Chapter 11

Prejudiced Providers

Unequal Treatment as a Determinant of African-American Men's Health

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Learning Objectives

*To appreciate the role of unequal treatment as a determinant of African-American men's health

*To acquire an overview of health care inequities affecting African-American men

*To understand the role of provider-level factors (health care interactions) in health care inequities affecting African-American men

*To understand the role of provider-level factors (health care decisions) in health care inequities affecting African-American men

*To gain an awareness of potential strategies for addressing provider-level health care inequities affecting African-American men

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African-American ("African American" and "black" are used interchangeably throughout this chapter) men face well-documented, staggering health care inequities, which are associated with appreciably higher rates of morbidity and mortality as compared with their white counterparts. A full understanding of the social determinants of health among African-American men

must include an account of these health care inequities. Although the better-known social determinants of health include low income, poor housing, poor neighborhood conditions, environmental hazards, and poor educational opportunities, unequal treatment is an often overlooked health care risk factor and social risk factor that determines health. As with other social risk factors, health care risk factors are to be distinguished from behavioral risk factors as being beyond the individual's control. In other words, these risk factors are not linked to the individual's behavior; rather, they are caused by societal stereotypes and biases that impact health providers' behavior, which leads to health care inequities.

Much of the existing public health literature on the topic of health care disparities affecting African-American men does not take a "social determinants of health approach"; more exactly, it reflects the predominant public health perspective on African-American men, which frequently focuses on behavioral risk factors or "patient-level factors" as significant causes of the health care disparities affecting them. Thus, existing literature often characterizes this population as "hard to reach" with "poor help-seeking attitudes and behaviors" (e.g., mistrust of the health care system, poor health literacy, negative attitudes toward screening services, inadequate utilization of health services). The role of "provider-level factors" (stereotyping and bias among health care providers) in health care disparities affecting African-American men has been virtually ignored in public health literature, yet there has been emerging evidence, which points to the significance of provider-level factors in racial health care disparities. Although a body of literature on this topic is slowly developing, there is nothing that specifically addresses this issue in relation to the health care of African-American men. The goal of this chapter is to take the first steps toward filling this gap, and lay the foundation for considering unequal treatment in health care as a determinant of African-American men's health. African-American men's health care is impacted by other social risk factors (e.g., insurance status, residential segregation), but the scope of this chapter is to review what has not been covered elsewhere, that is, the role of provider-level factors in the health care inequities affecting this population.

First, this chapter presents an overview of inequities in health care affecting African-American men (e.g., health care inequities in cancer, cardiovascular disease, kidney disease, HIV/AIDs, mental health). Second, it critically assesses the role of provider-level factors in health care inequities affecting African-American men, including a definition of provider-level factors, and the key ways in which provider-level factors manifest themselves (through health care interactions and health care decisions among health care providers and African-American men). Third, the author offers suggestions for reducing provider-level health care inequities affecting African-American men. These include:

*Conducting interventions that reduce racial bias among health care providers

*New legislation to reduce health care discrimination

*Increasing the number of African-American physicians

*Increasing research on provider-level health care inequities

Health Care Inequities Affecting African-American Men: An Overview

In discussing social determinants of health care inequities affecting African-American men, the first step is to provide an overview of the health care inequities affecting this population. The lower quality health care provided to African Americans, as compared with the majority population, is well documented in the public health research literature. African-American men are impacted by lower quality health care across a wide range of disease areas and medical services. A variety of examples are cited below with reference to the health care inequities between African-American men and their white counterparts.

Cancer

*Black men are less likely to receive "definitive therapy" (the most effective therapies for prostate cancer) (Underwood et al., 2004).

*African-American men's prostate cancer is more likely to be handled initially through "watchful waiting" (i.e., defer immediate prostate cancer treatment). This cannot be adequately explained by racial differences in the characteristics of the disease or life expectancy (Shavers et al., 2004a).

*African-American men on a watchful waiting protocol receive disproportionately low medical monitoring visits and procedures. These disparities cannot be explained by the characteristics of the disease or socio-demographic characteristics (Shavers et al., 2004b).

