

INFLUENCE OF STEREOTYPING IN SMOKING CESSATION COUNSELING BY PRIMARY CARE RESIDENTS

This study examined racial differences in primary care residents' rates of addressing smoking cessation. We expected residents to have higher rates of addressing cessation with White female patients as compared with African-American or Hispanic female patients, due, in part, to residents having higher outcome expectancies, self-efficacy, lower barriers, and less reliance on stereotypes. Residents ($N=90$) were an average of 31 years old; two-thirds were White internal medicine residents. Residents viewed a video of a lower-middle class White, African-American, or Hispanic female interacting with her physician about stomach pain. Results indicate that residents were very likely to address smoking cessation, regardless of patients' race. Compared to residents assigned to an ethnic minority patient, residents assigned to the White patient were less likely to believe the patient would follow their advice ($P<.03$) and also perceived more barriers to address smoking cessation ($P<.04$). Reliance on the stereotype of Whites mediated the racial difference in outcome expectancies. Implications are that residents may be relying on stereotypes when they assess lower-middle class White female patients' receptivity to smoking cessation advice. Future research on the role of stereotyping in medical settings is warranted. (*Ethn Dis.* 2002;12:578–585)

Key Words: Smoking Cessation, Primary Care Residents, Racial Differences, Stereotyping

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INTRODUCTION

Disparities in the rates of the leading causes of death (eg, heart disease and cancer) have increased between African Americans and Whites from the middle of the twentieth century to the present.¹ Although mortality rates and overall health have improved for both groups, Whites exhibited more dramatic improvements than other races. Recent racial disparities have been documented in cardiovascular disease treatment,² mammography recommendations,³ and kidney transplants.⁴ Although disparities in treatment clearly exist, factors that lead to disparate treatment are unknown. It is necessary to identify the predictors of healthcare disparities in order to aid development of interventions to eliminate these disparities.

Racial differences have been found in patient-reported smoking cessation counseling,^{5–12} with White patients being more likely than ethnic minority patients to report receiving physician advice for cessation. These disparities are important because smoking cessation counseling is one of the most cost-efficient and effective services physicians can provide.¹³ Although African-American patients are less likely to report receiving smoking cessation counseling, physicians do not report a difference in their rates of offering smoking cessation advice by patient race.^{14–16} Factors that have been found to influence physicians' likelihood of addressing smoking cessation include the physicians believing that a patient will heed the cessation advice, having confidence in their own ability to provide counsel, and having few perceived barriers for addressing

smoking cessation.^{15,16} These factors are consistent with Bandura's social cognitive theory,¹⁷ which states that outcome expectancies, self-efficacy, and barriers are related to the probability of performing a behavior.

It is possible that physicians' outcome expectancies, self-efficacy, and barriers for addressing smoking cessation differ by patient race. In an observational study of physician perceptions, van Ryn and Burke¹⁸ found that physicians believed their African-American patients would be less likely than their White patients to follow medical advice. In addition, the researchers found that, even when African-American patients were highly educated, physicians were more likely to consider them less intelligent than their White patients. The authors speculated that physicians might have relied on racial stereotypes that influenced their judgments about how patients would react to treatment recommendations and, therefore, tailored their recommendations based on these stereotypes. However, the authors did not measure stereotyping and thus could not test the influence of physician stereotyping on medical recommendations.

It is reasonable to assume that physicians use stereotypes when judging their patients because the use of stereotypes is common,¹⁹ automatic, and unconscious for all people.²⁰ Stereotyping in medical settings could be problematic if it leads to differential treatment, such as counseling only certain patients about cessation. If physicians use stereotypes to judge patients' probable responses to treatment recommendations and counseling, they may decide *a priori* which

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patients will follow their advice and/or may perceive more barriers for addressing certain topics with patients whom they have negatively stereotyped.

