a number of social contexts, including organizational (Ely & Thomas, 2001; Thomas & Ely, 1996), educational (Apfelbaum, Pauker, Ambady, Sommers, & Norton, 2008a; Pollock, 2004; Schofield, 2007), and legal (Kang & Lane, 2010; Peery, 2011; Sommers & Norton, 2008) settings. Within medical settings most racial interactions (about 80%) with Black patients will be racially discordant (Hamel et al., 2015). Thus, the color-blind strategy in these interactions is especially appealing given that most non-Black physicians (and practitioners more generally) see themselves as nonprejudiced and color blind (Epstein, 2005; Sabin, Rivara, & Greenwald, 2008). However, as mentioned previously, these physicians often harbor strong unconscious racial biases toward minority patients, and are more likely to negatively evaluate Black patients (i.e., label Black patients as uncooperative, Sabin, Nosek, Greenwald, & Rivara, 2009; Sabin et al., 2008). Such evaluations can negatively impact treatment decisions, treatment adherence (Hall et al., 2015), undermine patients' role in the medical interaction (i.e., physician dominance of medical dialogue) and lead physicians to have a lower positive emotional tone in visits (Blair, 2013a; Chapman, Kaatz, & Carnes, 2013; Hagiwara et al., 2013).

In contrast to the color-blind strategy, the multicultural strategy stems from the notion that it is important to acknowledge and empower all races by celebrating each other's diverse backgrounds (Markus, Steele, & Steele, 2000; Plaut, 2002; Wolsko, Park, Judd, & Wittenbrink, 2000). Modern approaches to the multicultural strategy emphasize

the importance of growing demographic shifts by harnessing the power of different backgrounds, perspectives, and experiences. For example, racial minorities make up over half of the population in California, Hawaii, New Mexico, and Texas (U.S. Census Bureau, 2012)–and by the year 2060 minorities will outnumber Whites (Ortman & Guarneri, 2009). In the United States, these preferences map onto the preferences of Whites and racial minorities, with racial and ethnic minorities preferring multiculturalism more than Whites (Ryan, Hunt, Weible, Peterson, & Casas, 2007). In the context of interpersonal interactions, the multicultural strategy is often one that involves perspective taking, which is critical to accurately gauging the individual motivations and perspectives of one's cross-race interaction partners. In the context of medical interactions, physicians who exhibit skills related to perspective taking (such as empathetic understanding and active listening) have better communication with minority patients (DiMatteo, 1995; Teal & Street, 2009), suggesting that when White providers are able to fully attend to the minority patient's needs and incorporates their unique experiences into the medical interaction, they are better able to serve these patients (Tervalon & Murray-Garcia, 1998). The ability of the patient and physician to accomplish this has the potential to decrease the degree of ambiguity and conflicting messages that disrupt communication in race-discordant relationships.

Effects of a Color-Blind Strategy on Interracial Interactions

To date, most research on how color-blind and multicultural strategies affect interpersonal interactions has been conducted outside of the practitioner–patient encounter. However, there have been a number of laboratory studies that have been conducted on the basic interpersonal and behavioral processes that underlie cross-race communication that are relevant to the medical setting, which we will review here.

We begin with a review of the color-blind strategy. For Whites who are motivated to appear egalitarian and have concerns with appearing prejudiced during interactions with racial out-group members (Bergsieker, Shelton, & Richeson, 2010; Plant & Devine, 1998; Richeson & Shelton, 2007), the color-blind strategy has intuitive appeal—attempting to appear color blind is one way of trying to appear unprejudiced. Acknowledging race is a necessary precursor to racism, and so individuals who do not want to appear racist might say to themselves: *"If I do not notice race, then I cannot be a racist"* (Norton et al., 2006, p. 949). However, race is encoded automatically and without conscious effort (Ito & Urland, 2003), and this incongruity between trying to appear as if one has not noticed race while still automatically noticing race can lead to a host of negative consequences during interpersonal interactions.

What are the specific behavioral consequences of attempting to be color blind? Managing self-presentational concerns of trying to appear unprejudiced can lead Whites to appear more uncomfortable, more anxious, and less friendly during interracial interactions (for a review see Gullett & West, 2016). In a controlled experiment examining how attempts at being color blind affect Whites' behaviors, Norton, Sommers, Apfelbaum, Pura, and Ariely (2006, Study 2) asked White participants to work with a partner (a Black or White confederate) on a cooperative task to guess the correct photograph that their partner was holding among 32 photographs of Black and White targets. In this task, race is a diagnostic

tool, and mentioning the race of the target in the photograph would help one's partner identify the correct photograph.

When the confederate was White, participants asked about the race of their partner's photo 94% of the time. However, when the confederate was Black, White participants suppressed their race-related questions and only mentioned the race of the person in the photo 64% of the time. Further, these color-blind behaviors during interracial interactions were associated with participant's negative nonverbal behaviors. When White participants interacted with a Black confederate, the less they mentioned race, the less eye contact they made with their partners and the less friendly they appeared to outside observers.

For Whites, attempts at being color blind represent a general attempt at suppressing negative race-related thoughts (Apfelbaum, Sommers, & Norton, 2008b; Norton, Sommers, Apfelbaum, Pura, & Ariely, 2006), which is cognitively taxing. When individuals are cognitively taxed, not only do they have fewer resources to attend to the behaviors in their partners, which can hinder their ability to process information that is communicated during an encounter (e.g., a patients' descriptions of symptoms in a medical encounter), but also, attempts at suppression can lead to activation of unconscious bias, which in turn leads to increased expression of negative nonverbal behaviors, such as anxiety (Apfelbaum, 2008a). In a direct demonstration of the causal association between color blindness, cognitive depletion (i.e., having reduced cognitive resources), and anxious behavioral cues, Apfelbaum (2008a, Study 2) measured White participants' automatic tendency to act color blind, after which they had them interact with White and Black confederates (using the same photo identification task as Study 1 described above). The authors then measured cognitive depletion with the Stroop task (Stroop, 1935; see Richeson & Shelton, 2003, for an example). Results indicated that avoiding the topic of race with a cross-race partner was associated with cognitive depletion, and cognitive depletion mediated the relationship between color-blind behavior and nonverbal unfriendliness in interracial interactions, such that increases in cognitive depletion due to avoidance of race-based target descriptions led to more negative nonverbal behaviors among White participants, as coded by outside observers. These findings suggest that because active attempts to suppress unwanted behaviors tax Whites' cognitive resources, Whites no longer have sufficient resources to successfully control their negative nonverbal behaviors.