*African-American men who have been diagnosed with prostate cancer are less likely to receive treatment with "curative intent" (TCI) (the goal of the treatment is to cure the patient). These differences cannot be explained by characteristics of the disease or sociodemographic characteristics (Richert-Boe et al., 2008).

Cardiovascular Disease

*Black men are less likely to be recommended for "coronary artery bypass grafting" (CABG) (a surgery that improves blood flow to the heart) than either white men or black women (van Ryn, Burgess, Malat, & Griffin, 2006). In the study conducted by van Ryn et al. (2006), 21 percent of

black men received a recommendation for CABG, as compared with 40 percent of white men, and 40 percent of black women.

*Black men are less likely to receive "reperfusion therapy" (a potentially life-saving therapy which restores blood flow to tissues and organs) than white men (Canto et al., 2000).

Cerebrovascular Disease (Leading to Stroke)

*African-American men are less likely to be prescribed a life-saving medication for ischemic stroke (Courtenay, 2002).

Kidney Disease

*Black men with end-stage-renal-disease (ESRD) frequently receive inferior care as compared with their white counterparts (Felix-Aaron et al., 2005).

*African-American men and women with ESRD are less likely to receive a kidney transplant than other racial/ethnic groups (Navaneethan & Singh, 2006). Further, African-American men are less likely than white men to be referred for evaluation at a transplantation center (53.9 percent versus 76.2 percent) (Ayanian, Cleary, Weissman, & Epstein, 1999). These disparities could not be accounted for by patients' preferences and attitudes about transplantation, socio-demographic characteristics, dialysis facilities, perceptions about care, health status, or the characteristics of the disease (Ayanian et al., 1999).

HIV/AIDs

*HIV-positive black men who have sex with men (MSM) are less likely than HIV-positive white MSM to be on "antiretroviral therapy" (ART) (a drug that suppresses the progression of HIV) (Millett, Flores, Peterson, & Bakeman, 2007).

Mental Health

*Black men are overdiagnosed with schizophrenia at five times the rate of other racial/ethnic and gender groups (Metzl, 2009).

*Recent studies suggest that in primary care settings, depressed African Americans are often underdiagnosed and ineffectively treated (Das, Olfson, McCurtis, & Weissman, 2006). For example, black Medicaid patients diagnosed with depression are less likely to be treated with newer antidepressant medications (which have fewer side effects than the older antidepressant medications) (Sambamoorthi, Olfson, Wei, & Crystal, 2006). Waldman et al. (2009) found depression-care disparities to be particularly marked among African-American men, with only 22 percent of moderately-to-severely depressed African-American men

receiving treatment with antidepressant medication as compared with 43 percent of white men.

Hospital Services

*African-American men are more likely to experience difficulties obtaining insurance authorization when accessing emergency care than their white counterparts (Courtenay, 2002).

Although racial inequities in health care are disconcerting in and of themselves, they are associated with worse health outcomes, making them even more troubling (Smedley, Stith, & Nelson, 2002). Indeed, a study conducted by Peterson et al. (1997) indicated that the lower levels of coronary artery bypass surgery among African Americans was a key factor in the racial disparity in five-year survival rates among heart disease patients. Thus, racial inequities in medical care affecting African-American men have important implications for their health outcomes in the respective disease areas.

It is important to note that the above examples of health care inequities affecting this population are not meant to be exhaustive; rather, they are intended to provide a snapshot of the types of inequities faced by African-American men when they access health services.