Physicians' reliance on stereotypes may be especially problematic for patients of color. In the United States, the stereotype for African Americans is decidedly negative.^{18,21-23} African-American women are stereotyped as antagonistic, hostile, and lower class.²¹ If physicians stereotype their African-American patients as hostile and lower class, they might have lower outcome expectancies for behavior change, lower self-efficacy for addressing smoking cessation, and/or higher perceived barriers for addressing cessation with their African-American patients. Hispanic women are stereotyped as passive, harmony seeking, and uneducated.²¹ If physicians ascribe this stereotype to their Hispanic patients, they may avoid addressing certain topics, believing that Hispanic patients will agree with instructions during the office visit, but will fail to comply due to lack of understanding.

This report investigated primary care residents' smoking cessation counseling to determine whether their rates of counseling varied by race. The experimental design included mediating mechanisms that could explain potential racial differences. Based on prior studies,⁵⁻¹² we hypothesized that: 1) resi-

dents would address cessation at higher rates with White lower-middle class female patients than with African-American or Hispanic lower-middle class female patients; 2) racial differences in addressing cessation would be mediated by residents' outcome expectancies, self-efficacy, and perceived barriers; and 3) racial differences in outcome expectancies, self-efficacy, and perceived barriers would be mediated by stereotyping.

METHODS

Participants and Recruitment

Email invitations and flyers were used to recruit residents from 3 primary care specialties (family practice, internal medicine, and obstetrics/gynecology). Two groups of residents ($N=3$ and $N=5$) served as expert panels: one to review the survey materials, and one to review the stimulus materials for the study. Over a 5-month recruitment period, residents completed Phase 1 and Phase 2. Phase 1 consisted of completing a 45-minute survey.²⁴ During Phase 2, residents viewed a video of a mock patient and were told the study was designed to examine residents' preventive health priorities. Residents were reimbursed (\$65 and lunch) for their participation. Both the expert panel participants and the study participants signed forms agreeing not to discuss the study with their colleagues.

Design

This report presents Phase 2, a 2×3 (receipt of a printed prompt by race of patient) between-subjects experiment. Residents were randomly assigned to one of 6 conditions in which they viewed a video of a lower-middle class female patient (African-American, Hispanic, or White) and either did or did not receive a printed prompt aimed at preventing reliance on stereotypes when providing health care. Fifteen residents were randomly assigned to each condition.

Stimulus Materials

Medical Chart

Residents viewed a mock patient's medical chart, similar to those used in residents' clinics, for their assigned patient. The visit encounter form included the patient's name (Jennifer Shipley, Lekeisha Jackson, or Maria Gonzalez), home address, and race. The intake form listed the patient's chief complaint (stomach pain) and the patient's vital signs (eg, height: 5' 5", weight: 150 lbs, temperature: 98.2, pulse: 73, blood pressure: 110/70, smoking status: smokes one pack/day). Chart notes of previous visits included 3 previous "no-show" appointments over the past 3 years. The chart also contained laboratory results and notes describing a case of gonorrhea. The last page of the chart was an Adult Patient Health Inventory that indicated that the patient was single, had graduated from high school, and worked as a waitress in an Applebee's, an inexpensive restaurant chain. All patients were characterized by their personal information as being lower-middle class. This trait fits the stereotypes for African-American and Hispanic females.²¹⁻²³ While it does not fit the typical stereotype for White females, it was important to control for patients' socioeconomic class.

Video

After reviewing the chart, residents were asked to watch a 3-minute video depicting the patient discussing her main complaint with a physician (See Appendix A for script). Women were filmed from the waist up, wore t-shirts, and no jewelry. The doctor's voice was off camera. The patient described her stomach pain and presented no information that linked her symptoms to smoking. The case was designed to have no obviously diagnosable problem but confirmed sexual activity with multiple partners and inconsistent condom use.

In a between-subjects design, psychology undergraduates ($N=60$) evaluated the comparability of videos for 6

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actors (2 for each target race). The 3 actresses whose videos were used in the study did not differ significantly in attractiveness, articulateness, intelligence, or socioeconomic class. Further, every student correctly identified the race of the actress/target.

