



Performing Black womanhood: a qualitative study of stereotypes and the healthcare encounter

Tina K. Sacks

To cite this article: Tina K. Sacks (2017): Performing Black womanhood: a qualitative study of stereotypes and the healthcare encounter, Critical Public Health, DOI: [10.1080/09581596.2017.1307323](https://doi.org/10.1080/09581596.2017.1307323)

To link to this article: <http://dx.doi.org/10.1080/09581596.2017.1307323>



Published online: 17 Apr 2017.



Submit your article to this journal [↗](#)



Article views: 66



View related articles [↗](#)



View Crossmark data [↗](#)

RESEARCH PAPER



Performing Black womanhood: a qualitative study of stereotypes and the healthcare encounter

Tina K. Sacks

School of Social Welfare, University of California-Berkeley, Berkeley, CA, USA

ABSTRACT

The US health system remains fraught with racial, gender, and class biases that lead to health care inequities. Although Black middle-class women are rarely studied in the context of health care disparities, they continue to face stereotyping and differential treatment. I argue that Black middle-class women are aware of pervasive stereotyping which leads them to emphasize specific class and cultural resources, i.e. cultural health capital, to mitigate discrimination. Based on in-depth interviews of 19 middle-class African-American women and two focus groups, the study explores stereotyping, bias and the use of cultural health capital as a strategy to mitigate them. Respondents overwhelmingly endorsed the importance of implementing these strategies, noting they were necessary to avoid differential treatment. The findings highlight pervasive stereotypes Black women face in health care settings and in general. Finally, the findings refocus our attention to the durability of race and gender discrimination across socioeconomic status and point to fundamental social inequities as determinants of health care disparities.

ARTICLE HISTORY

Received 22 April 2016
Accepted 6 February 2017

KEYWORDS

Health disparities; Black middle class; gender; qualitative methods; stereotypes; cultural health capital

In my own mind I try to avoid being stereotyped by doing certain things ... I just really think that sometimes how you present yourself, how you speak, how you're dressed ... unfortunately, that plays into the quality of care that you may receive—from the time you walk in all the way up to the time that you see the doctor.

Leona, 59, executive director of dance company

Introduction

At least since the Institute of Medicine's seminal study documenting racial and ethnic inequities in the US health care system (*Unequal treatment: Confronting racial and ethnic disparities in healthcare*, 2002), scholars have grappled with the underlying causes of differences in treatment. A growing body of evidence suggests provider bias is a significant driver of these inequities (Hall et al., 2015). Ethno-racial minorities, women, and others from disadvantaged social positions are particularly vulnerable to bias and stereotyping (Williams, 2006). Many studies have documented that health care providers exhibit unconscious or unintentional bias toward members of marginalized groups, which ultimately leads to differences in treatment across multiple domains, i.e. specialty care, pain management, mental health services, etc. (Aronson, Burgess, Phelan, & Juarez, 2013; Burgess, Fu, & Ryn, 2004; Ryn, Michelle, & Fu, 2003). Empirical tests of provider attitudes and behavior find implicit bias is relatively common in spite of the fact that providers often report an aversion to overt bias (Penner et al., 2010)

The purpose of this paper is to analyze how the perception of bias and stereotyping affect the health care experiences of racial minorities, i.e. Black middle-class women, who are not additionally burdened by poverty. I argue that these women anticipate being stereotyped and emphasize specific skills or resources in an effort to mitigate potential bias and discrimination.

Although the bulk of health care inequity research tends to focus on poor African Americans, scholars have recently turned their attention to health inequities that persist across class status. To that end, David Williams, the prominent health inequities scholar, has called for more attention to how risks and resources in the social environment are systematically patterned by race, ethnicity *and* socioeconomic status (SES) (Williams, 2006). Williams and colleagues also strongly emphasize that race matters even after SES is taken into account (Williams, Priest, & Anderson, 2016). By asking how race and racism affect minorities who are not poor, this line of inquiry broadens our focus to include both structural and individual determinants of health inequality.