The Role of Provider-Level Factors in Health Care Inequities Affecting African-American Men

In studying the social risk factors that contribute to health care inequities affecting African-American men, this chapter focuses on a major set of health care risk factors known as "provider-level factors" (see Smedley et al., 2002). Provider-level factors refer to biases, stereotypes, and clinical uncertainty among health care providers (Smedley et al., 2002). There are two key ways in which provider-level factors manifest themselves—health care interactions and health care decisions (Penner, Albrecht, Coleman, & Norton, 2007). Health care interactions refer to in-person patient-provider communication, which can lead to health care inequities, while health care decisions refer to health care providers' diagnosis and treatment decisions, which similarly can result in health care inequities (Penner et al., 2007). In short, provider-level factors are significant health care risk factors and social risk factors that can contribute to unequal treatment in health care and, as such, constitute an important social determinant of health (see McGibbon, Etowa, & McPherson, 2008).

Provider-level factors should be distinguished from the other identified causes of health care disparities—"health system-level factors" and "patient-level factors" (Penner et al., 2007). Health system-level factors are associated with socioeconomic variables (e.g., low incomes, medically underserved

neighborhoods) that affect access to quality health care (e.g., quality health insurance plans, quality primary care practices, and hospitals). Although health system-level factors clearly affect access to health care, health care inequities persist among populations with the same health insurance plans and medical facilities (Penner et al., 2007).

Patient-level factors consist of patients' attitudes and behaviors, which can have an effect on their health care outcomes (Penner et al., 2007; Smedley et al., 2002). As indicated in the introduction, much of the existing literature discussing health care disparities affecting African-American men focuses on these patient-level factors, which are associated with poor help-seeking attitudes and behaviors. Examples of work with this perspective include studies of African-American men's mistrust of the health care system (Blocker et al., 2006), poor health literacy (see Friedman, Corwin, Dominick, & Rose, 2009), negative attitudes toward screening services (Blocker et al., 2006), inadequate utilization of health services (Richardson, Webster, & Fields, 2004), and interventions that have focused on improving African-American men's health behavior (see, for example, Taylor et al., 2006). Although patient-level factors obviously play a role in health care inequities, they do not adequately account for these inequities (see Ayanian et al., 1999).

Provider-level factors are often overlooked in the literature pertaining to African-American health, especially the effect of provider-level factors on patient-level factors. Diala et al. (2000) found that, before using mental health services, African Americans' mental health help-seeking attitudes were similar to or more positive than whites, however, following the receipt of mental health services, African Americans held more negative attitudes towards mental health services, and were not as likely to seek help again as compared with their white counterparts. As such, provider behavior may have a significant impact on help-seeking behavior among African Americans. (This issue is further explored later in this section.)

Provider-level factors are considered in depth in the following section in relation to health care interactions and health care decisions affecting African-American men.

The Social Determinants of Health Care Interactions and Health Care Decisions in Health Care Encounters with African-American Men

An emerging literature indicates that health care interactions and health care decisions are often influenced by the social stereotypes and biases that health care providers have about their patients (see, for example, Penner et al., 2010; van Ryn et al., 2006). Certainly, in wider society, African-American men are often subjected to significant stereotyping. Woods, Montgomery, Belliard, Ramırez-Johnson, and Wilson (2004, p. 394) note that "the dominant stereotypic

perception of black men in American society as a 'bad guy' (e.g., thug, drug dealer) often limits the opportunity for a positive patient-physician relationship and black male engagement." In a similar vein, in the health care setting, Malebranche (2004, p. 223) observes the frequency with which black men are labeled as "'aggressive,' 'threatening,' 'difficult,' or . . . 'noncompliant'" when they ask questions, also pointing out that "the same physicians refer to white male patients who ask similar questions as 'well-read,' 'inquisitive,' or 'knowledgeable.'"

The above-mentioned observations are consistent with the theory that physicians are more likely to hold negative stereotypes of black patients than white patients (Penner et al., 2007). This also corresponds with research. In a study that measured physicians' implicit and explicit attitudes about race, Sabin, Nosek, Greenwald, and Rivara (2009) found that physicians showed implicit preferences for whites over blacks. In another study (van Ryn & Burke, 2000) physicians generally had more negative stereotypes regarding African Americans as compared to whites. For example, physicians were more likely to view black patients as being potentially noncompliant, would-be substance abusers, and were less likely to perceive black patients as intelligent or feel positive about black patients.