Printed Prompt

The printed prompt was a slip of paper clipped on the front of the mock patient's medical chart. The printed prompt was designed to increase residents' awareness of potential bias, increase the saliency of egalitarian views, and improve the residents' outcome expectancies so that they believe that they can change patients' behavior. It read,

"Some studies have shown that physicians may be biased in their delivery of health care. Because physicians have an impact on their patients' health, please remember that: All patients deserve equal health care."

Procedure

After reviewing the patient chart and video, residents were given the first section of a 2-part survey. The section started with the following description:

"The purpose of this study is to understand how residents address preventive health topics with a specific patient.

You have just viewed a medical chart for a mock patient and viewed a video of the beginning of her office visit. Please imagine that this is the last patient you would see in a day where you have only seen 4 patients total. You have an hour to spend with this patient."

The amount of time the residents could dedicate to this patient was determined by an expert panel of residents ($N=5$). The expert panel stated that allowing only 12 minutes with the patient (the average time physicians spend with each patient) would prevent residents from addressing any preventive health topics. Further, many of the study participants were expected to be in their first or second year of residency, during which time they are allowed 40–60 minutes with their patients. Thus, we

allowed 45 minutes for them to address preventive health with the hypothetical patient and 15 minutes to address the patient's main complaint.

After reading the description, residents were asked to complete the first part of the survey that assessed, in an open-ended format, the preventive health topics they would discuss with the patient. This first part was designed to assess which topics residents would address without being prompted. The second section, completed after the first section was returned to the research assistant, contained closed-ended questions about 12 preventive health topics. These topics were deemed appropriate by 2 practicing clinicians (a family doctor and an obstetrician/gynecologist) for females in their early 20s (alcohol use, smoking, drug use/substance use, domestic violence, STD prevention, pregnancy prevention, cervical cancer, breast cancer, physical activity, eating, calcium intake, and rubella immunity). All 12 behaviors were included to detract from the study's primary focus, assessing smoking cessation counseling intentions and beliefs. For each preventive health topic, residents were asked to report the likelihood that they would address the topic, outcome expectancies for the likelihood of the patient following their advice on that topic, self-efficacy for addressing that topic, and perceived barriers for addressing that topic. A final set of questions assessed the residents' demographic characteristics. This protocol was approved by the Institutional Review Board of the Duke University Medical Center to ensure the protection of human participants.

Measures

Unprompted List of Preventive Health Topics

Residents responded to, "What preventive health issues (ie, diseases or behaviors) do you believe are most relevant to address with the patient you just viewed? Please list a minimum of 3 topics." They could list up to 6 topics.

Prompted Preventive Health Topics: Likelihood of Addressing Topic

Residents were asked, "How likely are you to address [insert preventive health topic] with this patient?" (1=very unlikely to 5=very likely).

Outcome Expectancies

Residents were asked 2 items about their outcome expectancies about patients' reactions to their advice for each preventive health topic. The stem read, "How confident are you that this patient will . . . Listen to your advice" and "Follow-up with your medical recommendation" about [each preventive health topic] (1=not at all confident and 5=extremely confident). The items were averaged to form a scale; the scale had adequate reliability, Cronbach's $\alpha=.76$.

Self-efficacy

Residents were asked 3 items about their confidence for addressing each preventive health topic. The items were based on the Clinical Practice Guideline's^{25,26} "4 As" (Ask, Advice, Assist, Arrange),^a and were applied to the 12 health topics. An item to measure whether residents would "assist" the patient in changing her health behavior was not included because it did not apply to all of the 12 behaviors (eg, rubella immunizations). The stem read, "How confident are you that you can . . . discuss this health issue with this patient," "Advise this patient to change her behavior about this health issue," and "Follow up with this patient on this topic in future visits" (1=not at all confident to 5=extremely confident); $\alpha=.78$.