These findings are consistent with the general finding that attempts to suppress negative behaviors lead to expressions of negative affect for Whites, defined as how "hostile, uncomfortable, nervous, self-critical, and uncertain" participants were, as coded by outside observers (Vorauer, Gagnon, & Sasaki, 2009). Specifically, Vorauer et al. (2009) found that during interracial interactions, adopting the color-blind approach lead Whites to focus on suppressing negative behaviors, and this focus mediated the relationship between color-blind ideology and the behavioral expressions of negative affect (as defined above).

Importantly, not only does harboring a color-blind approach cognitively tax Whites, but also, interacting with a color-blind White interaction partner is cognitively taxing for minorities as well in part because being color blind can lead Whites' to act more prejudiced. For instance, Holoien and Shelton (2012) found that minorities demonstrated

greater Stroop interference when interacting with color-blind Whites, in part because those Whites appeared more prejudiced (operationalized as more offensive, and devaluing the importance of racial issues, as coded by ethnic minority observers; Holoien & Shelton, 2012). Depletion of cognitive resources is important when one considers the interactional contexts in which color-blind approaches are often implemented—schools and organizations (i.e., workplace environments, hospital settings). If interracial interactions in these settings are cognitively taxing, students, employees, and patients may not have sufficient cognitive resources to complete difficult or complex tasks, and to attend to critical information that is communicated during these encounters. For patients who have to make critical decisions about treatment (e.g., cancer patients) being cognitively taxed might lead to making less informed decisions and subsequently lower adherence rates (Penner et al., 2016).

Although the majority of research has examined how a color-blind strategy when adopted by the White partner affects both the White and minority partners, some work has examined how interacting with a minority partner who acts color blind affects Whites' tendencies to acknowledge race during an interaction. Apfelbaum, Sommers, and Norton (2008b) had White participants interact with White and Black confederates while completing a race-relevant person identification task. Confederates either acted color blind (i.e., did not voluntarily ask questions about the race of targets shown in the person identification task) or acknowledged the race of the targets shown in the person identification task. In response to their interaction partner's behavior, White participants who interacted with a Black partner who appeared color blind mirrored their color-blind behavior by only mentioning race 26% of the time. Participants with a partner who acknowledged race mentioned race 91% of the time. Moreover, for White participants, interacting with a color-blind interaction partner led to more negative nonverbal behaviors for those in interracial interactions than interacting with a noncolor-blind partner. Thus, while Norton et al.'s (2006) findings suggest that Whites' own attempts at color-blind behavior can result in the individual exhibiting negative nonverbal behaviors, Apfelbaum et al.'s (2008a) research shows that minorities' color-blind behaviors can set the stage for the encounter—shifting Whites' behaviors to align with their own—perhaps because Whites look to minorities to "set the stage" for how race can be handled in the interaction.

Together, these findings add to a growing body of literature demonstrating the negative effects that impression management concerns have on nonverbal behavior during interracial encounters. Interacting with a partner who displays negative nonverbal behavior (i.e., is anxious) is particularly problematic in cross-race encounters because the meaning underlying nonverbal anxious behaviors is ambiguous and open to interpretation by the interaction partner (Dovidio, Kawakami, & Gaertner, 2002). Whites and minorities in interracial interactions are especially prone to interpreting anxious nonverbal behaviors, such as averted eye gaze, as indicative of dislike and unfriendliness (Dovidio, West, Pearson, Gaertner, & Kawakami, 2007; Trail, Shelton, & West, 2009). In same-race encounters, these same behaviors are not interpreted negatively and have been shown to even be interpreted positively by one's interaction partners (i.e., as signs of genuine interest and attempts to make a good impression; West, 2011).

Thus far, we have focused on how for Whites, being color blind influences their own and their partners' cognitive and behavioral outcomes. These findings raise the question: Are racial minorities also negatively affected by embracing a color-blind strategy? Although the research is limited, it suggests that they are not. Vorauer, Gagnon, and Sasaki (2009) found that minorities were largely unaffected by acting color blind (specifically, on their desires to withhold certain negative behaviors) suggesting that the inhibitory effects of the color-blind approach primarily apply to Whites. These findings may be attributed in part to evidence indicating that minorities' impression management concerns center around being the target of prejudice, rather than being perceived as prejudiced (Richeson & Shelton, 2007). It may also be the case that color-blind strategy interventions are less likely to be successfully implemented by minorities, who prefer a multicultural approach (Ryan et al., 2007).

Finally, not only does endorsing a color-blind strategy negatively affect communication between Whites and minorities during interpersonal interactions, when endorsed at the level of the institution (i.e., by schools, universities, companies, and hospitals) a color-blind policy can also perpetuate racial disadvantage. For instance, for Whites who endorse a color-blind perspective in social and institutional policies (i.e., organizational practices; Plaut et al., 2009), denying racial differences prevents them from perceiving that their actions are racially motivated, and also, that any disparities that exist in treatment between Whites and minorities are due to race. Dovidio, Gaertner, & Pearson (2016) provide a comprehensive review of how institutional color blindness can perpetuate racial disparities at the institutional level. In so doing, they point to the important work of Bonilla-Silva and Dietrich (2011), who observed that "the ideology of color blindness is increasingly affecting even those who are at or near the bottom of the economic and social hierarchies in the United States: blacks and Latinos" (p. 195). In support of this notion, Apfelbaum et al. (2010) found that elementary school students who were exposed to a color-blind strategy (compared to a value diversity strategy), were less likely to detect overt instances of racial discrimination and to describe these instances in a manner that would prompt intervention by certified teachers, indicating that adopting a color-blind strategy is associated with less detection and effective reporting of racial discrimination by minorities (Apfelbaum, Paulker, Sommers, & Ambady, 2010). There is also growing attention to the negative effects that adopting a color-blind strategy within medical encounters can have on the Black community. For instance, focus groups organized by researchers to assess the role of race in medical practice found that Black physicians were more likely than White physicians to say that race is a relevant factor in determining the best treatment, and that in some cases, it is appropriate for doctors to take into account population-based probabilities of disease when deciding what protocols to follow (e.g., that African Americans are more likely to suffer from hypertension and diabetes than Whites; Longman, 2013).

