RACIST WHITE STEREOTYPES AND PHYSICIAN RACE: FACTORS INFLUENCING BLACK HEALTH
CARE RELATED RESPONSES

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ABSTRACT

The current research assesses whether Black anti-white bias (as measured by the Johnson-Lecci scale of anti-white bias) and/or physician race might influence Black participant health care related responses. The major results indicated that participants in the White physician condition reported less physician trust than those in the Black physician condition. Additionally, the results indicated that high bias participants reported less physician trust than low bias participants. However, these main effects were qualified by two interactions between bias level and physician race. Specifically, trust responses did not vary as a function of physician race for participants in the control and Black physician condition. Conversely, in the White physician condition, high bias participants reported less trust than low bias participants. Additionally, symptom severity threshold responses (i.e., the threshold for seeking medical assistance) did not vary as a function of bias level for participants in the control and Black physician condition. Conversely, in the White physician condition, high bias participants reported a higher severity threshold than low bias participants.

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DEDICATION

This thesis and more importantly all of my personal endeavors are dedicated to the people that

have sacrificed their lives to enrich mine; my father, mother and sister James, Myrtle and Janet

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INTRODUCTION

Despite the various advances toward equality that Blacks have made throughout the last one hundred years in various areas of life, numerous disparities still appear to exist between Blacks and Whites. The particular disparity most germane to the present research involves health related inequities in present day America that appear to be based on race (Ryn, 2002; Thomas & Quinn, 1991; Armstead, Lawler, Gorden, Cross, & Gibbons, 1989). Research has clearly indicated that Blacks are more likely than Whites to have undetected medical problems. More specifically, Logan & Freeman (2000) point out that although the overall health of Blacks has improved dramatically in the past one hundred years, it cannot be compared to the leaps and bounds Whites or the science of medicine have experienced in the similar time span. Even though the last one hundred years have brought about improved health care for Blacks, the distance has widened in the past ten years between Whites and Blacks with regards to health issues and how they are addressed (Nelson, 2002).

One of the most profound and observable medical facts is the difference in the number of years Blacks are expected to live, 70.2, compared to the life expectancy of Whites, which is 76.8 years (Nemecek, 1999). During the early 1900's Blacks were expected to live to their mid thirties, lagging behind their white counterparts by an average fifteen to twenty years (Cope & Hall, 1987). Death can be viewed as the most unbiased measure of health because of its evident nature. In conjunction with dying at an earlier age, Randall (1993) states that Blacks are also more likely to live their lives in a poorer state of health. Black males are expected to encounter death sooner than Black and White females and White males by no less than 6.2 years (Groves & Amuleru-Marshall, 1994).

Death tolls reveal that lung, prostate and bronchial cancer occurs more commonly in Black men than in White men (Johnson & Smith, 2002). Johnson and Smith (2002) also identify Black women as being more likely than White women to die of breast cancer primarily due to their choice or perhaps reluctance to seek early treatment or necessary precancer screenings. Taking into account that nationally cancer is responsible for twenty percent of deaths in the United States the toll numerically on the Black population is staggering (Bang, 1994). Survival rates of cancer patients also favor Whites by almost fifteen percent when compared to Blacks. While being treated for various forms of cancer, Whites, Warner (1999) discovered, are "treated more aggressively", despite not being as likely as Blacks to be diagnosed with this illnesses. Even a detrimental disease such as cancer kills Black men and women thirty-three percent more frequently than Whites (Shavers & Brown, 2002).

Twice as likely to suffer a stroke, Blacks in addition experience different types of hemorrhaging (subarachnoid, or intracerebral) more frequently than Whites (Groves & Amuleru-Marshall, 1994). One of the few reliable indicators that an individual may experience a stroke is hypertension (Groves & Amuleru-Marshall, 1994). Thirty-nine percent of Black adults experience incidence of hypertension, an occurrence that often leads to greater risk of physical disability by way of stroke or death sixty-percent more often than Whites (Whyte, 2000). The initial onset of hypertension Drizd, Dannenberg & Engel (1986) discovered occurs typically at an earlier age within the Black population as compared to Whites. Stress is often highly correlated with hypertension and has been identified as a contributing factor to its onset (Saunders & Williams, 1991).

Armstead, Lawler, Gorden, Cross & Gibbons (1989) found that even though possessing lower heart rates and leaner body mass which should physically ward off this ailment, the

majority of persons afflicted with hypertension are Black. Some researchers have suggested that the origins of overwhelmingly high rates of hypertension for Blacks might be due to their race and/or race-specific behaviors (racism, diet, socioeconomic status) (Bonham, 2001). In spite of becoming detectable earlier in the lives of Blacks, hypertension is more likely to become more severe for Blacks and consequently damage certain bodily organs (Hildreth & Saunders, 1992).

Reliance on medical procedures also seems to somehow place Blacks at a disadvantage. Lundberg (1991) found that Whites spend half of the time Blacks must wait to receive kidney transplants. The likelihood of being put on a waiting list to receive a kidney transplant and being informed about transplantation procedures and options is also lower for Blacks within the first eighteen months of dialysis treatment (Ryn, 2002). While waiting for transplantation Blacks are not treated for kidney disease as aggressively as Whites (Nelson, 2002). Although Whyte (2000) clearly states that kidney transplants may be affected by race because of the compatibility of the bodily organ due to race, it still does not fully account for the differences for this vital procedure.

Pain treatment, whether in emergency rooms, clinics or other medical settings is more readily and more extensively administered to Whites (Bonham, 2001). Comparing the frequency that analgesics are given in emergency room between Whites and Blacks, Bonham (2001) found that there was a seventeen percent greater chance Whites would be conceded analgesics. Blacks face a sixty-five percent greater chance of not receiving medication for pain (Mckeown, 2001). Even when White and Black patients demonstrate similar pain related complaints, Whites are treated more effectively (Bonham, 2001). A 1986 survey revealed that Blacks felt that the pain-relief-medication that there physician administered to them was either not effective or given sporadically and in inadequate doses (Blendon, Aiken, Freeman, & Corey, 1989).

The Role of the Physician-Patient Relationship and Black Attitudes/Behaviors

One factor related to racial health disparities involves the dynamic of the White physician-Black patient relationship. Collins et al., (2002) contend that Blacks want to have a physician-patient relationship that is similar to the bond they feel for a family member or close friend. Given that such a relationship may not occur with a White physician in part because of distrust on the part of the patient, Gillum & Gillum (1984) have noted that Blacks are very noncompliant with heeding therapeutic medical advice and disclosing details of their medical history. Similarly, Ridley (1984) found that Black patients are not willing to reveal all they can about their particular existing physical condition. Failure to disclose may be as Thompson et al., (1990) think a sign of the presence of "racism reaction" that Blacks have been identified as developing from their everyday experiences with racist behavior. Thompson et al., (1990) contend that Blacks learn to be suspicious of Whites in all situations and not trust their motives regardless of how beneficial they may appear to be. Mistrust may not have medical origins, but considering most medical doctors are White, mistrust that may have formed from other experiences could potentially be expanded to encompass medical encounters and possibly dictate health outcomes.

Evidence of miscommunication between Black patients and White physicians being a problem has been well documented. In fact, Sue & Sue (1977) contend that premature treatment termination can be attributed to the variations in methods of communication that exist between the two races. More specifically, the physicians may not understand the patients' inability to correctly express themselves and the patient may not realize that their knowledge about their condition is being relayed incompletely or inaccurately. Both parties have the power to unknowingly, singularly, or together predicate undesired health consequences. Some of the most compelling evidence concerning communication differences comes from Kirn (2002) who discovered that sixty-six percent of Whites, compared to sixty percent of Blacks understood the

prescription directions given to them by their doctors. When given explicitly, seventy percent of Blacks compared to eighty-two percent of Whites were able to comprehend instructions by their physician (Kirn, 2002).

Black health care attitudes, beliefs, and behaviors may also play a role in sustaining racial health care disparities. For example, there is significant evidence that Blacks have very strong negative attitudes involving being participants in medical research. The paucity of medical research involving Blacks has several adverse effects on the way they may receive medical treatment (Thompson et. al., 1990). Black based research is essential to discovering why certain medical conditions are more prevalent within the race than among other races. The dearth of Black-based research may lead Blacks to receive the inferior treatment that they wish to avoid by not making regular hospital visits.