Health Care Interactions

Perhaps not surprisingly, a significant number of African-American men have experienced negative interactions with health care providers. In a study conducted by Woods et al. (2004), 62.8 percent of black men considered that their race/ethnicity was the reason for the poor treatment that they received, and 58.6 percent believed that their race/ethnicity affected the quality of care that they received. Respondents were discouraged by their verbal and nonverbal communications with health care providers, describing a lack of respectful interaction, as well as generally limited interaction with health care providers (Woods et al., 2004). This is consistent with the findings of other studies documenting negative health care experiences among black men (Malebranche, Peterson, Fullilove, & Stackhouse, 2004; Ravenell, Whitaker, & Johnson, 2008). Interestingly, these studies (Malebranche et al., 2004; Ravenell et al., 2008) indicate that the stereotyping of African-American men, lack of respect, and lack of interaction may be as significant among foreign-born physicians (often non-white) as it is among their white American counterparts. Drawing on their study of barriers to health care among African-American men, Ravenell et al. (2008, p. 1157) quote the following remark from one participant: "Every time I go to the hospital . . . I'm getting a foreign doctor who barely speaks English and they treat me like a young black hoodlum so you know it's like, why even go." In a similar vein, in a study that explored perceptions of

health care among black men who have sex with men, Malebranche et al. (2004, p. 103) cite a number of respondents' comments on this issue including "[I've] seen some [foreign doctors] interact with white patients in a more personable, more sociable [sic] . . . but when it comes to black patients, some of them are like, 'whatever,' and they'll just do this and do that."

Negative health care interactions can lead to negative help-seeking behavior and the underutilization of health services, which is well documented among African-American men. Malebranche (2004) considers that the negative stereotyping of black men is a significant factor in men losing an interest in their own health care (e.g., reluctance to seek medical help, refusal of tests, noncompliance with medication regimens). This is consistent with Woods et al.'s (2004) study, which indicated that negative health care interactions had a significant impact on preventive health behavior among black men. In short, contemporary negative health care interactions can lead to "cultural mistrust" in the health care system (see Whaley, 2004) and "negative help-seeking behavior" among this population. It is worth noting the distinction between cultural mistrust based on ongoing discrimination as opposed to historical mistrust of health services. This is pointed out because public health literature often focuses on African American mistrust of the health care system in terms of historical mistrust of health services, emanating particularly from the Tuskegee experiments, which were conducted on African-American men between 1932 and 1972. The Tuskegee experiments are certainly a good reason for ongoing mistrust, but it is important not to overlook mistrust that is generated from contemporary health care experiences. If today, in twenty-first century America, African-American men have reason to believe they will be discriminated against by health service providers at a time when they are unwell and vulnerable, is it surprising that they delay or avoid seeking care? In short, contemporary negative health care interactions play a potentially important role in the underutilization of health services among African-American men, which has important implications for their health outcomes. As such, health care interactions are significant determinants of health among this population.

Health Care Decisions

The stereotyping of African-American men can result in disparities in health care decisions concerning African-American men as compared with their white counterparts. In other words, stereotyping can result in discriminatory behavior in the health care setting. In a study conducted by Bogart, Catz, Kelly, and Benotsch (2001), findings indicate that physicians' stereotypes of African-American men resulted in physicians' assumptions that

African-American men would be less likely to comply with highly active antiretroviral therapy (HAART) treatment. These kinds of predictions have serious implications as they are likely to have an effect on treatment decisions (Bogart et al., 2001).