In summary, despite continuing support for a color-blind strategy among White Americans (Ryan et al., 2007), the research presented herein suggests that there are pitfalls to adopting such a strategy at an institutional level and during interpersonal interactions. For Whites, attempts to act color blind lead to expressions of negative nonverbal behaviors and cognitive depletion during interracial interactions, which can inhibit Whites' ability to attend to their partners during interactions (Apfelbaum et al., 2008a; Holoien & Shelton, 2012; Norton et al., 2006). In medical encounters, their ability to process critical information that their

patient is providing them might be hindered, such as their patient's physical symptoms, their adherence, or any issues they are having with their medications. For minorities, interacting with Whites who exhibit negative behaviors because they are attempting to be color blind is cognitively taxing (Holoien & Shelton, 2012), which could affect their ability to attend to health-related information (e.g., prescription information) their physician is providing in a medical encounter, or potentially, recall of information after the encounter is over. At the institutional level, adopting a color-blind approach can lead Whites to disavow the importance of race, which can blind them from seeing race-based disparities in treatment.

Effects of a Multicultural Strategy in Interracial Interactions

We next review research on how adopting a multicultural strategy can affect interpersonal interactions between Whites and minorities. Unlike findings regarding the consistently negative consequences of adopting a color-blind strategy, findings regarding the utility of adopting a multicultural strategy are mixed.

At first glance, the multicultural strategy appears to be an ideal intervention for improving interracial interactions. It enhances perspective taking (Todd & Galinsky, 2012), promotes positive other-oriented remarks (Vorauer et al., 2009), and increases positive behaviors (Holoien & Shelton, 2012) without taxing interaction members' cognitive resources (Holoien & Shelton, 2012). However, scholars have raised concerns that adopting a multicultural approach might not be an ideal strategy for advancing minorities' status in society. Although proponents of the approach emphasize that a multicultural strategy can lead to more positive and secure ethnic identities for minorities (Verkuyten, 2005), critics assert that attending to race and race-based differences, even if in a positive way, can lead to minorities being valued primarily by virtue of their minority status (Purdie-Vaughns, Steele, Davies, Ditlmann, & Crosby, 2008). These concerns might be the most relevant in institutional contexts (i.e., schools, companies, university departments, hospitals) that are predominantly White, where hiring or accepting minorities is part of a large-scale effort to improve racial diversity. Increasing the numbers of minorities in these contexts is not only an ineffective strategy for promoting positive relations among groups, it also does little to promote minorities, who might face a host of roadblocks in achieving equal treatment once they are employed. Until the medical-provider workforce better reflects the increasing diversity of the nation, efforts to improve cross-cultural communication skills among providers need to be a priority of medical education.

Within interpersonal encounters, there is research documenting the positive relationship-relevant behaviors that adopting a multicultural strategy can lead to for both Whites and minorities. For example, Vorauer, Gagnon, and Sasaki (2009) found that relative to a control condition, White and minority participants who adopted a multicultural strategy made more positive other-oriented remarks (i.e., statements directly referencing their partner in a positive light) during written exchanges with a future interaction partner (Study 1) and during actual interactions with an interaction partner of another race (Study 2). Similarly, Holoien and Shelton (2012) found that when asked to interact with a minority partner, Whites who adopted a multicultural approach exhibited more positive behaviors than Whites who adopted a color-blind approach. Critically, expressing positive (i.e., support-related)

behaviors is just as important in shaping the quality of interracial encounters as expressing negative ones (Trail, Shelton, & West, 2009). For instance, Trail et al. (2009) found that being perceived as engaging in positive intimacy-building behaviors was just as important as being perceived as engaging in anxiety-related behaviors in predicting relational outcomes, such as a greater desire to live with a new roommate; these effects hold for both partners in the relationship—the person who is engaging in the behaviors and the person who is on the receiving end of them. Similarly, in physician–patient interactions, expressing positive behaviors, such as perspective-taking and empathic concern, are critical for effective communication.

Other research has revealed that the effect of multiculturalism on relational outcomes is not this simple and straightforward; investigations into the importance of individual differences present a more nuanced picture of how multicultural ideology may shape interracial interactions. One psychological variable that is critical to the success or failure of adopting a multicultural approach for Whites is how threatening to their identity they find changes to the status quo. For instance, for Right Wing Authoritarians—those who value respecting authority and societal norms and who view challenges to their social structure and values as threats (Asbrock, Sibley, & Duckitt, 2010; Jost, 2006)–adopting a multicultural perspective can backfire, leading to strong expressions of racial bias (Kauff, Asbrock, Thorner, ¨ & Wagner, 2013). Right Wing Authoritarians find multiculturalism's emphasis on disrupting current social dynamics by taking power away from Whites (i.e., the current social norm) and redistributing it to empower all races to be extremely threatening. As a result, exposure to multicultural messages leads to decreased acceptance of diversity for them.

Adopting a multicultural strategy might also lead Whites to feel excluded by the focus on culture and individuality that is espoused by multiculturalism, to the extent that they do not feel that their White identity contributes to multiculturalism or is not relevant (Plaut, Garnett, Buffardi, & Sanchez-Burks, 2011). As a result, Whites who feel a strong need to belong within the groups that they are members of (e.g., work groups or social groups) may show less interest in working for an organization that endorses a multicultural rather than a color-blind approach because they have a hard time feeling included within these groups (Plaut et al., 2011). For White Americans who strongly identify with their ethnicity, priming multiculturalism can increase their prejudice toward racial minorities (Kauff et al., 2013; Morrison, Plaut, & Ybarra, 2010). Applying these findings to the medical context, to the extent that workplace settings activate or bring out concerns about belonging and fitting in, it is possible that White physicians who have a strong need to belong would be less likely to want to work or feel comfortable in medical institutions that strongly value multiculturalism.

Finally, negative effects of adopting a multicultural strategy have also been observed in the context of interracial interactions for individuals who are relatively high on explicit racial prejudice. Vorauer and Sasaki (2010) asked participants to exchange notes with an interracial partner with whom they believed they would have the opportunity to interact with at the end of the study. Focusing on multiculturalism before writing to their partner allowed low prejudiced people to relax and exhibit more warmth toward their interracial partner in the written exchange, but for high prejudice people, multiculturalism was threatening and led them to demonstrate less warmth toward their future interracial partner (the authors

published a corrigendum in 2015 regarding an error in the analyses, but note that their conclusions remain the same). As previously reviewed, to the extent that the partner in turn picks up on these behaviors, they will be less likely to want to engage in long term contact with their White partner (Trail et al., 2009). In medical training settings, learner resistance to cultural competency training has also been documented, as students may view cultural competence training as a "soft science" (Boutin-Foster, Foster, & Konopasek, 2008)

We have reviewed research that has examined the conditions under which adopting a multicultural strategy positively affects individuals within interpersonal settings. Additional research has examined how harnessing the benefits of a multicultural strategy while maintaining the importance of individuals' own racial identities might work best at fostering positive outcomes (sometimes referred to as the dual identity approach). For Whites, recognition of a subgroup identity conveys greater respect for the low status group than adopting a color-blind approach, which often downplays the importance of minorities' identities. Thus, the dual identity approach allows Whites and minority groups to feel satisfied because both of their identities are valued (Bergsieker et al., 2010; Dovidio, Gaertner, Ufkes, Saguy, & Pearson, 2016; Glasford and Dovidio; 2011; Shnabel, Nadler, Canetti-Nisim, & Ullrich, 2008).