^a AHCPR is now Agency for Healthcare Research and Quality (AHRQ) and the guideline specifies "5 As" rather than "4 As" (Ask, Advice, Assess, Assist, Arrange). The survey was constructed prior to the release of the new guideline.

Barriers

Residents reported their level of agreement with 6 reasons why they would not address each preventive topic with the patient. These items were based on a previous study that assessed physicians' barriers for addressing smoking cessation.²⁷ The stem read, "I would not address [each preventive health topic] with this patient because . . ." (1=strongly disagree to 5=strongly agree). Exploratory factor analysis revealed 2 barriers. The first barrier, named "priorities barrier," contained the items: "Too much time is required," "This patient may not be interested in discussing this health issue," and "Other health problems require attention." The scale had adequate reliability, $\alpha=.69$. The second barrier, named "discomfort barrier," included, "I do not feel adequately trained to discuss this health issue," "Cultural or language barriers pose difficulties for discussing this health issue," and "This health topic may be too embarrassing for this patient to discuss"; $\alpha=.72$.

Stereotypes

Residents were asked to rate their assigned patient on a list of adjectives. These adjectives comprised the stereotype scales for African-American, Hispanic, and White females. The stem read, "Based on the information you have been provided, please make your best estimate of how much you believe that each adjective describes the patient you just viewed" (1=strongly disagree to 5=strongly agree). Based on past work²¹ and pilot work with Duke University psychology undergraduates, 3 factors were used to measure the stereotypes for White women, African-American women, and Hispanic women. Each factor contained 12 adjectives. Adjectives for the White stereotype included "assertive," "college-educated," and "talkative"; $\alpha=.64$. Adjectives for the African-American stereotype included "antagonistic," "lower class," and "promiscuous"; $\alpha=.78$. Adjectives for the

Hispanic stereotype included "believe in God," "family-oriented," and "money-hungry (reverse scored)"; $\alpha=.77$.

Demographics and Manipulation Checks

Residents were asked to provide information about their age, race, sex, specialty, and year in residency. They also were asked to indicate the race of the patient (Black, Hispanic, Asian, Caucasian, or Other). Residents rated their patient on the trait "lower class" from the stereotyping adjectives to serve as a manipulation check for the socioeconomic class of the target patient.

Analyses

The analyses for this report focus on determining whether residents who were randomly assigned to a White lower-middle class female patient were more likely to address smoking cessation than those randomly assigned to an African-American or Hispanic lower-middle class female patient. The design included another dimension (not included in this report): whether receiving a printed prompt reduced reliance on stereotyping when addressing smoking cessation. No statistically significant interactions between race of the patient and receipt of the printed prompt were found for addressing smoking cessation. To be conservative, all analyses included receipt of the printed prompt as a covariate.

Chi-square analyses were conducted to compare whether residents who were assigned to the White patient were more likely to list smoking in their open-ended section than those assigned to the African-American or Hispanic patient. Further, 2 mediation models were tested using logistic regression (for unprompted responses), and multiple regression (for prompted responses). If racial differences for listing smoking were statistically significant, outcome expectancies, self-efficacy, or barriers were tested as mediators of the relationship between the race of the patient and smoking being listed. In addition, models were test-

ed to determine whether racial differences in outcome expectancies, self-efficacy, and barriers were mediated by reliance on stereotypes. All analyses were conducted using SAS 6.12; $\alpha=.05$ was used to determine statistical significance.

RESULTS

Participants

Fifteen of the 24 family practice residents, 11 of the 28 obstetrics and gynecology residents, and 64 of the 128 internal medicine residents participated. Some of the residents who were ineligible had out-of-town rotations ($N=7$), or had participated in one of the 2 expert panels ($N=8$). Thus, the overall participation rate was 54% (90/165). Residents averaged 31 years of age ($SD=3.7$). Almost half were female (47%), and 63% were White, 27% were Asian, and 10% were African-American. Thirty-nine percent were in their first year of residency, 27% were 2nd year, 27% were 3rd year, and 8% were 4th year (Ob/Gyn) residents. Compared to residents further along in their residency, those in their first year were more likely to participate; no other differences between participants and non-participants were found [data not shown]. There were no differences in addressing cessation based on the residents' race, gender, age, specialty, or year [data not shown].