It is important to note that in contemporary health care settings, discriminatory decision making is likely to be subtle and unconscious as opposed to overt or intentional (Penner et al., 2007). Penner et al. (2007) propose that the aversive racism theory developed by Gaertner and Dovidio (1986) is particularly applicable to discriminatory decision making in the health care setting (see Penner et al., 2007). Aversive racism theory holds that while "aversive racists" consciously support racially egalitarian values, concurrently they have unconscious negative emotions and stereotypes about specific racial/ethnic groups (Dovidio et al., 2008). Thus, there is an inherent contradiction between their "explicit egalitarian attitudes" and their "implicit negative racial attitudes" (Dovidio et al., 2008, p. 479). Further, automatic and unconscious negative attitudes and stereotypes are particularly likely to lead to discriminatory behavior when health care providers are coping with time constraints or tasks that require extensive thought and deliberation (Dovidio et al., 2008). Drawing on Geiger's work (2001), Dovidio et al. (2008) note that racial disparities in medical treatment appear to be greater when physicians are dealing with "high-discretion" procedures (e.g., making a referral for a procedure or drug) than when they undertake "low-discretion" procedures (e.g., emergency surgery) (Geiger, 2001). For example, in a study that explored race disparities in treatment recommendations for men with coronary artery disease, black men were less likely to be recommended for coronary artery bypass grafting (CABG) than either their white male or black female counterparts. Concurrently the physicians in this study also exhibited negative stereotypes about the black male patients as compared with their white counterparts with regard to a number of factors, including medical compliance, substance abuse, and intelligence (van Ryn et al., 2006). High-discretion decision making is particularly pertinent in the mental health setting. Drawing on a number of scholars' work (Abreu, 1999; Loring & Powell, 1988; Rosenfield, 1984), Whaley (2004) argues that the unconscious stereotype that black men are violent plays a significant role in the misdiagnosis of paranoid schizophrenia in black men.

In summary, the literature suggests that discriminatory decision making contributes to health care inequities affecting African-American men. This has important implications for health outcomes among this population. As such, health care decision making is an important determinant of health among African-American men.

Reducing Provider-Level Health Care Inequities Affecting African-American Men

To date, the public health community (funding bodies, researchers, program developers, policy makers) has often overlooked social determinants of health care inequities affecting African-American men, frequently focusing on African-American men themselves, as the chief "cause" of their health care inequities. The earlier part of this chapter has demonstrated that this is not the case, that in fact, health care provider-level factors play a critical role in health care inequities affecting African-American men. To this end, the following section sets out some key areas that stakeholders should consider in reducing the health care inequities affecting this population.

Conduct Interventions That Reduce Racial Bias

African-American men are a population group that is particularly vulnerable to racial bias in health care, facing special challenges with stereotyping from health care providers. As such, it is imperative that strategies are developed that address this issue head-on. Although significant funds have been dedicated to programs that improve health care providers' communication with patients from diverse cultures (Burgess, van Ryn, Dovidio, & Saha, 2007) these programs tend to neglect issues of racial bias (Gregg & Saha, 2006) and thus are limited in their potential to adequately address unconscious stereotyping (Burgess et al., 2007). Accordingly, the author recommends interventions that draw on a social cognitive psychology framework developed by Burgess et al. (2007), which outlines evidence-based strategies and skills, and addresses the shortcomings of cultural competency curricula. The aim is to teach strategies and skills to medical trainees and practicing physicians, which will address the unconscious racial attitudes and stereotypes, which negatively impact health care interactions and health care decisions. Burgess et al. (2007) emphasize the need for interventions to be implemented in a safe space, where new skills can be practiced, and that intervention implementers should be careful not to make providers feel ashamed of having stereotypes. The proposed strategies and skills (Burgess et al., 2007) are intended to:

*Develop providers' personal motivation to reduce bias

*Develop providers' psychological understanding of bias

*Develop providers' confidence in interacting with patients from different racial/ethnic groups

*Increase providers' ability to regulate their emotions

*Increase providers' ability to understand patients' perspectives and be empathetic

*Improve providers' ability to effectively partner with patients

New Legislation to Address Health Care Discrimination

Research indicates that discrimination in health care is likely to be a frequent reality among African-American men. While intervention strategies to reduce racial bias in health care are vital as outlined in the last section, it is also imperative to provide for legislation that better protects African-American men and other vulnerable populations from discriminatory health care. Current civil rights legislation has significant shortcomings in that it was originally designed to address overt forms of discrimination, and does not address subtle discrimination that is a feature of contemporary health care settings (Randall, 2006). In view of that, Randall (2006) argues for legislation that expands the law to deal with more than overt or intentional discrimination. In other words, the law should allow for the more subtle kinds of discrimination (e.g., aversive racism) that is experienced by African-American men in the twenty-first-century health care setting. Randall (2006) proposes a Health Care Anti-Discrimination Act designed to:

*Acknowledge a variety of forms of discrimination (e.g., "intentional discrimination"; "subtle discrimination"; and "unthinking discrimination").