The propensity of Blacks to avoid hospital visits may also contribute to the racial health gap. Various reasons have been proposed to explain the differing habits of Blacks and Whites concerning hospital visits. Shavers et al., (1997) found that Blacks are more likely to resort to religious alternatives and family support before they choose to seek medical attention for an ailment. The hierarchy Capers (1985) found that Blacks use to alleviate the presence of maladies was God, midwives, and thirdly physicians. God is also looked upon as a member of the support system Blacks employ especially the elderly when they seek to conquer illness and disease (Brashears, 2000). Other theories have discovered that Blacks have a different ways of perceiving what sorts of bodily pain or ailments are worthy of medical attention (Shavers, et al., 1997; Capers, 1985). Blacks were identified by Kressin, Clark, Whittle, East, Peterson, Chang, Rosen, Ren, Alley, Kroupa, Collins, & Petersen, (2002) as being very persistent in their belief

that making decisions with the guidance of God was more beneficial to guide their course of action regarding medical treatment than consulting a doctor.

There is also evidence that Blacks tend to engage in other types of health care related avoidance activities, in addition, to avoiding hospital visits. For example, Daniels, Jiles, Klevens, & Herrera (2001) found that numerous Black preschoolers are not receiving the necessary vaccinations that are required to attend school. Some Blacks report that avoiding school vaccinations is a practice that they learned from their parents and they intend to instill this type of behavior in their children as their parents did with them Daniels et al., (2001).

The Role of Racism and Black Cultural Mistrust

Another reason for racial health disparities involves Black cultural mistrust, which thereby minimizes the probability that they will seek health care. Cultural mistrust is defined by Terrell &Terrell (1980) as "the inclination of Blacks to distrust Whites". The most commonly recognizable avenues for cultural mistrust to be manifested are educational arenas, occupational settings, and through social interactions. Phelps, Taylor, and Gerard (2001) found that most of the research that has been performed in the United States concerning mistrust shows that Blacks are very likely to be suspicious of the motives and actions of whites.

One of the major that reasons Blacks may exhibit cultural mistrust of the health care system involves the Tuskegee Syphilis Experiment (TSE) which has been described as the, "the longest non-therapeutic study in medical history" (Gamble 1993; Freimuth, Quinn, Thomas, Cole, Zook, & Duncan 2001). The TSE involved several hundred Black men who unknowingly were denied treatment of syphilis in 1932. Because of the covert nature of the TSE, which was conducted in Macon County, Alabama, many Blacks feel that by visiting a physician they may unknowingly become part of a medical experiment (Freimuth et al., 2001). This type of

apprehension may be one of the reasons that the rates of Black medical research participation are not representative of the Black population and their medical needs.

Usage of the term cultural mistrust has been in the past synonymous with "healthy cultural paranoia" (Grier & Cobbs, 1968; Ridley, 1984; Thompson et al., 1990). Several pertinent distinctions however between the two terms have led to a clear and concise separation of the two once interchangeable phrases. Healthy cultural paranoia, Thompson et al., (1990) feel describes the apprehension and suspiciousness that some Blacks develop as a result of ongoing exposure to an environment that they do not trust. Grier & Cobb (1968) argued that healthy cultural paranoia has its inception from actually experiencing racist behavior, while cultural mistrust addresses the fear or the threat of being discriminated against. Interestingly, Black patients have reported that the care that they receive in hospitals is in their opinion inferior to the kind of treatment they think Whites receive (Blendon, Aiken, & Freeman, 1989). Blacks have also been identified by Malat (2001) as having a lower level of satisfaction with the quality of medical treatment they receive compared to that which Whites receive. One of the major purposes of the present study is to assess how Blacks' beliefs or schemas associated with Whites might influence their health care related beliefs and the subjective likelihood of seeking health care treatment.

The Impact of Schemas

Previous research on the impact of schemas provides theoretical leverage to the contention that the health care perceptions and/or behaviors of Blacks could be influenced by their previously held beliefs regarding Whites. Schemas represent knowledge or beliefs about events, people, and other human phenomena, which enable a person to draw conclusions and remember information. A schema has the ability to guide a person through unfamiliar and ambiguous situations so that

they can make sense of what has happened and store it for future cognitive examination. With the use of schemas the world as we perceive it is a much less confusing place because information that may not readily fit into a specific category is schematically categorized, therefore forming an associative network of ideas and experiences. Fiske & Taylor (1991) identify the purpose of schema formation as being to primarily guide and support understanding of behavior in a very general way across many different situational instances. Schemas allow clustering of information instead of individual processing which can reduce the time needed to mentally process information. Schema formation (Fiske & Taylor, 1991) occurs when a person encounters direct or abstract forms of particular experiences and generalizes the experiences in a way that simplifies them.

Memory function, theorist have proposed, is heavily dependent on schemas due to the nature of schema development, maintenance, and usage. The ability to recall information can be restricted or enhanced depending on the relevance of a schema. Hastie (1981) found when people encountered information that was consistent with previously formed schemas this particular information was more readily remembered and the opposite was discovered when schema-inconsistent information was available, although there are instances where this theory does not hold true (Fiske & Taylor, 1991; Marshall, 1995).

With scientific theory pointing to the assertion that schemas assist with mental processing of new information, the link between memory and schemas is twofold (Marshall, 1995). Schemas not only store information within memory they also systematize information held in memory (Fiske & Taylor, 1991). Schematic models represent the necessary knowledge required to correctly or incorrectly lead us to conclusions of events and behaviors that can be expected to occur (Kintsch, 1977). Schemas that are notably weak or still in the process of being developed

are more susceptible to being altered by information that is inconsistent, while strong stable schemas are upheld with little interference from contrary facts (Fiske & Taylor, 1991). In addition to taking more time than schema-consistent information to process, information that is inconsistent also is less likely to be recalled when the perceiver tries to recall details about an event (Fiske & Taylor, 1991).

Numerous different types of schemas have been identified (event, role, person, and content-free schemas) and to varying degrees depending on the particular situation are responsible for having influence on memory. The strongest schemas are ones that are present from the outset at initial encoding (Fiske & Taylor, 1991). The notable characteristics of a strong schema are its resistance to inconsistent contrary, disconfirming evidence. A weak schema has the potential to become a more dominant one if consistent information is added to it thereby transforming it into a more readily useful schema that will also be more resistant to incongruent information. Therefore a strong schema will have a more profound impact on memory than one that has just formed and is weak. This point explains why when encountering new situations people are subject to revert back to previously formed cognitive structures instead of employing newly acquired facts to asses the current situation.

The theory of a dominant schema or set of schemas possessing sole control over behavior is not the only route behavior originates. Various schemas, primarily relevant schemas, are influential in constructing memory. Along with memory-consistent details, ingroup and negative-outgroup information is more likely to be recalled. Categorizing people can consequently bias judgments depending on if salient features (race, gender, age etc.) can place them in either an ingroup or outgroup category.

One of the more relevant issues concerning schemas and memory encompasses the degree to which a person behaves in accordance to the particular schematic models they posses. Each schema is person-specific, making subsequent behavior subject to personal interpretation about the proper course of action that should be taken. Although a specific schema may be influential on behavior the associative nature of schemas means that a single action may be brought about by numerous interrelated schemas, which guide a specific behavior.

The Johnson-Lecci Scale

Extensive research in the past has focused on the impact of White beliefs or schemas of Blacks on various judgmental responses and behaviors (Whaley, 2001), but a clear shortcoming of the literature involves the minimal focus on Black's beliefs regarding Whites. One way to address many of the criticisms of intergroup research and to increase our understanding of the psychology of minorities is to directly examine the views of Black respondents. These sentiments have been voiced by a number of individuals. For example, Graham (1992) contends that modern day social concerns demand increased attention to the psychological functioning of Black Americans, particularly since less than 4% of current research in major psychological journals involves Black participants and these figures appear to be on the decline. Moreover, Judd, Park, Ryan, and Krause (1995) have noted that one major limitation of the stereotyping literature is that "very rarely have the views of ethnic minorities been assessed or documented" (Readier, Capaldi, Paris, Polivy, & Herman, 1996). They further state that racial tension is a complex problem that requires a complete understanding of both groups' perspectives (see also Devine, 1995).