For example, the empirical research has documented that Blacks remain vulnerable to poorer health outcomes, differences in treatment, and mental health disparities across SES (Hudson, Neighbors, Geronimus, & Jackson, 2016; Jackson & Cummings, 2011; Williams, Mohammed, Leavell, & Collins, 2010). In addition to physical health outcomes, Hudson and colleagues have found that middle-class Blacks are at even greater risk than their lower SES counterparts for mental health problems associated with exposure to racial discrimination (Hudson et al., 2016). They also found that greater levels of education were associated with increased levels of racial discrimination and depression (Hudson et al., 2016). This finding bears out Williams et al.'s work documenting the fact that although Black middle-class health improves with additional SES resources, they do not receive the same health protections as their White counterparts (Williams, 1999; Williams & Collins, 1995). This has also been called the 'diminishing returns' hypothesis, in which Farmer and Ferraro (2005) found that Blacks actually receive declining health returns as SES (i.e. education) increases.

The pernicious effects of stereotyping may help to explain mental and physical health disparities that persist for the Black middle class. Scholars have long noted that stereotyping is a critical component of a system that creates racist subordination (Omi & Wyant, 1994). Stereotyping may also negatively affect health through interpersonal pathways, e.g. increasing vigilance and allostatic load, and structural pathways, e.g. perpetuating social and physical environments that degrade health (Kwate & Meyer, 2011). Black women experience the health care system in the context of pervasive negative stereotypes about their race and gender, including the angry Black woman, mammy, welfare queen, and prostitute (Harris-Perry, 2011). In describing the particular stereotypes Black women face in the US, noted Black feminist scholar Patricia Hill Collins also theorizes the connection between stereotyping and oppression:

From the mummies, jezebels, and breeder women of slavery to the smiling Aunt Jemimas on pancake mix boxes, ubiquitous Black prostitutes, and ever-present welfare mothers of contemporary popular culture, negative stereotypes applied to African-American women have been fundamental to Black women's oppression. (2000, p. 7)

In addition to Collins, in their seminal book on shifting identities, Jones and Shorter-Gooden (2003) analyzed the specific challenges Black women face in the USA. They found that Black women are routinely confined to caricatures that are grotesque, narrow, and unfair. Going a step further, intersectional scholars have long noted that Black women face a double bind based on race and gender such that any analysis of their experience must consider the multiplicative impact of these identities (Collins, 2000; Crenshaw, 1991; Samuels & Ross-Sheriff, 2008).

In spite of the pervasiveness of negative stereotypes of Black women, relatively few studies consider how stereotyping may create a less-than-ideal health care environment. The work of medical sociologist Janet Shim, who conceptualizes the health care encounter as a transaction between patient and provider, may help us understand how Black women approach the particular challenges of the health care encounter.

Rooted in Bourdieu's concept of habitus, cultural health capital theorizes that one's ability to reproduce certain cultural actions is central to the patient-provider interaction (Shim, 2010). Shim defines this form of capital as a specialized collection of cultural skills, attitudes, behaviors and interactional styles that are valued, leveraged, and exchanged by both patients and providers during clinical interactions.

These skills and resources may include styles of dress, verbal skills, scientific knowledge, educational credentials, etc. Cultural health capital is also rooted in the historical and cultural moment, which currently emphasizes patient consumerism, initiative, and self-surveillance.

For Black middle-class women, elements of cultural health capital are particularly relevant. For example, Shim notes that cultural health capital rests on one's ability to communicate social privilege and resources that can act as cues of favorable social and economic status and consumer savvy. To establish these resources, patients must demonstrate knowledge of medical topics and vocabulary and also have the ability to convey health care information to the provider in an efficient and rational manner. All of these skills are critical to a successful health care encounter. Cultural health capital presupposes a belief in the value of, and resources to, practice self-discipline and the ability to take an instrumental attitude towards one body. Given that Black people are often reduced to caricatures about laziness, lack of intelligence, etc., demonstrating one's cultural health capital may be thought of as a form of resistance to stereotyping.