*Approve and finance the use of individuals appointed as "medical testers" to provide evidence of discrimination.

*Provide individuals (including testers) and organizations (e.g., civil rights organizations) the right to bring a case before a court.

*Require health care organizations to collect disaggregated race-based health care data to make discrimination in health care more detectable.

*Require a health report card for health agencies, providers, or facilities to encourage accountability in health care discrimination issues.

*Establish an equality health care council as a key agency for antidiscrimination work in health care.

*Set adequate fines for antidiscrimination law violations.

*Pay the attorney fees of individuals and organizations who win lawsuits.

*Permit the punitive damages awarded to be used to fund health care equity programs.

Increase the Number of African-American Physicians

Increasing the number of African-American physicians is another strategy that can be used to improve the health care experiences of African-American men (see Cooper et al., 2003). Research indicates that patients with physicians of the same race have longer physician visits, are more satisfied, and regard their physicians as more participatory than those who do not (Cooper et al., 2003). In a study conducted by Malebranche et al. (2004, p. 103), several of the black male interviewees indicated a preference for black physicians because they considered that they could "relate on a more personal level" as compared with non-black physicians. Moreover, individuals who have been subject to discrimination in health care frequently prefer same-race health care providers (Malat & van Ryn, 2005). At present, the lack of African-American physicians (only 4 percent of physicians are African American) has meant that this preference cannot be easily exercised among African-American men (African Americans make up 13 percent of the population in the United States) (see Rao & Flores, 2007).

The following recommendations are an adaptation of the Institute of Medicine's proposed strategy to increase diversity in the health care workforce (Smedley, Butler, & Bristow, 2004) with an emphasis on increasing the numbers of African-American physicians, an underrepresented group of minority physicians:

*Health education institutions should have African Americans represented on admission committees, and they should consider the race of applicants in admission decisions.

*Congress should increase funding for initiatives to increase the number of African-American physicians.

*Health profession accreditation groups should encourage medical schools to recruit African-American students, and include African Americans on their boards.

Increase Research on Provider-Level Health Care Inequities

Public health research relating to African-American men has focused largely on their health behavior (patient-level factors) as a cause of health care disparities; interventions have frequently sought to address poor health-seeking attitudes and behaviors. Although these efforts are worthy in and of themselves, focusing on African-American men's health behavior in isolation is not enough. As this chapter has argued, provider behavior plays a key role in health care inequities affecting African-American men. There is also a need to contextualize health behavior by exploring the impact of provider-level factors

on health behavior/patient-level factors. Suggestions for addressing this research gap are discussed in the following sections.

The effect of racial bias and stereotypes on health care interactions and health care decisions.

There is a need for research that examines stereotypes and attitudes of providers toward African-American men, and how this might have an impact on physician recommendations, physician referrals, and receipt of the optimum treatments (see National Institutes of Health [NIH], 2010). This should include experimental studies on the effect of providers' stereotypes and attitudes on health care decisions, as well as health care interactions (Penner et al., 2007). Future researchers might consider using aversive racism theory (e.g., consider implicit attitudes and stereotypes among providers). As stated earlier, health care provider implicit attitudes and stereotypes are particularly appropriate for studying discrimination in contemporary health care settings (Penner et al., 2007).

The effect of health care interactions and health care decisions on health care disparities.

Although there is a great deal of indirect evidence that points to the association between provider-level factors and racial health care disparities, there is a need for research that directly addresses this issue (Smedley et al., 2003). Further, since African-American men are impacted by specific forms of stereotyping, there is a particular need for gender-specific research on this topic.