Due to lack of empirical focus on the minority group perspectives in intergroup processes, Brigham (1994) published the first scale to assess Black racial attitudes toward

Whites. Items were largely drawn from previously published White attitude scales (with racial designations reversed) and augmented with items generated from round table discussions among biracial panels. Although this initial empirical analysis was an important contribution to the literature, ideally, the study of anti-White attitudes held among Blacks would involve the use of Black respondents to generate an original pool of items that reflects their everyday experience of anti-White attitudes, rather than borrowing items from anti-Black racial attitude measures. The co-opting of items largely developed to evaluate anti-Black attitudes held among Whites is problematic, as there may be meaningful differences between the anti-Black attitudes held among Whites, and the anti-White attitudes held among Blacks (i.e., the reversal of racial designations may be an inadequate solution; see also Brigham, 1994). Indeed, social scientists otherwise run the risk of drawing premature conclusions regarding the intergroup generalizability of various psychological processes and principles (Sue, 1999).

In an effort to provide a more meaningful assessment of Black racial attitudes towards Whites, Johnson and Lecci (2002) developed a four-factor scale that directly measured Black anti-White bias. The Johnson-Lecci Scale (JLS) was generated from the everyday experiences of Black respondents using an act-frequency approach, and the scale configuration was derived using factor analysis. The factor structure was shown to be robust, as it was cross-validated in an independent sample. The resulting JLS factors (subscales) were: Ingroup directed stigmatization and discriminatory expectations, Outgroup directed negative beliefs, Negative views toward ingroup-outgroup relations and Negative verbal expression towards the outgroup. The subscales of the JLS were shown to predict the perceptions of discrimination in ambiguously racist scenarios (i.e., perceived racism) and converged with peer evaluations of the participants' anti-white attitudes.

The Present Study

Participants from a historically Black university were informed that they would be participating in two separate studies. The first study, entitled "group dynamics" ostensibly involve measuring the participants' perceptions of various groups. Participants will complete items from one factor of the Johnson-Lecci scale (which assesses the extent of Black anti-White bias) and a median split was performed to determine those in the high bias and low bias conditions. In the second study entitled "decision-making processes", participants were asked to imagine that they have to seek health care at an HMO with White, Black, or race unspecified physicians. Thus, the design is a 2(Bias Level-High, Low) x 3(Physician Race-Black, White, race unspecified) factorial. Subsequently, participants answered questions that assess physician trust, expected health outcomes, and the level of symptom severity necessary for seeking health care (i.e., threshold of symptom severity).

HYPOTHESES

Hypothesis One (Bias Level) High bias participants were expected to report less physician trust, expect poorer health outcomes, and have a higher symptom threshold for seeking treatment than low bias participants.

Hypothesis Two (Physician Race) When compared to participants in the Black physician and control conditions, those in the White physician condition were expected to report less physician trust, expect poorer health outcome, and have a higher symptom threshold for seeking treatment.

Hypothesis Three (Bias Level x Physician Race Interaction) Responses should not vary as a function of bias level for those in Black physician condition. In the control and White physician condition, high bias participants were expected to report less physician trust, expect

poorer health outcome, and have a higher symptom threshold for seeking treatment than low bias participants.

METHOD

Participants

All participants were Black introductory psychology students attending a predominantly Black university located in the southern part of Georgia. Participants fulfilled a portion of their psychology research requirements by participating in this research project. Participation for both portions of this project was strictly voluntary. All of the participants were informed that they would be participating in two different portions of the research project concurrently.

Procedure

Study one (Group Dynamics study). Participants were informed that the purpose of the study was to focus on processes associated with "group dynamics". A Black experimenter distributed the booklets containing the "Group Dynamics" questionnaire. A portion of the instructions given was as follows:

"At any given time in America, there are hundreds of people who must live and work together despite obvious differences. Consequently, intergroup relations are important. We have planned a series of studies on many of the groups (e.g., the blind, homeless). Our focus today will be on three distinct groups, lawyers, environmentalist, and Whites. You will be asked questions that will assess your general attitudes of these groups."

Participants then responded to 60 items regarding the three various groups. Twenty of the items focused on lawyers (e.g. Most lawyers are untrustworthy) and twenty concerned environmentalist (I feel that environmentalist do not make a significant difference in the way people view the environment). Participants also answered twenty questions (intermingled among the forty questions) from the Ingroup Stigmatization and Discriminatory Expectation factor of the Johnson-Lecci Scale (see Johnson & Lecci, 2003). A 4 point scale, (1- strongly disagree, 2-

disagree, 3-agree, 4- strongly agree), was utilized to measure responses on all items in this portion of the experiment. Some examples of the items are: a) I believe that most Whites would love to return to a time in which Blacks had no civil rights; b) I believe that most Whites really do support the ideas and thoughts of racist political groups; and c) I believe that most Whites really believe Blacks are genetically inferior. Each subject's mean score on the JLS was assessed by using a median split for the purpose of separating subjects into either a *high bias* or *low bias* category.

Study Two (Decision Making Processes) Once all participants had completed the first portion of the experiment, testing booklets were collected, and experimental participation slips were distributed and the first experimenter exited the room. A different Black experimenter entered the testing area and passed out booklets labeled "Decision Making Processes". An excerpt is given below:

> "Many decisions in life have lifelong implications. (e.g. Do I stay in a relationship with my boyfriend or should I end the relationship?) The current portion of this research project is intended to examine your decision-making processes through presenting three different situations. You will read three passages involving decisions that cover a broad span of the choices that reflect situations that we must make during our life."

Each participant was unknowingly randomly assigned to either a (Black physician, White physician, or Control) experimental condition. Two passages were presented during the second phase of the experiment. The first of two passages, irrelevant to the study, involved realistic situations that asked participants to make judgments about the course of action that should be taken. The first passage involved a dating scenario (I.e., leaving a boyfriend/girlfriend). After reading the passage the participants gave their opinions on several statements using a scale spanning from (1- strongly disagree to 5-strongly agree). All answers for the filler passages were discarded.

The experimental passage, which was labeled "health care choices", concerned the issue of health care seeking behavior and related attitudes. Participants were initially asked questions on a five-point scale (1-strongly disagree, 5-strongly agree) that assessed their general health care attitudes (e.g., "Personal health care is extremely important to me"). The participants were then asked to imagine they worked in a company that offered an HMO that provided free health care coverage if they chose to visit one of the company's approved health care providers for medical care. They were given a brief description of an all White, all Black, or race unspecified "approved health care group" of eight physicians. The experimental design for the experimental passage was a 2 (Bias Level- High Bias, Low Bias) x 3 (Physician Race- White, Black, Control).

Expected health care outcomes. Participants were asked, "What sort of health outcomes would you expect after visiting these physicians?" (1-extremely negative, 7-extremely positive).

Threshold of symptom severity. Participants were asked, "Assume that you had symptoms of some type of health problem. How severe would the symptoms have to be for you to seek care from this HMO"? (1-not severe at all, 7-extremely severe).

Physician Trust. Items from this scale were adopted from the Wake Forest Physician Trust Scale (Hall et al., 2002). Participants responded on a five-point scale (1-strongly disagree, 5-strongly agree) to two sets of items. The items measuring competence included: a) The physicians will be as good as they should be; and b) The physicians will be extremely thorough and careful. The items measuring global trust included: a) I will completely trust the physicians' decisions about which medical treatment are best for me; b) The physicians will think about what is best for me; c) I have no worries about putting my life in the physicians' hands; and d) All in all, I completely trust my physician. The competence and global trust items will be average to create a competence score and a global trust score.

A 2(bias level-high, low) x 3(physician race-Black, White, and race unspecified-control) ANOVA was performed on expected health outcomes, threshold of symptom severity, and both physician trust averaged scores.

RESULTS

General Health Related Responses. Graph 1 indicates, that there was no main effect of bias level F (1, 106) = .05, p > .25, physician race F (2, 106) = 1.45, p > .25, or the interaction between bias level and physician race F (2, 106) = .35, p > .25, for health importance scores. Similarly, there was also no main effect of bias level, physician race, or the interaction between bias level and physician race for health thoughts.