Importantly, although cultural health capital suggests that patients may indeed possess the resources to manage the health care encounter, these transactions may come at a cost. Shim posits that cultural health capital may contribute to the accumulation of power and the persistence of inequality. For example, Dubbin, Chang, and Shim found health care providers have particular expectations of what makes a capable and proficient patient (2013). Patients who do not meet the provider's expectation of astute self-management are considered less appealing, which may lead to a rupture in the patient-provider relationship (Dubbin et al., 2013). Given the pervasive stereotypes of Black women, they may feel even more pressure to emphasize certain elements of such capital in the hopes of mitigating prevailing notions of Black illegitimacy.

Data and methods

Analytic strategy

The study followed the general theoretical assumptions of grounded theory as outlined by Charmaz (2006). Charmaz's constructivist approach advocates the use of sensitizing concepts, which provide conceptual grounding while remaining open to emergent themes. The findings are based on 19 in-depth interviews and two focus groups, one with African-American lower-middle-class women and one with upper-middle-class women. In total, 30 respondents were enrolled in the study. The study was also designed to better understand subtle differences in intra-racial class variation, i.e. lower-middle-class Black women relative to upper-middle-class Black women.

The focus groups were conducted first and were designed to inform the development of the interview instrument. As such, the focus groups served as a credibility check of the interview instrument and were also a source of data. The focus groups allowed me to explore the implementation of the recruitment and enrollment strategy, which is in keeping with the iterative nature of qualitative inquiry (Denzin & Lincoln, 2011). Lastly, I selected study respondents based on their status as Black middle-class women. Given the relative dearth of research on the health care experience of non-poor minorities, the sample was explicitly recruited to explore the perceptions of respondents and does not make claims about health care providers themselves.

Focus group recruitment and sample

I used multiple strategies to recruit focus group participants, including posting flyers in public spaces throughout Chicago, e.g. grocery stores, coffee shops, the Chicago Black Women's Expo, etc. Given that identifying a group with this particular combination of race, gender, and class attributes was relatively difficult, I also asked members of my own extended network (including men and women of all backgrounds) to identify possible respondents. As such, although I used acquaintances to identify possible respondents, the acquaintances were not all Black middle-class women themselves. Therefore, I argue

that this strategy did not lead me to enroll respondents who were systematically similar. Although the respondents ostensibly shared the same race, class, and gender, they were no more or less similar than any other person would be based on those characteristics.

Further, I purposively recruited respondents based on their educational status. Although individual measures of SES are imperfect (Braveman et al., 2005), educational status is relatively stable over time, less likely to be influenced by health status than income or occupation, and provides a relatively simple way to categorize potential respondents (Shavers, 2007). As such, I recruited focus group respondents based on their educational attainment. 'Upper-middle' class respondents were required to have an advanced degree (i.e. anything beyond a bachelor's degree) and women in the 'lower-middle' group were required to have a bachelor's degree or less. I also conducted a follow up screening phone call in which I asked about their profession, marital status, and home ownership.

Respondents in the lower-middle group ranged in age from 35 to 57 with an average age of 38.6. Five respondents had some college education. One respondent in the lower-middle-class focus group had a bachelor's degree, but after conducting a follow up phone screening I determined that based on other SES measures (i.e., income, home ownership, and occupation), this respondent's experience would be more accurately categorized as lower-middle class. Respondents in the upper-middle group ranged in age from 37 to 48 with an average age of 44.2. Four respondents had advanced degrees while one had a bachelor's degree. The groups were conducted in 2010 in Chicago, and each lasted approximately two hour. As noted above, the focus group data were used to inform the development of the in-depth interview instrument and as a source of data (Morgan & Krueger, 1998). As such, the focus groups were conducted in the months leading up to enrollment for the interviews.

I asked focus group respondents to share their general impressions of seeking health care, including positive and negative experiences. Respondents were also asked to reflect on their most recent health care experience and questions about whether they purposefully managed their persona to try to get better treatment. Focus group respondents were also encouraged to share their experiences as a group. Based on the focus group data, I developed a semi-structured interview instrument. As such, in-depth interview respondents were asked similar questions, which facilitated comparison across data collection methods.