In summary, multiculturalism can be a useful strategy for fostering positive outcomes in cross-race interactions, but it is certainly not a magic bullet. It is important to consider individual differences in psychological traits that are associated with resistance to changes in the status quo (i.e., changes in racial demographics) and racial attitudes more generally when implementing a multicultural strategy. Although multiculturalism is a potentially effective tool for improving interracial interactions for Whites who are well-intentioned and motivated to appear unprejudiced, in contexts in which Whites are high in Right Wing Authoritarianism or prejudice, multiculturalism may harm rather than help interracial interactions. Minorities generally benefit from a multicultural strategy, but as is the case with research on interacting with a partner who is color blind, it is important to consider how minorities might be affected by a White partner who is adopting a multicultural strategy.

Applying Color Blindness and Multiculturalism to the Medical Context

As we have discussed thus far, color blindness and multiculturalism can shape the ways in which Whites and racial minorities think, feel, and behave in interracial interactions, and how they communicate with each other. We now turn our attention to how these two strategies might directly affect medical encounters. Given that there has been limited research directly testing these concepts with medical contexts, we will draw from the reviewed research on how color blindness and multiculturalism affect interpersonal communication to theorize about their roles in dyadic interactions and medical education. Before doing so, we will first discuss what communication processes underlie effective practitioner–patient interactions, and different types of cultural training practitioners receive in the medical setting. Then, we will map the psychological and behavioral processes that are related to color-blind and multicultural strategies to research on practitioner–patient communication. Although we primarily discuss how these two strategies, from the

perspective of the practitioner (and the medical institution) affect medical encounters, we extend our theorizing about the patient, at the end of this section.

Communication Processes That Underlie Successful Medical Interactions

For several decades, the concept of patient-centered care has been at the forefront of medical education; nearly every aspect of the medical interview can be helped or hindered by the quality of the discussion between patient and practitioner. Critical to the concept of patient-centered care is the notion that medical interactions that focus on patients' preferences should be more fulfilling and have better outcomes for patients (i.e., better adherence, disease self-management, satisfaction) than less personalized or practitioner-centric interactions that do not focus on patients' preferences. Patient-centered care relationships require the patient and practitioner feel mutual respect in order to develop rapport, and for the practitioner to elicit the patient's story in order to understand the unique aspects of a patient's life that affect their healthcare choices. (Makoul, 2001; Mauksch, Dugdale, Dodson, & Epstein 2008).

Scholars have also emphasized the importance of developing meaningful relationships in medical interactions (Beach & Inui, 2006). Here, the focus is on the level of reciprocity that is created between the patient and practitioner as well as the values and perspectives each possess and add to the interaction (Tresolini and Shugars, 1994). The quality of communication between patients and practitioner is not viewed as a result of the behaviors of one of the members of the interaction, but rather, as an interactive process that is dependent on the efforts of both members. In this regard, the focus is on the dyadic interaction between patient and practitioner with each partner equally contributing their unique knowledge and experiences to the interaction, as opposed to outcomes being the result of one partner's behaviors (most often the practitioner's).

To illustrate the importance of patient involvement in the medical encounter, studies have consistently shown that medical visits characterized by higher levels of shared decision making (i.e., practitioners outline the pros and cons of various treatment options, and elicit patient preferences for treatment; patients participate in the decision making and express their values and preferences for treatment, Bultman and Svarstad 2000, Beach, Duggan, & Moore, 2007) patient-centeredness (i.e., practitioner elicit the patient's concerns and preferences and ensures that the patient's values guide medical decisions; Beach, Keruly, & Moore, 2006, Fuertes, Mislowack et al. 2007), adequate information-exchange (i.e., practitioner data gathering and patient information sharing Heisler, Bouknight, Hayward, Smith, & Kerr, 2002; Piette, Schillinger, Potter, & Heisler, 2003), and responsiveness to emotion (de Haes and Teunissen, 2005; Epstein & Street, 2007) are associated with improvements in patient satisfaction, knowledge about their condition, self-reported health status, adherence to self-management behaviors, emotional health, and recovery from discomfort (Edwards, Elwyn, & Thompson, 2016; Ong, De Haes, Hoos, & Lammes, 1995; Stewart et al., 2000).

Moreover, research has also emphasized the importance of practitioners "drawing the patient in" to the encounter by encouraging them to reveal information about their health and

barriers they perceive to achieving healthy behaviors. For instance, analysis of audiotaped patient–physician interactions has shown that physicians that use multiple, collaborative communication strategies (i.e., open-ended questions, using lay terminology, asking follow-up questions) are more effective in facilitating discussions about patient's behaviors than those that used closed-ended questions and directives (i.e., prescribing or changing medications without any patient input; Bokhour, Berlowitz, Long, & Kressin, 2006).

Physicians who exhibit best practices in communication styles also tend to be less verbally dominant (i.e., by taking over the interaction), engage in more discussions about psychosocial (i.e., mental health, social support) and lifestyle issues, and use more positive talk (Roter, Larson, Fischer, Arnold, & Tulsky, 2000). These basic communication processes —being genuine and open, encouraging disclosure in one's partner, engaging in perspective taking and expressing positive partner-oriented responses—are also characteristics of communication that underlie positive interpersonal interactions in general.

The Role of Race in Medical Encounters

Race plays a critical role in shaping many of the communication processes outlined above. As noted previously, about 80% of Black patients' medical interactions are racially discordant (Hamel et al., 2015; Laveist and Nuru-Jeter, 2002); that is, their primary physician is not Black. Given racial disparities in health outcomes and the poorer health of Blacks in medical encounters, the Institute of Medicine (IOM) published a seminal document, Unequal Treatment that emphasized the need to establish a framework that identifies, organizes, and embeds individual, healthcare system, and sociocultural (physical and social contexts in which people live, work and interact) variables into our conceptualization of the practitioner–patient dyad. In the report, Cooper and Roter provided evidence suggesting that both patient and practitioner race can affect the interpersonal dynamics that occur within the practitioner–patient relationship, leading to a differential provision of healthcare. For instance, practitioners tend to deliver less information and supportive talk to minority than White patients (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004)—critical components of patient centered care. Black patients participate significantly less and report lower levels of trust in their physicians than White patients (Fiscella et al., 2004; Gordon, Street, Sharf, Kelly, & Souchek, 2006; Kaplan, Gandek, Greenfield, Rogers, & Ware, 1995). Trust is developed when patients believe that their practitioners are honest and truthful, and when their physicians show them respect—factors that a patient-centered approach to care emphasizes. Poor communication between physicians and patients directly contributes to poor adherence among minority patients (Doescher, Saver, Franks, & Fiscella, 2000; Saha, Jacobs, Moore, & Beach, 2010; Schoenthaler et al., 2009), which is a major driver of racial disparities in health. Given these findings, the IOM report called for further examination into how shared socialization of medical students into 'the culture of medicine' serves as a means to foster or mitigate the effects of negative racial attitudes (including implicit and explicit attitudes, and the combination of the two) on interactions with minority patients.