Health Outcome Related Responses. As shown on Graph 2 there was not a main effect of expected health outcomes as a function of bias level, F (1, 106) = .015, p > .25. However, the effect of physician race on expected health outcomes did reach significance F (2, 106) =7.81, p = .001. Participants in the control conditions (M = 4.95) expected less positive health outcomes than those in the Black physician (M =6.05) and White physician (M = 5.66) conditions. The interaction between bias level and physician race on expected health outcomes did not reach significance, F (1, 106) = .08, p > .25. There was no main effect of bias level F (1, 106) = .01, p > .25, physician race, F (2, 106) = .09, p > .25 or the interaction between bias level and physician race F (2, 106) = .72, p > .25 for health importance scores

Symptom Severity Threshold (Behavioral Intention Related Response). Graph 3 indicates the influence of bias level, F (1,106) = 1.73, p > .25 or physician race F(2,106) =2.06, p > .25 on symptom severity threshold reached significance. However, there was a significant interaction between bias level and physician race, F (2,106) =3.26, p < .05. Responses did not vary as a function of physician race for participants in the control and Black physician condition.

Conversely, in the White physician condition, high bias participants reported a higher severity threshold for seeking health care than low bias participants.

Physician Competence (Stereotype Unrelated Response). As expected, Graph 4 indicates that there was no main effect of bias level $\underline{F}$ (1, 106) = .79, $\underline{p}$ > .25, physician race $\underline{F}$ (2, 106) = .38, $\underline{p}$ > .25, or the interaction between bias level and physician race $\underline{F}$ (2, 106) = .95, $\underline{p}$ > .25 for physician competence scores.

Physician Trust (Stereotype Related Response). Graph 5 indicates that high bias participants ($\underline{M}$ = 2.86) reported less physician trust than low bias participants ($\underline{M}$ = 3.22), $\underline{F}$ (1, 106) = 5.25, $\underline{p}$ < .05. In addition, participants in the White physician condition ($\underline{M}$ = 2.56) reported less physician trust than those in the control ($\underline{M}$ = 3.04) or Black physician trust ($\underline{M}$ = 3.45) conditions, $\underline{F}$ (2, 106) = 8.45, $\underline{p}$ < .001.

Of central importance to the present study, the results indicated that the interaction between bias level and physician race did reach significance, $\underline{F}$ (2, 106) = 4.13, $\underline{p}$ < .001. Responses did not vary as a function of physician race for participants in the control and Black physician condition. Conversely, in the White physician condition, high bias participants reported less trust than low bias participants.

DISCUSSION

The present study indicated that a number of factors could influence the health related responses of minority participants. The major results indicated that the influence of physician race and bias level had minimal influence on responses that were not related to the stereotype of White racism such as health importance and physician competence. However, these factors did seem to influence responses that were more closely related to variables associated with the stereotype. To amplify, participants in the White physician condition reported less physician trust

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than those in the Black physician condition. Additionally, the results indicated that high bias participants reported less physician trust than low bias participants. However, these main effects were qualified by two interactions between bias level and physician race. Specifically, symptom severity responses did not vary as a function of bias level for participants in the control and Black physician condition. Conversely, in the White physician condition, high bias participants reported a higher severity threshold for seeking health care than low bias participants. Additionally, trust responses did not vary as a function of physician race for participants in the control and Black physician condition. Conversely, in the White physician condition, high bias participants reported less trust than low bias participants. Implications of Intergroup Research

The present findings extend the previous literature focused on the role of bias level on intergroup responses. The majority of the previous research has focused on the consequences of variations in White participant biases towards Blacks. This research often indicated that Whites holding higher levels of bias tend to hold more negative cognitions toward Blacks than Whites that have lower levels of anti-Black bias. For example, Devine (1989) demonstrated that high bias Whites demonstrated an increased level of hostility toward Blacks after being primed by adjectives that stereotypically described Blacks compared to less extreme feelings about Blacks possessed by low bias Whites after similar subsequent priming. It has also been empirically demonstrated that low prejudiced Whites are more likely than high bias Whites to behave inconsistently with their personal views toward Blacks (Devine, Monteith & Zuwerink, 1993, study 1, Devine & Monteith, 1993, study 3). More specifically, a low bias White person, even though possessing negative feelings toward Blacks will be less likely to behave in a congruent manner, while high bias Whites will usually behave in the same prejudiced manner toward Black in which they process information concerning Blacks.

Additional empirical findings demonstrate that highly biased Whites do not feel any discomfort concerning the way they mistreat Blacks because such behavior matches their feelings and therefore the connection reinforces the bond between attitudes and behavior that Blacks are inferior without the interference of guilt or shame on their conscience (Devine, Monteith, Zuwerink, & Elliot, 1991, study 1). This seems to suggest that low bias individuals feel compelled to behave in a converse manner when confronted with negative Black stereotypes. A phenomena that scientist have recognized by studying levels of bias is that high bias Whites are aware of and endorse negative stereotypes concerning Blacks but feel very little internal conflict about their subsequent behavior (Lepore & Brown, 1997).

Health Care Related Implications

Insufficient insurance, rural residency, and medical mistrust are some of the more prominent reasons that scientist theorize that Blacks receive the quality of treatment that leads to health disparities (Bach, Cramer, Warren, Begg, 1999). In an attempt to resolve these and additional issues health disparity research has become prominent. Among the most prominent of these areas of study has been a direct focus on the amount of physician trust Blacks possess. According to Levy (1995) it should not be surprising Black patients have more confidence in the abilities and feel more comfortable with physicians of a similar race. The patient-physician relationship dictates a plethora of other aspects of a health care scenario (i.e., compliance, communication, etc.). Rundall (2000) assures that remedies to better patient-physician trust relationships may be a key to actually ending other health care disparities that are not blanketed directly by the caregiver-medical recipient relationship.

Literature documenting health disparities is plentiful. These disparities span across a variety of medical instances that include accelerated incidence of a variety of ailments in addition to not being administered the same types of physician care (e.g., medical test, therapeutic treatment,

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etc.) (Weiss, 1998). The present study extends the existing body of work by demonstrating that variation in Black anti-White bias can have a direct influence on health related responses. Past research concerning health disparities facing Blacks has not involved any efforts to address the consequences of variation in Black attitudes towards Whites. The present study employed a measure of anti-White bias to determine if bias level would play a role in determining if there was a difference between perception of stereotype relevant and stereotype irrelevant dimensions in the context of health care decisions.

The implications of the research method and its results have a great impact on not just individuals interested in the psychological issues addressed but also the realm of health care. The present methodology is composed of several key features that make it distinct from other studies in the past that have attempted to measure the attitudes and expectations of Blacks concerning their interactions with Whites and the medical system. Measuring anti-White attitudes means that future research can focus on making concerted efforts to understand why some Black patients may be more suspicious of their doctors than others. This type of research can be beneficial to physicians who may be unaware that these attitudes subsist, and the broader medical community that seems satisfied to just identify and not make attempts to alleviate the problem of health disparities. The results and the issues they raise should be used as a justification for similar research to be performed that not just acknowledge health disparities between Blacks and Whites but delves deeper into this issue by empirically examining facets of these disparities that uncover why they exist and potentially offer solutions.

Findings revealed and issues brought up by this research project should no just be heeded by Blacks or medical researchers. White physicians should be aware that their Black patients might be judging them on more than just their performance as medical professionals. Hence, a

concerted, purposeful effort should be made by White physicians to not just treat their Black

patients but to provide them with the same care they give to their White patients while keeping in

mind that historical components concerning race may be guiding the actions and the thoughts of

their Black patients. Although cultural barriers may exist between Black patients and Whites

physicians (socioeconomic, differences is verbal expression, etc.) Kajubi (1999) believes that

these issues do not carry the weight that a physician's displays of sympathetic and compassionate

manner of behavior toward their patients can.

Limitations and Future Research

The average age of participants in the described study was 21 years of age. It may be

questioned as to exactly how much prior medical/health exposure these students may have had.

The reason this is important is because an absence of knowledge about medical etiquette would

likely prompt participants to revert to other, more familiar aspects of the situation to make

judgments. It may be the case that all though using participants who are older would likely mean

that they have more past experiences to draw from concerning medical care and their schemas of

Whites will also be much stronger. So essentially the findings presented using a college

participant pool may not differ as a function of age and in fact it may be hypothesized that a

more profound effect may be obtained for the individuals in the high bias Black condition due to

their expectedly more extensive history with not just medical experiences but with Whites as

well.