Manipulation Check

Ninety-nine percent correctly identified the race of the patient.^b Residents rated the patients equally on the trait "lower class," which indicates that the socioeconomic class manipulation worked, $F(2, 87)=0.4$, $P<.66$ ($M_{\text{White}}=3.30$, $SD=0.6$, $M_{\text{African-American}}=3.20$, $SD=0.8$, $M_{\text{Hispanic}}=3.10$, $SD=1.0$).

^b The one resident who incorrectly listed the race of the patient likely listed his own race when asked the race of the patient.

Table 1. Frequency for listing smoking as a preventive health topic (unprompted) by race of randomly assigned patient

Race of Patient	Mentioned Smoking (%)	Did Not Mention Smoking (%)	χ^2 (2)
White (N = 30)	73	27	
African-American (N = 30)	73	27	
Hispanic (N = 30)	87	13	
Total	78	22	2.06, $P < .36$

Addressing Smoking

Most residents (78%) listed smoking cessation as a topic they would address with the patient. Residents had an average score of 4.6 (SD=0.7) on the 5-point Likert scale for the likelihood of their addressing smoking. The race of the patient was not associated significantly with listing smoking (unprompted) (Table 1), or with likelihood of addressing smoking (prompted). Race of the patient was not associated significantly with addressing any topics that residents listed [data not shown]. Because no racial differences in addressing smoking were found, no mediation analyses were conducted for explaining racial differences in addressing smoking.

Racial Differences in Mediators

We expected that residents assigned to the White patient would have higher outcome expectancies and self-efficacy and lower perceived barriers than those assigned to the African-American or Hispanic patient. The race of the randomly assigned patient was associated with outcome expectancies and per-

ceived barriers when controlling for receipt of the printed prompt. Scheffe's posthoc test revealed that residents assigned to the White lower-middle class patient reported lower outcome expectancies ($F [2, 86]=3.73, P < .03$), and higher scores on the priorities barriers scale, ($F [2, 85]=3.42, P < .04$), compared to residents assigned to the lower-middle class African-American or Hispanic woman (Table 2). To test whether stereotyping mediated the effect of patient race on outcome expectancies or barriers, the relationships between patient race and these factors were examined.²⁸ Scheffe's posthoc test revealed that residents assigned to the White patient were less likely to describe their patient as being consistent with the stereotype (eg, intelligent, talkative, assertive), compared to the residents assigned to the African-American and Hispanic patient, ($F [2, 86]=4.94, P < .009$). Residents who viewed their assigned patient as fitting the White stereotype were more likely to have higher outcome expectancies for the patient than those who rated the patient as not fitting the

White stereotype, ($F [1, 87]=6.63, P < .01$). Endorsement of the White stereotype was not significantly related to low endorsement of the priorities barrier scale, ($F [1, 86]=2.84, P < .09$). When the White stereotype scale was included in the model testing the association between the race of the patient and outcome expectancies, the effect of race became insignificant while the effect for the White stereotype remained significant (Figure 1). Thus, racial differences in outcome expectancies were mediated by reliance on the White stereotype. The mediation model was not tested for the priorities barrier because endorsement of the White stereotype was not significantly associated with endorsing barriers. Further, no differences were found for the African-American or Hispanic stereotype scales.

DISCUSSION

In this study, patient race had no effect on residents' preventive health priorities; smoking cessation counseling ranked high on their list of priorities regardless of the patients' race. This study differs from other studies that employed experimental designs to assess the effect of race² in that socioeconomic class was held constant across all patient races. Thus, the lack of racial differences could mean that previously detected differences may be attributable to assumptions physicians made about socioeconomic class, rather than about race. Alternatively, previously found racial differences in patients' reports of smoking cessation advice also may be indicative of differences in patient recall, rather than of physician behavior.