The effect of provider behavior on help-seeking behavior.

The predominant focus within the public health literature concerning African-American men is on their help-seeking and health behavior. To the author's knowledge, there is currently no work that has explored the impact of racialized health care interactions on help-seeking and health behavior among African-American men. To be sure, the need for research on this issue has been emphasized by the National Institutes of Health (NIH) in a 2011 funding opportunity announcement (http://grants.nih.gov/grants/guide/pa-files/PA-11-162.html), which identifies the need for research that explores patients' experiences of discrimination in health care and its association with future help-seeking behavior and health behavior. Moreover, Penner et al. (2009) argue that future research must consider that the sources of racial health care disparities may emanate from patients' experiences of discrimination in health care rather than from patients per se. This is consistent with Ford and Airhihenbuwa's (2010) assertion that currently, public health literature is overly colorblind, and in many instances does not deal adequately with issues pertaining to race and racism. In this vein, future researchers may wish to consider utilizing Critical Race Theory (CRT) to study the effect of racialized provider behavior on patients' help seeking behavior, as well as other aspects of provider-level health care inequities.

CRT places race at the forefront of inquiry, and is a useful theory for studying the causes of health disparities; since it critiques colorblindness, it is particularly helpful in keeping the discussion focused on the principles of equity and social justice (Ford & Airhihenbuwa, 2010).

Summary

This chapter has shown that African-American men face health care inequities across a wide range of disease areas and medical services, and has focused on provider-level factors as important determinants of these inequities. To be sure, these unique health care risk factors have significant implications for health care experiences, health care quality, and health outcomes among African-American men. In exploring the role of provider-level factors in health care inequities, this chapter has emphasized the need to seriously consider the impact of negative health care interactions (e.g., lack of respect, lack of interaction) on African-American men's health care experiences, and particularly their future utilization of health services. It has also underlined the significance of discriminatory health decision making (e.g., questionable prostate cancer decision making, biased cardiovascular referral decisions) in contemporary health care settings, and its association with health care inequities. Together, negative health care interactions and discriminatory health decision making not only reduce health care quality, they also have obvious implications for the worsening of health conditions, which may have been previously manageable, and thus implications for increased morbidity and mortality among African-American men.

Finally, this chapter has drawn from multidisciplinary sources to propose a number of recommendations for tackling the social determinants of health care inequities affecting African-American men. This includes interventions that reduce racial bias among health care providers, new legislation to address health care discrimination, increasing the number of African-American physicians, and developing the research base on provider-level health care inequities.

Unequal treatment in health care has huge implications. Health care (or the lack of it) tends to impact individuals when they are ill, a time when they are at their most vulnerable. Moreover, poor health care is a basic denial of an individual's human rights. As Martin Luther King Jr. (1966) argued, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." It is imperative that policy makers place the issue of health care equity for African-American men, and other vulnerable minorities higher up the policy agenda than is currently the case. There is also a need to move beyond patient-level factors in understanding and addressing these inequities.

Key Terms

African-American men
aversive racism
bias
health care decisions
health care disparities
health care inequities
health care interactions
health care risk factor
health system-level factors
help-seeking attitudes and behaviors
implicit and explicit attitudes
patient-level factors
provider-level factors
social determinants of health
social risk factor
stereotyping
unequal treatment

Discussion Questions

1. Unequal treatment is presented in this chapter as being a significant determinant of African-American men's health. Do you agree with this assessment? Why/Why not?
2. Were you surprised to learn the extent of health care inequities affecting African-American men? Why/Why not?
3. How important are negative health care interactions versus discriminatory health care decisions as determinants of health among African-American men? In other words, are health care interactions and health care decisions equally important in terms of their potential to affect African-American men's health outcomes? Why/Why not?
4. Discuss the advantages and potential barriers to implementing the strategies suggested in this chapter for tackling health care inequities affecting African-American men. Can you think of any additional strategies?

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