Perhaps using an older population would also allow for researchers to investigate how

older Blacks who have children may feel toward being presented with a similar scenario as the

one used in the second experimental section of this study and how they may or may not alter

their attitudes toward White physicians when the health of their children and not their own was

the critical issue. The reason this is important is because just as other personal habits and beliefs are passed along from parents to their children, attitudes about health care can also be taught. Evidence of this is the TSE and how Black adults have relayed the details of this tragedy to younger generations. Many researchers believe that this is why many Blacks feel that the HIV/AIDS epidemic is viewed as a governmental form of genocide created to primarily plague the Black race because Blacks have learned that their health and ultimately their lives can be compromised by the medical system. Beliefs such as this are a primary example of why the health of a whole generation of Blacks may be at stake.

The second portion of the described experiment offered just one experimental passage with several questions addressing several areas. It would be advantageous to expand this experimental section in order to test how robust the current findings are using more questions for the same major areas of interest used (physician trust, physician competence, symptom severity, and health related outcomes) and using different aspects of the patient/physician interaction such as patient compliance, and likelihood to return for treatment if it is needed to measure if physician race can be used to predict attitudes of Blacks who are either high or low bias individuals. Expanding the experimental section could also serve to perhaps identify which aspects of a medical encounter are more pertinent to individuals who are designated as being high bias Blacks which in turn could assist physicians in addressing these issues.

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Figure 1

Health Importance
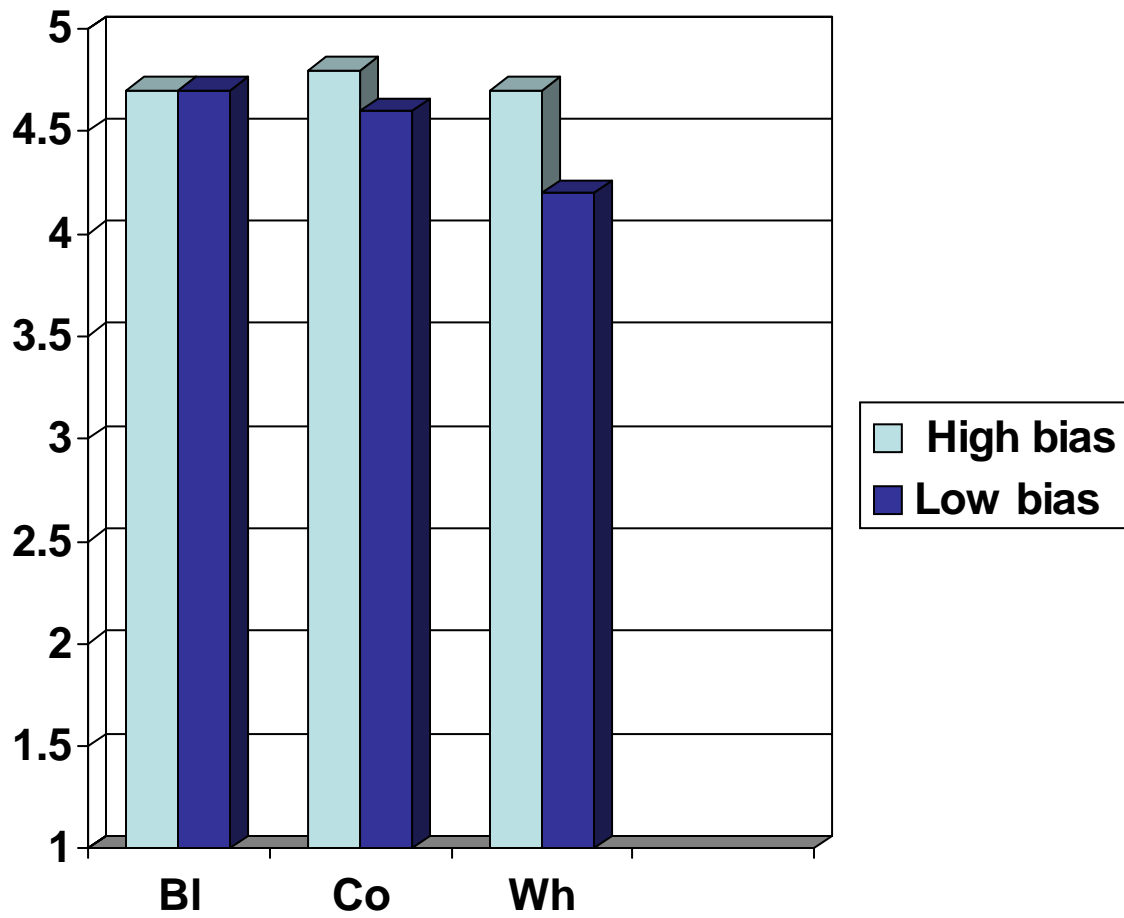
Note: Greater scores denote greater health importance

(1 – strongly disagree, 5 – strongly agree)

Figure 2

Health Outcome
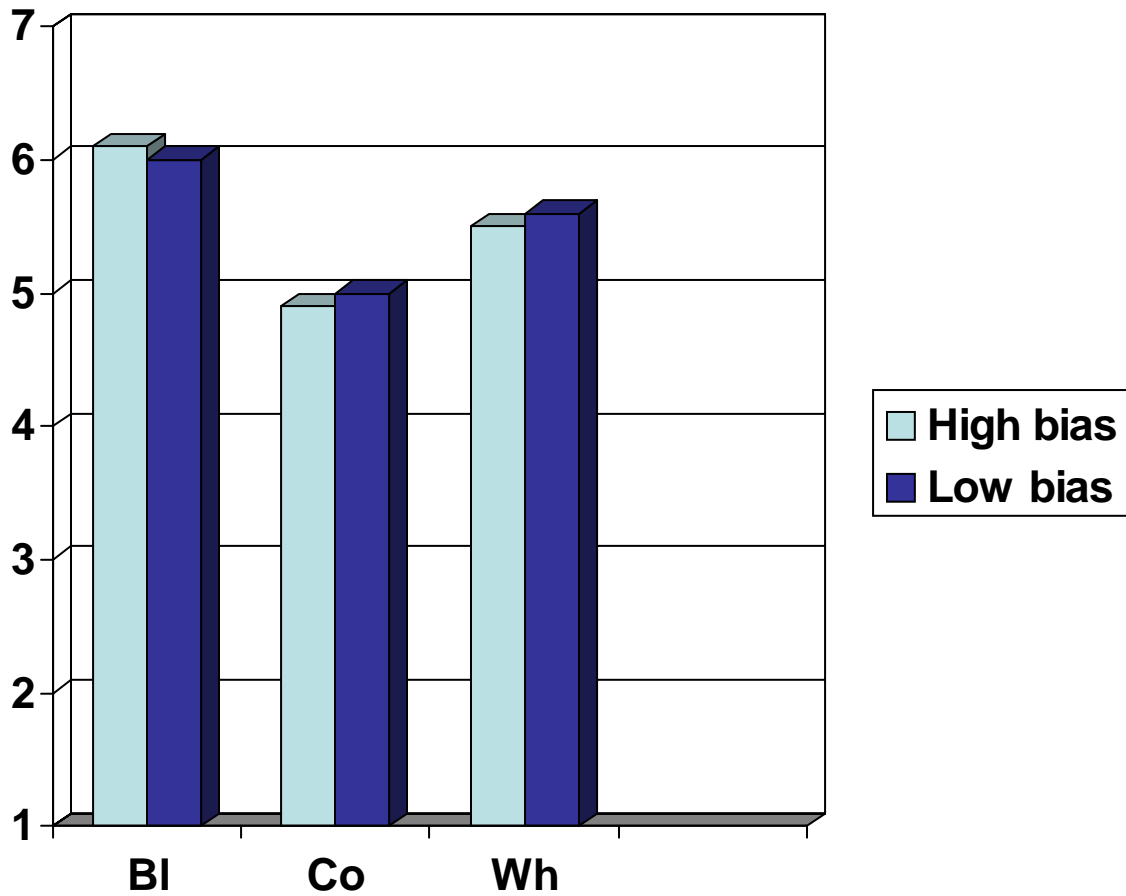
Note: Greater scores denote better-expected health outcomes

(1- extremely negative, 7 – extremely positive)