However, racial differences were found for outcome expectancies. Residents assigned to the lower-middle class White female patient had more negative impressions of the patient and were less likely to believe the patient would follow their medical recommendations compared to those residents assigned to

Table 2. Mean differences in mediators by race of randomly assigned patient

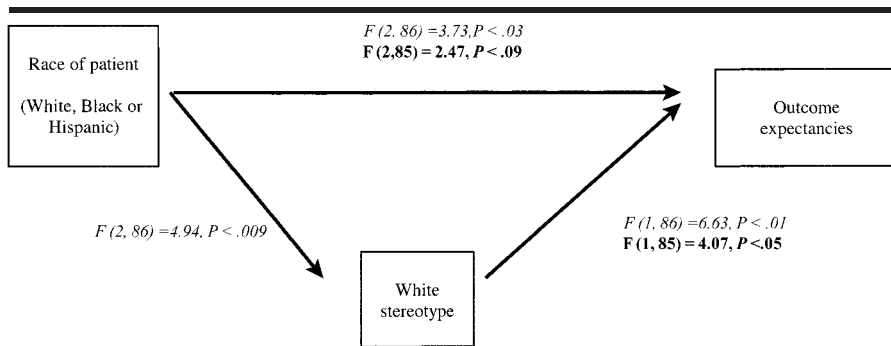
	White (M, SD)	African-American (M, SD)	Hispanic (M, SD)	Total (M, SD)
Outcome expectancies*†	2.4 (0.8) ^a	3.0 (1.0) ^b	2.7 (0.8) ^b	2.7 (0.9)
Self-efficacy†	4.3 (0.6)	4.6 (0.5)	4.6 (0.6)	4.5 (0.6)
Priorities barrier*‡	2.4 (0.9)	1.9 (0.8)	2.0 (1.0)	2.1 (0.9)
Discomfort barrier‡	1.4 (0.5)	1.2 (0.4)	1.3 (0.4)	1.2 (0.4)

^{a,b} Means are significant as indicated by Scheffe's post-hoc analyses.

* $P < .05$.

† Scales measured on 5-point Likert scales where 1 = not at all confident; 5 = extremely confident.

‡ Scales measured on 5-point Likert scales where 1 = strongly disagree; 5 = strongly agree.



Note: Statistics in italics are bivariate. Statistics in bold are multivariate (mediation analyses).

Fig 1. Endorsement of White stereotype mediating the effect of race of the patient on outcome expectancies

either of the ethnic minority patients. When people have high expectations for an individual and that individual fails to meet those expectations, the individual is viewed even more negatively than someone for whom the initial expectations were low.²⁹ White females are ascribed a relatively positive stereotype; however, in this study, residents were presented with a White female patient who was high-school educated, unassertive, and sexually promiscuous.

Because the White patient did not fit the typical stereotype, she may have been viewed more negatively and less receptive to health suggestions than the African-American or Hispanic female patients who were presented more stereotypically. Implications of this finding are that physicians may be aware of racial biases but not of class biases, especially for Whites. The impact of stereotyping on physicians' outcome expectancies is especially important because physicians who report higher outcome expectancies (that their patients will quit smoking as a result of their counseling) are more likely to address smoking cessation with their patients.^{15,24,30} Therefore, future interventions might focus on educating physicians about the association between reliance on stereotypes and outcome expectancies and ways to reduce stereotype use.