Interview recruitment and sample

Similar to recruitment for the focus groups, I recruited interview respondents through multiple mechanisms, including snowball sampling and placing announcements on Facebook and Craigslist asking self-identified Black women living in Chicago to participate in a study about their health care experiences. Like the focus groups, women were initially recruited to the study based on their education, i.e. I asked women with some college education or beyond to participate in the study. Although the definition of 'middle class' is contested, many social scientists use median income, educational attainment, or individual aspirations (e.g. being able to send children to college) to categorize this group (Renwick & Short, 2014). Based on a follow-up phone screening, women were included in the study if they met one or more of the following criteria: (1) income (a household income of 50,000 or more); (2) education (having a bachelor's degree or beyond); (3) occupation (having a professional job or owning a business); and (4) home ownership. Enrollment for the study was concluded at 19 respondents because saturation of the main themes had been reached.

Table 1 summarizes the demographic characteristics of the interview respondents. In addition, given that people with health problems are more likely to have engaged the health care system, I asked each respondent to rate their own health status and to disclose any serious chronic or acute illnesses/injuries they experienced as an adult. Of 19 respondents, eight had no significant health problems and rated their health as excellent or good. Six had a previous acute, serious illness like breast cancer. These respondents also rated their current health as excellent or good. Five had chronic conditions including autoimmune diseases or work-related injuries. Respondents with chronic illnesses ranged in their self-reported health from good to poor.

Table 1. Interview respondent demographics.

	Range	#Participants	Average	Minimum	Maximum
Age	35–44	3	48.8	38	67
	45–54	7			
	55–64	8			
	65+	1			
Health insurance ^a	Public	4			
	Private	13			
	None	2			
Education	Some college	6			
	BA	5			
	Advanced degree	8			
Income	<\$30k/year	4			
	\$30k–\$49,999/year	3			
	\$50k–\$99,999/year	6			
	\$100k+	4			
	Declined to state	2			
Home ownership	Own	12			
	Rent	7			
Marital status	Married	8			
	Single	4			
	Divorced	7			

^aTwo respondents had insurance coverage for the majority of their lives but were uninsured at the time of data collection.

In-depth interviews

I conducted individual interviews in 2010 and 2011. The interviews were conducted in the respondents' homes or location of their choice and were approximately 90–120 minutes in length. A University of Chicago institutional review board approved all study protocols. Pseudonyms are used to refer to respondents throughout this paper.

The semi-structured in-depth interview guide included questions and probes organized into the following categories: (1) general impressions of the health care system and health care encounters; (2) race and gender preference in health care settings; (3) racial attitudes and discrimination based on race, gender, class and other factors; and (4) intra-racial solidarity. The interview guide included questions that were adapted from Lacy (2007) about intra-racial class variation and Malat, van Ryn, and Purcell (2006) about positive self-presentation strategies. However, the interview guide was open-ended and allowed respondents to bring up topics that were salient to them. Similar to the focus groups, I asked respondents to reflect on their experiences with health care providers overall, their own health status, and their experiences of discrimination, both in health care settings and in general. I did not specifically ask about stereotyping or cultural health capital. These concepts emerged during the analysis.

Analysis

The focus groups and in-depth interviews were audio-recorded and transcribed. The analysis was informed by grounded theory analytical techniques and texts on coding and analyzing qualitative data (Auerbach & Silverstein, 2003; Charmaz, 2006; Corbin & Strauss, 1990; Creswell, 2007; Padgett, 2008). The transcriptions of the individual interviews and the focus groups were imported into the NVivo software program, which assisted in data management. I also used Excel to organize my observations of the data and to record emergent themes. The transcripts were checked for accuracy against the audio recordings.