Figure 3

Symptom Severity Threshold
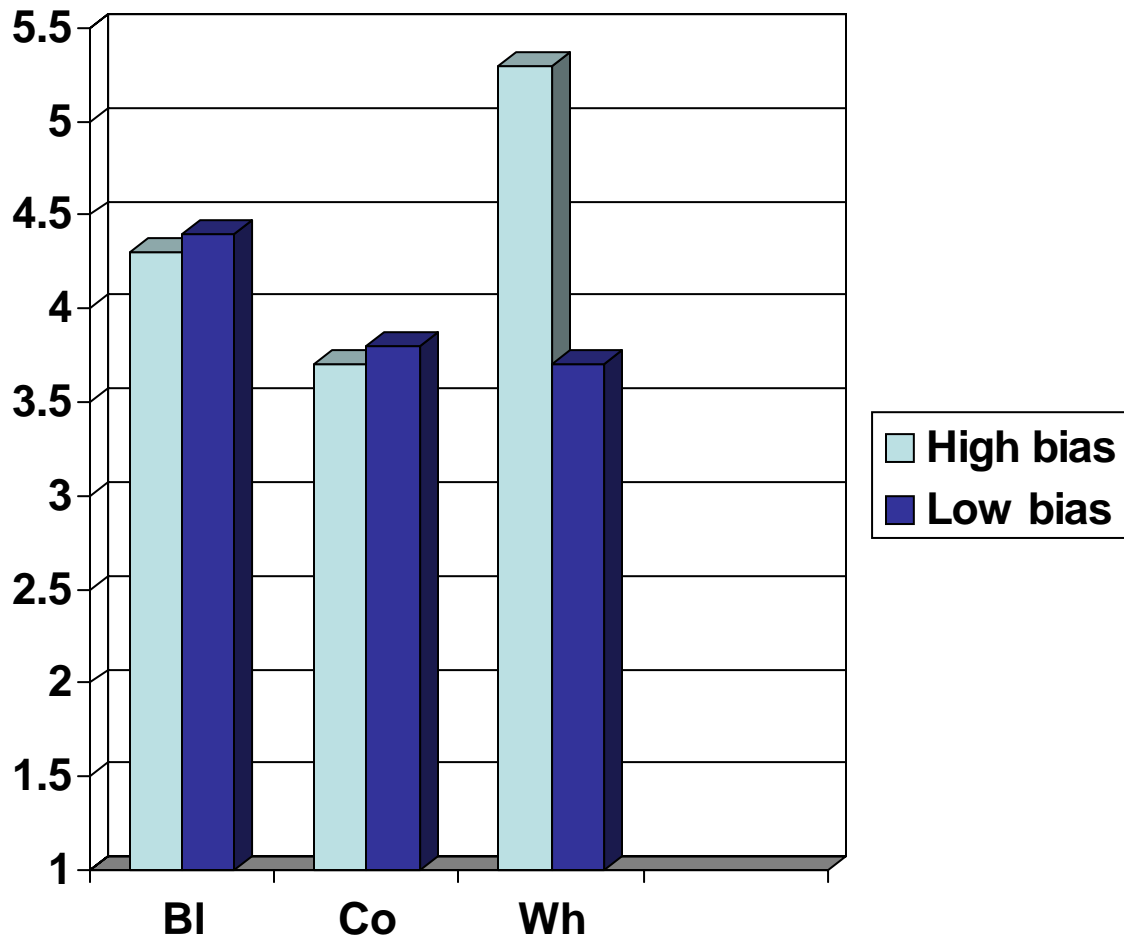
Note: Greater scores denote greater symptom severity

(1 – not severe at all, 7 – extremely severe)

Figure 4

Physician Competence
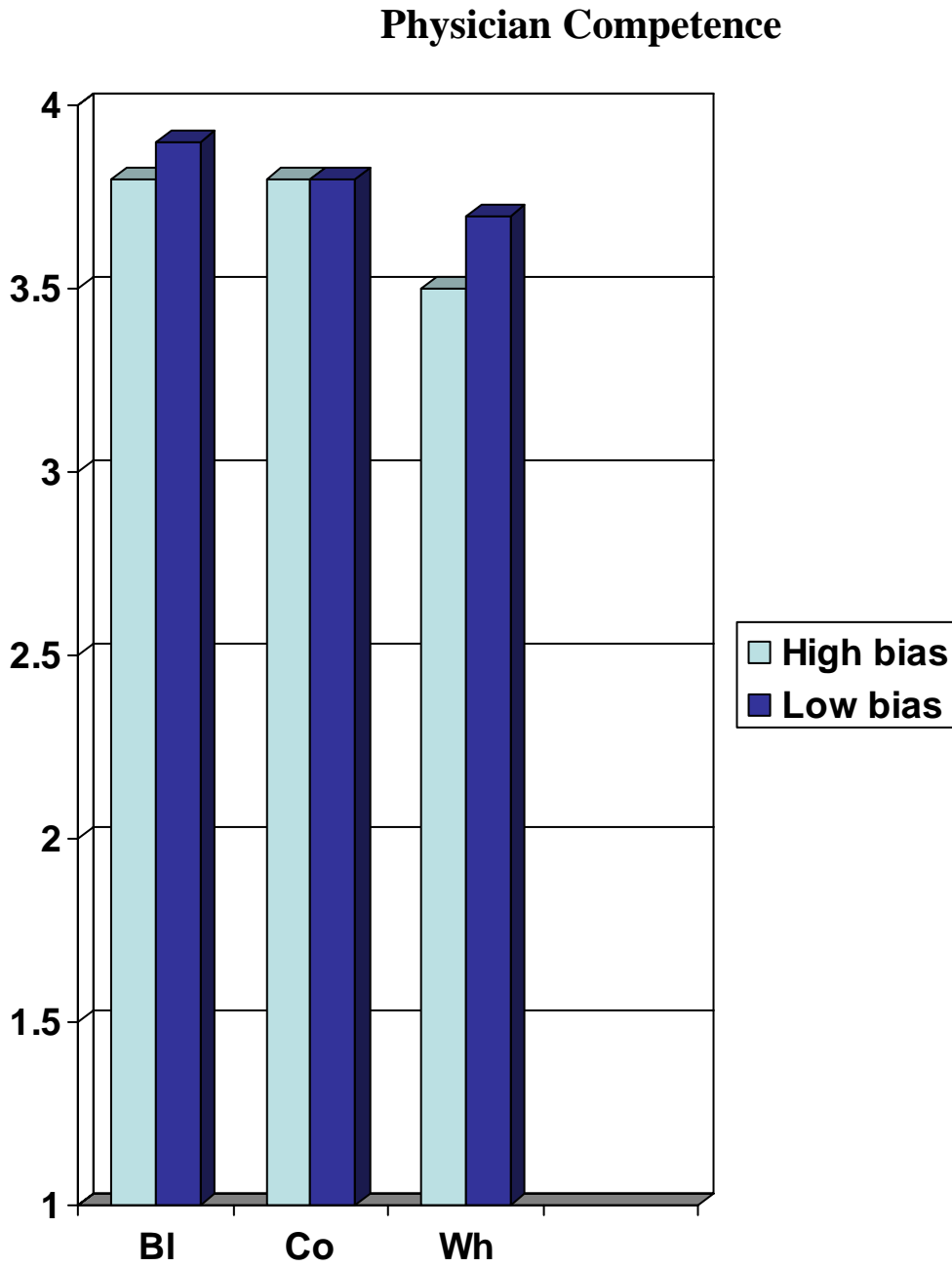
Note: Greater scores denote greater perceived competence

(1 – physician will not be very competent, 7 - physician will be very competent)