Cultural Competence Education

The primary method through which medical institutions have tried to address issues of race in practitioner–patient interaction is through cultural competence education. The Association of American Medical Colleges (AAMC) defines cultural competence as “a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations.” In healthcare, culturally competence connotes the provision of patient-centered care combined with an understanding of the broader sociocultural influences that affect the quality of care.

How are medical students trained to be “culturally competent”? To begin, while many medical institutions acknowledge the inherent value of cultural competence, the efficacy of the curriculum hinges on whether medical institutions regard cultural competency as an educational priority, and on whether medical students have positive attitudes about the principles (Association of American Medical Colleges, 2005). Two primary approaches have been used to teach cultural competency in medical education: categorical and cross-cultural. The categorical approach focuses on teaching students about the attitudes, values, and beliefs of diverse sociocultural groups by presenting information directly. Scholars should be cautious in simply adding didactic lectures about cultural competence to the curricula without giving students information on how to apply this knowledge to clinical setting (Eiser & Ellis, 2007). Didactic lectures alone can increase the likelihood of stereotyping as it oversimplifies cultural beliefs and behaviors in order to categorize cultural groups rather than acknowledge their complexity (Betancourt & Green, 2010).

Alternatively, the cross-cultural approach emphasizes the development of practical tools and skills for medical interviewing and communication that “allows practitioners to assess—for an individual patient—what sociocultural factors affect the patient’s care” (Betancourt & Green, 2010). These skills align with models of patient-centered care and can include: asking question to elicit patients’ explanatory models of health and illness, adapting to different communication styles, determining patients’ preferred decision-making style, incorporating the family into patients’ care, and addressing issues related to cultural mistrust, traditions, and alternative medicines. Some programs have enhanced the cross-cultural curricula by having medical students partner with community clinics to provide services to medically underserved patients from diverse racial/ethnic groups (Albritton & Wagner, 2002; Brill, Ohly, & Stearns, 2002).

The effectiveness of cultural competency training programs has been mixed. For example, a systematic review of training programs found some improvements in practitioner knowledge, attitudes and skills, and patient satisfaction, whereas an evaluation of an online continuing medical education curriculum for providing culturally competent care found little change in practitioners’ attitudes (Beach et al., 2004) More importantly, any gains documented in practitioners’ knowledge, attitudes or skills have not translated to improvements in minorities’ health (Goode et al., 2006). Moreover, few institutions have systematically incorporated formal cultural competency education into the medical school curricula. Of the existing programs, the curricula tend to be fragmented, rely on didactic lectures, vary in content, restricted to the first 2 years of school, and forgo evaluation

(Betancourt & Green, 2010; Dykes 2011). Moreover, schools have failed to address the impact of physician implicit bias or the "hidden curriculum" (i.e., the institution's racial climate and attitudes about diversity) on student's behaviors, which has a profound effect on the quality of healthcare for minority patients (van Ryn et al., 2015). Unfortunately, although many medical students endorse the benefits of becoming culturally competent, many feel unprepared to work with diverse patient populations (Park et al., 2005; Weissman et al., 2005). This feeling extends beyond a concern for a lack of skills to believing that learning everything about the patients' culture will increase the tendency to stereotype (Park et al., 2006).

Finally, scholars have pointed out that the cultural competency approach emphasizes how the racial identities of people of color depart from the standard of Whiteness, and thus interacting with them requires "special training" (Tsai, 2016). This idea is similar to the notion that any identity that departs from the status quo (which in America, is White; Knowles, Lowery, Chow, & Unzueta, 2014) needs to be defined and explained. In so doing, imbedded within the cultural competency approach is a failure to acknowledge that hospitals and training programs have their own culture that influences how practitioners interact with patients—a culture that also needs to be studied and understood.

How Color-Blind and Multicultural Strategies Affect Practitioner–Patient Interactions

As we have reviewed above, contemporary approaches to understanding the process of communication between practitioners and patients emphasizes how both partners play a critical role in shaping dyadic patterns of behavior. Existing models (i.e., patient-centered care) emphasize the importance of perspective-taking for practitioners, and openness and honesty regarding health behaviors and perceived barriers to achieving health behaviors for patients. Moreover, modern approaches to practitioner–patient communication emphasize the unique behaviors that practitioners and patients engage in to facilitate positive dyadic patterns of communication, such as information exchange and shared decision making (for a review see Edwards, Elwyn, & Thompson, 2016). As we have also reviewed, racial disparities in health exist and have been widely acknowledged by scholars, and the practitioner–patient relationship has been identified as a critical context where racial disparities can be combated. Medical institutions are invested in improving the quality of practitioner–patient interactions, and have developed cultural competency training programs to prepare students for racially discordant medical interactions. However, cultural competency approaches have received little empirical support, and some scholars have argued that they might backfire by inadvertently creating a culture where minorities are seen as deviant from the status quo, and where White practitioners feel ill-equipped to discuss race and culture during medical interactions.

Next, we bridge research on how adopting a color-blind or multicultural strategy can influence communication within practitioner–patient interactions to address the question: how might these strategies help or hinder racially discordant practitioner–patient relationships? We also focus on how institution-wide programs such as cultural competency

training intersect with these strategies to influence racially discordant medical interactions. We first consider the strategies that practitioners and patients are most likely to adopt naturally, and how these strategies might affect their own and their partners' behaviors.

In interpersonal interactions, Whites and minorities are often motivated to shape the discourse in a way that reflects their preference for color-blind or multicultural strategies. As reviewed above, Whites who are motivated to be egalitarian typically prefer a color-blind strategy, whereas minorities typically prefer a multicultural one (Ryan, Hunt, Weible, Peterson, & Casas, 2007). Some research has found similar effects in the physician–patient domain, with White physicians preferring a color-blind strategy during racially discordant encounters (Burgess, Warren, Phelan, Dovidio, & Van Ryn, 2010).