The use of stereotypes by medical professionals has not been examined in

other studies. This study enrolled primary care residents rather than attending physicians because residents' relative lack of negative experiences with minority patients may have rendered them less likely to endorse ethnic stereotypes. Further, residents were expected to address smoking cessation at higher rates than practicing physicians for the following reasons: 1) they were more likely to have had training in smoking cessation counseling in medical school; 2) they have been trained more recently; and 3) they spend more time with patients than practicing physicians. We attempted to make addressing smoking cessation somewhat challenging by asking residents to provide preventive health to a young woman whose visit was for acute care. Young women have more preventive health needs than other subgroups (eg, young men), forcing residents to prioritize among many preventive health topics. Further, preventive health is less likely to be addressed in acute care visits.^{31,32}

Limitations

Although this study presents a unique examination of racial differences in physicians' expectations of young female patients, the results have limitations. Methodological issues limit the interpretation of the results. Residents answered a survey about how they would respond to a videotaped interac-

... the lack of racial differences could mean that previously detected differences may be attributable to assumptions physicians made about socioeconomic class, rather than about race.

tion with a patient; their actual interactions with patients in a clinical setting were not observed and may differ. The results apply for a "best case" scenario, but it is unknown how residents would respond if they could only spend the amount of time physicians typically allow for patients (12 minutes). Residents may have provided socially desirable responses to avoid seeming racially biased. Also, residents may have been more likely to use stereotypes with these "mock" patients.

Further, the generalizability of the results may be limited. Residents at Duke University Medical Center may not be representative of all US residents. Further, because residents were allowed 45 minutes to spend with the patient, the findings may have limited generalizability for more advanced residents or for practicing physicians. In addition, these findings may be generalizable to preventive health for young lower-middle class females, but not for older populations, males or patients from higher social classes.

Further, residents' smoking cessation responses were skewed (with most residents listing smoking and reporting that they were very likely to address smoking). Power calculations were conducted assuming more variability in the measures, which would have produced more clinically meaningful differences (expecting a .5 difference in likelihood of addressing smoking). Therefore restricted ranges limited analyses conducted

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with these outcomes. Small sample sizes also precluded the ability to test differences due to provider race/ethnicity, gender, specialty, or year of residency.

Implications and Future Research

Despite these limitations, the study may have implications for clinical practice. Physicians-in-training inadvertently may view lower-middle class White women more negatively than lower-middle class women of color. These differences may be due to physicians' reliance on stereotypes, which is related to their expectations of the patients. To investigate this further, future research could vary the socioeconomic class of the patient, while holding race constant, or could vary race and class to determine whether race and class have a synergistic effect on residents' behavior. Examining patients' expectations and how they contribute to racial disparities also is warranted. Future studies should examine how stereotyping affects actual patient-physician interactions and whether changes in outcome expectancies translate to greater likelihood of the physician providing cessation counseling.

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Acquisition of funding: Pollak
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Appendix A. Patient–Provider script

Dr: Good morning (*Jennifer, Lekeisha, Maria*) I'm Dr. Lewis.
P: Good morning . . .
Dr: What brings you in today?
P: Well I've been having some stomach pain and I feel sick to my stomach.
Dr: Describe the pain to me.
P: I feel a bad crampy grabbing pain. It makes me miss work sometimes.
Dr: Where?
P: Down low, here (points to lower abdomen).
Dr: When do you get the pain?
P: Before my monthly and a few days after. It lasts all day and happens most times for the past 6 months.
Dr: When was your last period?
P: About 2 weeks ago.
Dr: Was it normal and on time?
P: Yes
Dr: Do you have any vaginal discharge or any burning on urination?
P: No
Dr: I see that 3 years ago you had a case of gonorrhea. Have you had any other STD's lately?
P: No, not that I know of.
Dr: Have you been tested for STD's recently?
P: No
Dr: Do you have a new partner recently?
P: No
Dr: Do you have a regular partner?
P: Yes
Dr: For how long?
P: For about a year.
Dr: So this is a different partner from 3 years ago?
P: Yes
Dr: Is this the only partner you have had in the last 6 months?
P: No, there have been a couple of guys here and there.
Dr: What kind of birth control do you use?
P: None
Dr: Do you use condoms with all of your partners?
P: Yes
Dr: How often?
P: Well almost all the time.
Dr: Are any of your current partners having discharge from their penis or had an STD lately?
P: No