Figure 5

Physician Global Trust
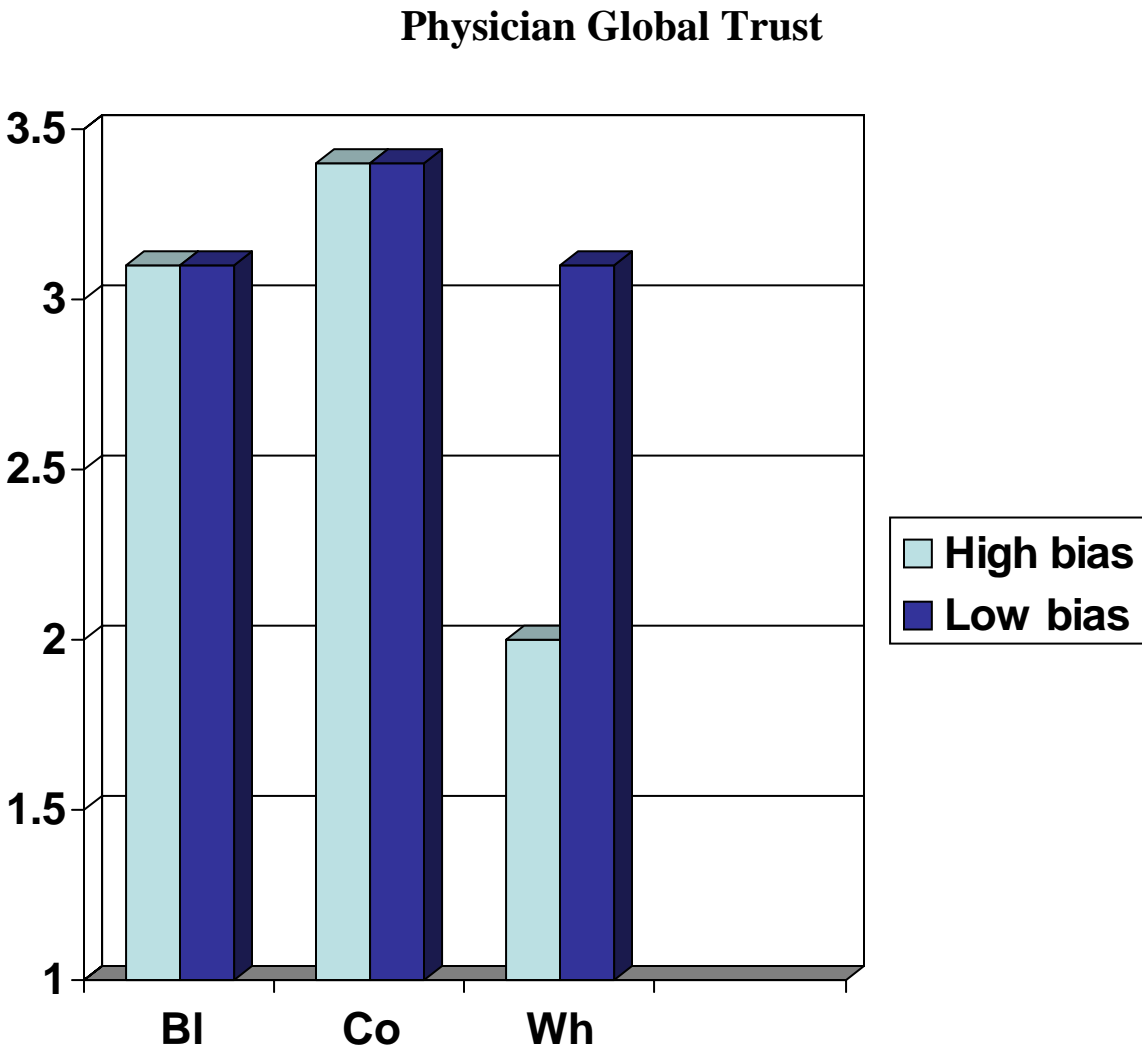
Note: Greater scores denote greater trust

(1 – strongly disagree, 5 – strongly agree)

APPENDIX

Appendix A. Group Dynamics Packet

GROUP DYNAMICS

QUESTIONAIRE

AGE:_____

Last four digits of social security number_____

Group Dynamics Questionnaire

At any given time in America, there are hundreds of different groups who must live, work, play and learn together (i.e., men, women, foreigners, obese, slim, tall, short, Blacks, Whites, Hispanics, etc.). These groups can and do come from varied backgrounds and cultures. Consequently, intergroup relations are a major area of interest for social scientist, policy makers, and the general public. We are interested in better understanding the factors that underlie people's feelings toward other groups. We have planned a series of studies to focus on various groups and their relations to each other. Our focus is this particular study intends to measure your personal feelings toward several different groups.
Please rate your agreement with the following statements with regard to how you generally think, feel, and/ or act.

PLEASE CONTINUE YOUR RESPONSES ON THE BLUE COMPUTER FORM
a = strongly agree
 b = agree
c =disagree
d = strongly disagree

1. I believe that whites smell.

2. I believe environmentalists are not concerned with the "greenhouse effect".

3. I believe environmentalists often exaggerate environmental conditions.

4. I have referred to whites as "crackers".

5. I believe being a lawyer is an honorable profession.

6. I believe that lawyers usually ac in the best interests of the individuals they are
    hired to defend.

7. I believe that most of the negative actions of whites towards blacks are due to racist
    feelings.

8. I believe environmentalists should do more to preserve urban areas.

9. I have made racial comments.

10. I believe a lawyer will defend a person that they know is guilty.

11. Most environmentalists are "hippies".

12. I have made negative comments about lawyers in the past.

13. I believe that most whites really do support the ideas and thoughts of racist political groups.

14. I believe environmentalists spend valuable monetary resources unnecessarily.

15. I believe that most whites really believe that blacks are genetically inferior.

16. I believe that most whites would discriminate against blacks if they could get away with it.

17. I believe that lawyers make their own personal judgments of their client's guilt or innocence.

18. I believe most environmentalists think people should be more conscious of how their actions affect the environment.

19. I have blamed whites for my problems or for the problems of other blacks.

20. I believe most environmentalist think not enough is done to preserve the environment.

21. I think the causes environmentalists undertake are worthwhile.

22. I look negatively upon those involved in interracial relationships.

23. I believe that lawyers are usually involved in corrupt activities.

24. I believe that lawyers often portray their clients as being guilty or innocent based on their own personal judgment.

25. I believe lawyers are respected pillars of their community.

26. Most environmentalists are vegetarians.

27. I have spoken negatively about whites without concern for their feelings.

28. I have referred to a white person as a "honkey".

29. I have suspected whites of trying to destroy something created by blacks.

30. I believe that most whites think they are superior to blacks.

31. I believe that lawyers are usually involved in corrupt activities.

32. I believe that most whites would love to return to a time in which blacks had no civil rights.

33. I believe environmentalists have a minimal impact on the way people view the environment.

34. Most environmentalists do not make significant differences in the existing environmental conditions.

35. I believe that most whites would harm blacks if they could get away with it.

36. I would fully trust a lawyer's advice.

37. Most environmentalists are highly intellectual.

38. I believe lawyers are trained to be dishonest.

39. I believe that most whites would love to return to a time in which blacks had no civil rights.

40. I believe the work of an environmentalist is important.

41. I would be hesitant to solicit the services of a lawyer.

42. Most lawyers respect their clients.

43. I believe that the success of a white person is due to their color.

44. I believe environmentalists are very judgmental toward those who do not regularly recycle plastic materials.

45. Most lawyers respect their clients.

46. I have ignored the messages environmentalists have conveyed about the current state of the environment.

47. I believe the criticism lawyers receive is unfair.

48. Most lawyers are concerned about the welfare of their clients.

49. I feel that environmentalist do not make a significant difference in the way people view the environment.

50. I have called a white person "redneck".

51. I believe lawyers perform their duties to the best of their abilities.

52. I believe most people do not heed the warnings of environmentalists.

53. I feel great concern for generations due to the messages I have heard environmentalists convey.

54. I have referred to mixed couples as "sell outs".

55. I believe the public should show greater support for the efforts of environmentalists.

56. I believe lawyers perform their duties without bias.

57. I have insulted a white person.

58. I believe lawyers help convict innocent people.

59. I would donate money to causes that assist an environmentalist.

60. I consider myself to be racist toward whites.

Appendix B. Health Care Attitudes

Control, Black, and White Physician Condition

Health Care Attitudes

AGE:_____

Last four digits of social security number_____

Public policy makers, social scientists, and the general public have always been interested in issues associated with health among various communities and groups. We will ask you to answer a number of health related questions. You will also read a few health related scenarios and we will ask you to also respond to those.

Health Care Attitudes

Please circle the response that is closest to your beliefs.

1. My health care is extremely important to me.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

2. The government should spend more money on health care issues.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

3. People should spend more time thinking about their health.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

4. Health care us a major concern for President George Bush.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

Please read the following scenarios associated with health care. We are interested in your perceptions and responses to these situations.

Scenario #1

This story involves the recent operation on the "conjoined twins" from Iran. These women were 37 years old and they were conjoined at the head. They had separate brains, but they shared a blood vessel that supplied both brains. These were very intelligent and articulate young women. A team of 28 world class doctors were assembled to "separate" the twins.
The twins were informed before the operation that there was only a "50-50" chance of success. The twins realized the risk, but they chose to go forward. In the second day of the operation, the first twin died from excessive blood loss. The vein between their brains simply could not be closed completely once it was cut. Three hours after her sister, the second twin succumbed to the blood loss.