If practitioners do attempt to appear color blind, what are the potential costs to themselves and their patients? Recall that attempting to appear color blind is cognitively taxing. For practitioners, having limited cognitive resources may interfere with a number of critical psychological processes needed for successful communication. Reduced cognitive resources might limit practitioners' ability to process critical information regarding their patients' health behaviors, their symptoms and their concerns. Such "cognitive load," as it has been termed, has also been shown to predict a lower of likelihood prescribing pain medications to Black vs. White patients (Burgess et al., 2014), perhaps because racial biases are more likely to drive decision making when practitioners have limited cognitive capacity to override these biases in favor of more deliberative processing. (Sabin et al., 2009). Indeed, for pain in particular, racial bias is associated with inaccurate beliefs regarding the amount and type of pain experienced by minority patients (Blacks in particular, Hoffman, Trawalter, Axt, & Oliver, 2016); for practitioners, being under cognitive load could exacerbate these biases in judgment, leading to greater racial disparities in the treatment of pain.

Generally speaking, having limited cognitive resources is also associated with a reduced ability to attend to a partner's subtle (i.e., nonverbal) behavioral displays of emotion and correctly interpret their meaning (i.e., be empathically accurate) because doing so requires complex, deliberative processing (Ickes, 1997). Although it remains to be tested, it is possible that practitioners who attempt to appear color blind may not only be less likely to accurately perceive verbal and nonverbal cues in their patients that are important for identifying their basic emotional states, they may also be less accurate in inferring the meaning of these emotion states (i.e., that fidgeting and avoiding eye contact is related to a fear of side effects, or that a puzzled expression is related to a lack of understanding information about the new medication). Finally, having limited cognitive resources may also increase the likelihood that clinically irrelevant stereotypes are automatically activated and applied to minority patients, particularly when there is clinical uncertainty about case (Burgess, 2009). Clinical uncertainty is an influential determinant of a practitioner's decision-making process. Coupled with the highly adaptive strategy of categorization, clinical uncertainty can actually increase the tendency for practitioners to rely on representative heuristics when treating patients. Balsa and McGuire (2003) labeled this occurrence as an "uncertainty gap" whereby communication in race/ethnic discordant practitioner–patient relationships is characterized by uncertainty about the minority patient's needs and interests, ultimately producing differential treatment. Clinical uncertainty in

discordant relationships may also lead practitioners to rely on heuristics, such as their racial stereotypes, when making judgments about a patient likelihood to adhere to treatment (Balsa, Seiler, McGuire, & Bloche, 2003).

How might minority patients react to a practitioner who acts color blind? Recall that Norton et al. found that acting color blind leads to displays of anxiety and discomfort—in part because of cognitive depletion—and a complete avoidance of talking about race even when it is clearly relevant to the social context. Given evidence from research on aversive racism indicating that minorities' interpret behavioral displays of anxiety and discomfort as indicators of racial bias (Dovidio et al., 2002), patients of practitioners who "leak" their discomfort when trying to appear color blind might perceive these physicians to be biased. For patients, believing that their practitioner is biased might lead them to experience a host of negative relational outcomes (i.e., lower trust in the physician; Penner et al., 2010). As noted above, attempts at appearing color blind might lead practitioners to experience even more implicit bias—akin to a basic suppression effect—which would also negatively impact patients' perceptions of them, and their comfort level with being open regarding their symptoms and health behaviors. Indeed, physicians higher in implicit bias are less patient-centered, less warm, appear less engaged to outside observers, and are less sensitive to Black's pain.

In line with the negative impact of color blindness on practitioner behavior, minorities may also experience cognitive depletion when they interact with a color-blind practitioner. In situations that are ambiguous or provoke anxiety, such as during a medical visit, nonverbal communications become the primary means patients use to interpret the interaction (Mast, 2007). If the patient is unable to accurately interpret their color-blind practitioner's nonverbal cues, conflicting signals are sent and the communication process is disrupted, thereby inhibiting patient trust and limiting information exchange—essential elements of patient-centered care, which affect shared decision making (Edwards et al., 2016), and potentially, adherence.

One way in which minorities might be able to prevent practitioners from attempting to act color blind is to bring up race themselves. Apfelbaum, Sommers, and Norton (2008b) showed that minorities can set the stage for race-related conversation by bringing up race themselves—Whites whose minority partners first brought up race where more likely to then use race in a face identification task. Although this might be a successful strategy for breaking the barrier to talk about race, White practitioners need to be adequately prepared to discuss race and cultural associations with race in order for it to be effective. For example, if a minority patient mentions how his ethnic community perceives certain health behaviors negatively, or how certain culturally celebrated foods are advised against for diabetics like himself, the practitioner needs sufficient cultural competency to respond appropriately. Simply not being color blind is probably not enough, and as illustrated by criticisms of the cultural competency approach, having knowledge about different cultures but being ill-equipped to talk about race may inadvertently lead to the activation of racial stereotypes. Moreover, although creating contexts in which minorities feel comfortable discussing race may be an important first step in creating an environment in which race is on the table,

patients and physicians alike need to be informed that the burden should not fall on the patient to create a comfortable environment for physicians to discuss race.

In summary, attempts to appear color blind likely hinder a number of critical psychological and behavioral processes necessary for effective practitioner–patient interactions. Moreover, resistance to bringing up race or acknowledging its relevance to healthcare, particularly under conditions where it is not simply appropriate to do so, but necessary, will likely negatively affect the quality of care patients receive.

How Might a Multicultural Strategy Affect Practitioner–Patient Interactions?

Although White practitioners may be less inclined to adopt a multicultural than a color-blind strategy within racially discordant medical encounters, institutional-level changes in medical education, such as cultural competency training, encourage practitioners to do so by emphasizing the importance of race and culture in communication and health decision making. Here, we will highlight psychological and behavioral outcomes of a multicultural strategy that might also influence the success or failure of cultural competency approach.

To begin, it is important to consider the sociodemographic variables in people's environments that influence why they would adopt a multicultural strategy. For Whites who are motivated to be egalitarian, a shift in demographics in their communities might lead to changes in institutional policies regarding diversity and "diversity training" at the companies they work for and the schools they attend. Shifting demographics might also motivate individuals to understand the culture that their new neighbors, coworkers, teachers, and community members bring to their everyday living environments. However, demographic shifts that have occurred in the United States more broadly are not reflected in the racial and ethnic make-up of physicians in the United States. The percentage of physicians who identify as non-White remains low (approximately 6% identify as Black or African American, American Indian or Alaska Native, and Hispanic or Latino; Association of American Medical Colleges, 2006). Moreover, although the rates of non-White physicians are increasing, the rate of Black physicians has remained constant. For example, in medical oncology, African Americans will likely continue to be underrepresented, with only 4.0% of hematology/oncology fellows in the United States identifying as African American; similarly low percentages of African American physicians are found for hematology/oncology in internal medicine (4.0%), pediatric hematology/oncology (4.6%), and radiation oncology (4.2%).

For minority patients, their physician–patient interactions will predominantly be with non-Whites (about 80% of Black patients' medical interactions are racially discordant; Hamel et al., 2015; Laveist and Nuru-Jeter, 2002). How might racially homogeneity at the level of the practitioner influence practitioners' willingness or ability to adopt a multicultural approach? There is some research to suggest that in order for multicultural perspectives to be successful within hospitals, the body of medical students at the institutions where they learn medicine needs to also be racially and ethnically diverse. For example, White medical students who attend racial/ethnic diverse medical schools report being better prepared to care for diverse patients than those students that attend less diverse schools (Saha, Guiton,

Wimmers, & Wilkerson, 2008), and show less implicit racial bias (van Ryn et al., 2015). It is likely the case that exposure to different races and ethnicities among peers is imperative for practitioners to learn about and be confident in discussing race and ethnicity-related issues with their patients (Pettigrew & Tropp, 2006).

If practitioners do adopt a multicultural strategy within medical interactions, how might they and their patients be affected? As discussed in the review of the work of Vorauer, Gagnon, and Sasaki (2009), adopting a multicultural approach is associated with perspective taking and making positive other-oriented remarks. For practitioners, taking the perspective of the patient is a hallmark of patient-centered care (Ha, 2010). If adopting a multicultural approach or any other approach prompts practitioners to perspective-take, their level of understanding, empathy, and appreciation for the individual patient might be improved. For this process to occur, patients need to also actively participate in the interaction (i.e., by asking more questions, stating their concerns and opinions, and expressing their beliefs) as research has shown the physician's perception of minority patients' belief do not match their actual beliefs (Street & Haidet, 2011). When practitioners are able to engage in perspective-taking, patients may feel more understood and appreciated—two outcomes are related to physician empathy, which has been linked to increased patient satisfaction and adherence, particularly among Blacks (Blatt, LeLacheur, Galinsky, Simmens, & Greenberg, 2010; Kim, Kaplowitz, & Johnston, 2004).

Patients might receive further benefits when practitioners are willing to openly discuss race and cultural-related health beliefs in an effort to find solutions that are practical and feasible. Finding such solutions is particularly important when breaking bad news or discussing end-of-life care, where respecting patients' diverse cultural beliefs and preferences plays a large role (Crawley, Marshall, Lo, & Koenig, 2002). These findings, taken together with the finding that racial demographics of practitioners' medical schools can influence their ability to communicate with minorities, suggests that assessment should be done to gauge physicians' receptiveness and ability to act on multicultural approaches within dyadic interactions before they were implemented at the level of the medical institution. In addition, although social psychological research has focused on the role of race-related attitudes by looking at individual differences, it is also the case that institutions (i.e., hospitals) have belief systems that likely permeate dyadic interactions (i.e., "the hidden curriculum"). These "system level" beliefs should also be assessed before institutions encourage multicultural approaches among their practitioners. Together, these findings suggest that scholars need to adopt multilevel approaches to examine the interplay between institutional context and dyadic cross-race medical interactions.

It is also important to emphasize that although there has been some support in the basic social psychological literature for adopting a multicultural approach in dyadic encounters, much like the work on cultural competency training, there is very little empirical research documenting its success at an institutional level. As reviewed by Rosenthal and Levy (2010), there have been many applications of the multicultural approach within institutions, where the approach is operationalized as an attempt to provide knowledge and understanding of diverse groups; however, many of these programs have not been evaluated (see Rosenthal & Levy, 2010). Similar to the criticism of cultural competency training that teaching about

ethnic minorities highlights their “differentness” from Whites, critics of the multicultural approach also note that by emphasizing the distinctness of racial and ethnic groups (“important differences”), substantial differences and divisions exist between groups are maintained, even if differences are cast in a positive light (i.e., Bigler, 1999; Prashad, 2001). To our knowledge, there is no existing research on whether institutional-level implementations of multicultural approaches translate into successful dyadic interactions among members within those institutions. Within medical institutions, it would be critical to test whether information taught at the institutional level (i.e., cultural competency taught in a broad scale in classrooms in medical schools) translates to practical skills within dyadic interactions. From an educational perspective, it would ideal to have medical students learn how to adopt multicultural approaches in contexts in which they would actually use them—dyadic interactions with patients (Paluck, 2016).

Finally, when implementing any race-based approach in dyadic interactions, it is important to assess whether the practitioner and patient share an approach or are adopting different approaches. As reviewed by Dovidio, Gaertner, & Pearson (2016), one of the challenges for intergroup relations is that members of high status and low status groups typically prefer different approaches to handling race and discussing race in interpersonal interactions: Members of high status groups (i.e., Whites) typically prefer color blindness in interactions for minorities to assimilate to their culture; members of low status groups (i.e., Blacks) generally prefer multiculturalism and integration (as opposed to assimilation), in part because they have different motives within these interactions (Bergsieker, Shelton, & Richeson, 2010; Richeson & Shelton, 2007).

Within interactions, differences in these approaches to discussing and thinking about racial identity can produce negative intergroup outcomes, and there is some research to indicate that in some intergroup contexts (e.g., between immigrants and members of the “host society”), relationships are less strained when individuals from both groups converge in their approaches (Bourhis, Montreuil, Barrette, & Montaruli, 2009; Pfafferott & Brown, 2006; Plaut, Thomas, & Goren, 2009). Scholars have suggested that perhaps the best strategy to facilitating positive intergroup relations in which the two members of the dyad have opposing perspectives is to focus on a dual identity (or multiculturalism, so long as it does not threaten members of the majority group), as doing so can acknowledge and value group differences. By contrast, a mutual focus on color blindness may lead people to become blind to disparities in treatment (Saguy, Tausch, Dovidio, & Pratto, 2009). As empirical support for this idea, Vorauer, Gagnon, and Sasaki (2009) prompted both members of a cross-race dyad to adopt a corresponding ideology and found that a mutual focus on multiculturalism produced greater positive, other-directed behavior in the intergroup interactions than a mutual focus on color blindness. In medical institutions, it is important to assess what strategies patients and practitioners naturally gravitate toward; to the extent that both members of the dyad have the same strategy, they will likely experience better communication outcomes.