Many people have questioned the ethics of the operation. Should the physicians have gone forward? Was it too risky? Should the physicians have worked harder to make the risks clear?

Please answer the following questions.

1. The operation should have never occurred.

        a. Strongly Disagree
        b. Disagree
        c. Neutral
        d. Agree
        e. Strongly Agree

2. The physicians were only concerned about the well being of the twins.

        a. Strongly Disagree
        b. Disagree
        c. Neutral
        d. Agree
        e. Strongly Agree

3. The physicians were motivated by the desire to gain fame and recognition from
   a successful operation.

       a. Strongly Disagree
       b. Disagree
       c. Neutral
       d. Agree
       e. Strongly Agree

4. All conjoined twins should seek to be separated.

       a. Strongly Disagree
       b. Disagree
       c. Neutral
       d. Agree
       e. Strongly Agree

5. If I were "conjoined", I would take a risk to be separated from my twin.

       a. Strongly Disagree
       b. Disagree
       c. Neutral
       d. Agree
       e. Strongly Agree

Scenario #2
Control Physician Condition

Assume that you were employed by a local company such as General Electric.
This company has contracted with a Health Maintenance Organization (HMO) so that your
health care is free after a minimal annual deductible of $15 for the year. The HMO has approved
a local group of physicians to address your health care needs. This group is comprised of eight
physicians who have experience ranging from 10 – 30 years. These physicians are from all over
the country and they attended medical school from a number of different areas in the country.
Please answer the following questions regarding how you would respond to certain situations
involving this HMO.

Please circle the response that is closest to your beliefs.

    Assume that you had symptoms of some type of health problem (e.g., chest pains, diminished
    energy). How severe would the symptoms have to be for you to seek care from this HMO?

1   2   3   4   5   6   7
|----------|----------|----------|-----------|-----------|----------|

not severe   moderately   extremely
at all   severe   severe

    What sort of health outcomes would you expect after visiting these physicians?

1   2   3   4   5   6   7
|----------|----------|----------|-----------|-----------|----------|

extremely   extremely
negative   moderate   positive

    What is the probability that you will feel better after the visit?

1   2   3   4   5   6   7
|----------|----------|----------|-----------|-----------|----------|

definitely   definitely
  not   yes

*** The following questions will assess your beliefs regarding the physicians in the HMO. While we realize that you have not met these doctors, we are still interested in your "expectations" of the characteristics and traits of the physicians. These impressions are important for health care professionals to understand their patients.

1. The physicians will be very competent.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

2. The physicians will be very intelligent.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

3. The physicians will be very athletic.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

4. The physicians will be very kind.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

5. The physician's skills will be as good as they should be.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

6. The physicians will be extremely thorough and careful.

   a. Strongly Disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

7. I will completely trust the physician's decisions about which medical treatments are best for me.

   a. Strongly Disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

8. The physicians will only think about what is best for me.

   a. Strongly Disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

9. I have no worries about putting my life in the physicians; hands.

   a. Strongly Disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

10. All in all, I would have complete trust in my physician.

   a. Strongly Disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

Scenario #2
Black Physician Condition

Assume that you were employed by a local company such as General Electric.
This company has contracted with a Health Maintenance Organization (HMO) so that your
health care is free after a minimal annual deductible of $15 for the year. The HMO has approved
a local group of physicians to address your health care needs. This group is comprised of Black
physicians who have experience ranging from 10 – 30 years. These physicians are from all over
the country and they attended medical school from a number of different areas in the country.
Please answer the following questions regarding how you would respond to certain situations
involving this HMO.

Please circle the response that is closest to your beliefs.

   Assume that you had symptoms of some type of health problem (e.g., chest pains, diminished
   energy). How severe would the symptoms have to be for you to seek care from this HMO?


```
1         2         3         4         5         6         7
|---------|---------|---------|---------|---------|---------|
```

not severe   moderately   extremely
at all   severe   severe

   What sort of health outcomes would you expect after visiting these physicians?


```
1         2         3         4         5         6         7
|---------|---------|---------|---------|---------|---------|
```

extremely   extremely
negative   moderate   positive

   What is the probability that you will feel better after the visit?

```
1         2         3         4         5         6         7
|---------|---------|---------|---------|---------|---------|
```

definitely   definitely
  not   yes

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*** The following questions will assess your beliefs regarding the physicians in the HMO. While we realize that you have not met these doctors, we are still interested in your "expectations" of the characteristics and traits of the physicians. These impressions are important for health care professionals to understand their patients.

1. The physicians will be very competent.

     a. Strongly Disagree
     b. Disagree
     c. Neutral
     d. Agree
     e. Strongly Agree

2. The physicians will be very intelligent.

     a. Strongly Disagree
     b. Disagree
     c. Neutral
     d. Agree
     e. Strongly Agree

3. The physicians will be very athletic.

     a. Strongly Disagree
     b. Disagree
     c. Neutral
     d. Agree
     e. Strongly Agree

4. The physicians will be very kind.

     a. Strongly Disagree
     b. Disagree
     c. Neutral
     d. Agree
     e. Strongly Agree

5. The physician's skills will be as good as they should be.

     a. Strongly Disagree
     b. Disagree
     c. Neutral
     d. Agree
     e. Strongly Agree

6. The physicians will be extremely thorough and careful.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

7. I will completely trust the physician's decisions about which medical treatments are best for me.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

8. The physicians will only think about what is best for me.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

9. I have no worries about putting my life in the physicians; hands.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

10. All in all, I would have complete trust in my physician.

    a. Strongly Disagree
    b. Disagree
    c. Neutral
    d. Agree
    e. Strongly Agree

Scenario #2
White Physician Condition

Assume that you were employed by a local company such as General Electric.
This company has contracted with a Health Maintenance Organization (HMO) so that your
health care is free after a minimal annual deductible of $15 for the year. The HMO has approved
a local group of physicians to address your health care needs. This group is comprised of White
physicians who have experience ranging from 10 – 30 years. These physicians are from all over
the country and they attended medical school from a number of different areas in the country.
Please answer the following questions regarding how you would respond to certain situations
involving this HMO.

Please circle the response that is closest to your beliefs.

   Assume that you had symptoms of some type of health problem (e.g., chest pains, diminished
   energy). How severe would the symptoms have to be for you to seek care from this HMO?


```
1         2         3         4         5         6         7
|---------|---------|---------|---------|---------|---------|

not severe            moderately            extremely
at all                  severe                severe
```


   What sort of health outcomes would you expect after visiting these physicians?


```
1         2         3         4         5         6         7
|---------|---------|---------|---------|---------|---------|

extremely                                   extremely
negative              moderate              positive
```


   What is the probability that you will feel better after the visit?

```
1         2         3         4         5         6         7
|---------|---------|---------|---------|---------|---------|

definitely                               definitely
   not                                      yes
```


54

*** The following questions will assess your beliefs regarding the physicians in the HMO. While we realize that you have not met these doctors, we are still interested in your "expectations" of the characteristics and traits of the physicians. These impressions are important for health care professionals to understand their patients.

1. The physicians will be very competent.

   a. Strongly Disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

2. The physicians will be very intelligent.

   a. Strongly Disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

3. The physicians will be very athletic.

   a. Strongly Disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

4. The physicians will be very kind.

   a. Strongly Disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

5. The physician's skills will be as good as they should be.

   a. Strongly Disagree
   b. Disagree
   c. Neutral
   d. Agree
   e. Strongly Agree

6. The physicians will be extremely thorough and careful.

     a. Strongly Disagree
     b. Disagree
     c. Neutral
     d. Agree
     e. Strongly Agree

7. I will completely trust the physician's decisions about which medical treatments are best for me.

     a. Strongly Disagree
     b. Disagree
     c. Neutral
     d. Agree
     e. Strongly Agree

8. The physicians will only think about what is best for me.

     a. Strongly Disagree
     b. Disagree
     c. Neutral
     d. Agree
     e. Strongly Agree

9. I have no worries about putting my life in the physicians; hands.

     a. Strongly Disagree
     b. Disagree
     c. Neutral
     d. Agree
     e. Strongly Agree

10. All in all, I would have complete trust in my physician.

     a. Strongly Disagree
     b. Disagree
     c. Neutral
     d. Agree
     e. Strongly Agree