In summary, we have reviewed research on the factors that contribute to successful communication in practitioner–patient interactions, including how adopting a multicultural or color-blind strategy, particularly for practitioners, might affect these communication

processes. We take a pretty dim view of adopting a color-blind approach within medical encounters, and a less dim but cautious view of adopting a multicultural approach. In the last section, we highlight recommendations of how communication might be better understood within practitioner–patient interactions.

Policy Implications and Recommendations

In the final section of this article, we discuss the policy implications of the research reviewed in the prior sections. We also provide recommendations for how educational training and policy can be changed to improve racially discordant patient–provider interactions.

One consistent finding from our review is that implicit bias and color-blind strategies can be cognitively taxing, both for the person who is harboring negative implicit attitudes and/or is attempting to appear color blind, and this person's interaction partner. Studies in basic social psychology have documented cognitive depletion effects in the context of cross-race encounters. Within practitioner–patient encounters, increased cognitive load could inhibit a number of critical communication processes, such as the ability to attend to a partner's emotional cues and to accurately recall information that is shared in the encounter. We recommend that medical institutions become more aware of the effects that reduced cognitive resources can have on both patients and physicians, and work toward documenting factors that make patients and practitioners vulnerable to the effects of cognitive load. Such factors include high practitioner workload, greater clinic chaos, inadequate staffing time pressures, communicating with patients of limited English language proficiency, and feeling anxious or stressed (Burgess, 2009). Understanding the role of cognitive load is imperative for understanding critical health behaviors, such as adherence to prescribed treatments. If patients are unable to attend to or recall information related to their adherence regimen, even the most motivated patients will be unable to completely follow prescribed behaviors. For physicians who are cognitively taxed, medical decision making may be compromised. We recommend that policies should be in place to document when patients and physicians are most strongly cognitive affected, and to bring knowledge of the potential costs of reduced cognitive capacity during medical encounters to the forefront of medical education and training.

Another implication for policy is the critical role that nonverbal behavior plays in shaping racially discordant practitioner–patient interactions, including patient trust during the encounter, and adherence outside of it. Research using basic social psychological approaches has shown that nonverbal behaviors expressed automatically can override deliberative behaviors in shaping how people feel about their partners in interracial encounters, yet policy makers and educators have not directly addressed or sufficiently acknowledged the role that nonverbal behaviors play in helping or hindering communication during practitioner–patient interactions. Medical training institutions need to address the interactive effects of practitioner and patient nonverbal behaviors on medical encounters. For instance, in the practitioner–patient relationship, eye contact and touch has been shown to signal physician empathy, liking and connectedness (Montague, Chen, Xu, Chewning, & Barrett, 2013). Patients also use physician tone as an indicator as to whether or not they are interested in them (Marcinowicz, Konstantynowicz, & Godlewski, 2010). Educating

practitioners and patients about the importance of facilitating positive nonverbal patterns of behavior, such as actively engaging in eye contact, may go a long way in improving the quality of communication during medical encounters. Also, educating them about the deleterious effects of negative nonverbal behaviors, such as closed posture, increased physical distance, and eye contact avoidance may also go a long way toward developing a greater understanding the subtle ways in which bias is communicated in medical encounters.

Although making changes to the ways in which patients are educated about communication (and nonverbal behaviors, in particular) is critical, these changes should be met with increased efforts of researchers to more carefully elucidate the processes through which nonverbal behaviors affect racially discordant practitioner–patient relationships. These goals can be achieved through video-taping and evaluating medical interactions with a standardized coding system to identify the verbal and nonverbal behaviors predictive of a more collaborative practitioner–patient relationship (e.g., Albrecht et al., 2008; Eggly, Barton, Winckles, Penner, & Albrecht, 2015). Results of these trials can then help guide medical educators in devising cultural competency curricula that incorporates the principles of nonverbal behaviors into medical interviewing and communication skills training.

Improving policy also requires improving theoretical models of physician–patient communication. We want to make a call to scholars to develop richer theoretical models that link the processes of communication to outcomes as well as the broader contextual factors that may serve as mechanisms through which the quality of communication affects these outcomes (Street, 2013; Street, Makoul, Arora, & Epstein, 2009). Comprehensive conceptual models are needed to organize findings from diverse areas of research to guide hypothesis generation and testing. Such models would help to clarify inconsistencies in the literature as well as build evidence for understudied aspects of the practitioner–patient relationship (such as the intersection between implicit bias and nonverbal communication) that may have significant effects on the health of patients. Without these models, policy makers will be limited in the number of concrete suggestions that they can make to improving racially discordant physician–patient interactions.

In terms of practical steps moving forward, we have reviewed literature suggesting that simple cultural competency programs that incorporate hands-on experience with individuals from different cultures into the curriculum will likely be more effective at promoting communication than those that focus only on learning about individuals from those cultures in a classroom setting. Educators in medical training settings could couple hands-on experience with minority populations with motivational strategies that have been shown to promote positive interactions across the racial divide, such as the “dual identity” approach. Moreover, hands-on training that focuses on basic skills applicable to all medical encounters, such as “empathy training,” might work more effectively if practitioners are motivated to be empathic during these encounters and have some basic skills with discussing race and culture.

In summary, scholars need to develop clear theoretical models and consistent methodological approaches that aim to precisely measure nonverbal behaviors of both partners, and the cognitive processes that affect behaviors during these encounters. In the

interim, policy makers should focus on making physicians and educators more aware of the cognitive and behavioral processes that occur during medical encounters, as these processes can shape patient health outcomes.

Conclusions

In this article, we provided a theoretical and empirical overview of how adopting color-blind and multicultural strategies influence dyadic cross-race interactions. Although the majority of empirical work on these strategies has been conducted in social psychological laboratories, the basic psychological and behavioral processes affected by them are generalizable to the medical interaction setting. Not only do these strategies have the potential to affect the practitioner–patient interaction directly, they also have the potential to affect training at the institutional level. Institutions that emphasize the importance of cultural understanding and competency are well-suited to create programs that foster motivation to understand race-based differences and to teach the skills needed to effectively discuss race; however, much research is needed to develop programs that are effective at doing so. These programs should address potential backfiring effects of singling out minority groups and activating race-based stereotypes. Given that medical training alongside minorities may be important for non-Black practitioners to develop skills at discussing race, it is important to consider methods that would increase the inclusion of Blacks into medical fields. In going forward, we strongly encourage scholars to adopt dyadic approaches that fully incorporate the behaviors, cognitions, and perceptions of patients and practitioners during interpersonal interactions, and also consider features of the institutions in which these encounters take place.

Biographies

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