The second phase of data analysis included line-by-line coding and using the constant comparative method, a process in which newly collected data are compared to existing data to arrive at new codes, themes, and conceptual foci. First, I used *in vivo* codes that reflected the women's own words and overall perception of health care providers. Second, based on these codes, I grouped the responses into themes including: (1) maintaining their appearance or physical self-presentation; (2) conducting research prior to the health care encounter; (3) connecting with the health care provider; and (4) emphasizing their

professional and/or educational credentials. Last, I developed additional theoretical codes that reflected the constitutive elements of cultural health capital, including knowledge of relevant information to share with provider, ability to communicate social privilege, etc.¹ Focus group data were analyzed similarly according to Morgan and Krueger's focus group analysis techniques (Morgan & Krueger, 1998).

Findings

'Dressing the part': physical presentation in health care settings

To understand how Black women navigate the health care encounter, respondents were asked how they prepared for doctor's visits. Respondents noted that manner of dress and physical self-presentation exerted the most immediate effect on the health care encounter. For example, Effy, a divorced woman in her 50s diligently pursuing her bachelor's degree, stated:

We used to always look nice and be clean wherever you go, but first impressions have a lot to do with the way people treat you. They may not know you, but whatever they see first that's what's going to be the long lasting.

Another respondent, Christina, suggested that what she wears affects the care she receives. She stated:

I have went to the doctor's office in jeans. Sometimes I went dressy, but I do think they do look at you different. One day I wore my Coach (designer) purse, and they said, 'You look so good. Where did you get that purse from?' ... I do think they look at you different, like, 'You've got that diamond ring on your finger?' She might report me if I don't treat her right. But you walking around with some raggedy shoes, and your hair sticking out, I think they might say, 'She ain't going to report me.'

43 year-old married mother of two; owns home daycare business

Effy and Christina's comments illustrate a domain of cultural health capital, the ability to communicate the appearance of social privilege and cues of favorable economic and social status. Christina noted that wearing certain clothing or accessories gives the impression she is a person to be taken seriously. Furthermore, Christina alluded to the fact that her concerns were taken more seriously if people believed she had money, or that she was 'not poor'. Christina's comments illustrate the cultural health capital domain of communicating social privilege and material resources through manner of dress. They also highlight Christina's perception of the US health care system's antipathy to the (Black) poor.

Other women in the study reported similar attitudes. For example, a focus group participant strongly implied that because of Black women's vulnerable position in society, managing one's physical presentation is crucial:

... And look it, as African Americans, we were told – I was told never to go to the doctor looking worn down and torn down, to always come together. But you think if I took the time to get myself together, I wasn't as sick? No. My mother told me to always have something together.

Focus group respondent in her 50s

This respondent suggested that because Black women are often devalued in American society, pride in one's personal appearance is essential to maintaining a sense of self and projecting competency to the broader world. Given pervasive stereotyping and bias, woman may anticipate being devalued based on their physical appearance and preemptively emphasize elements of social privilege to try to mitigate negative perceptions.

'Demonstrate that you are also a person': women's efforts to connect with health care providers

Although many women agreed that dress was an important way to telegraph their social privilege, respondents noted that forging a relationship with the provider went even further toward establishing themselves as rights-bearing health care citizens. The majority of (16 of 19) respondents indicated that developing a good relationship was personally important to them.

When asked how she is treated at the physician's office, Chris, a 59-year old married woman with a doctorate in divinity responded:

I think that they first look at me as being inferior because of my gender. I think they look at me being even more inferior because of my race ... I think a lot of people get surprised when you finally start talking to them and they realize that—That you are intelligent, you are articulate, you work hard to communicate accurately. I think they also get surprised when you demonstrate that you are also a person. You've got to click in order for them to understand that hey, I'm not chopped liver here. But I think that unfortunately, the onus is on the patient to be aggressive, oh, that's terrible, isn't it?

Chris's comments convey a subtle but determined quest for personhood and recognition. She noted the particular gender and race stereotypes that may have led the provider to devalue her. In Chris's case, she described another cultural health capital domain, the skill to communicate health-related information in a medically intelligible and efficient manner, as the strategy she employed to minimize stereotyping and bias.

Chris's class and cultural resources allowed her to use articulation to connect with the provider, presumably to secure better interpersonal treatment than if she did not have these skills. However, her statement that 'the onus is on the patient to be aggressive ... is terrible' suggests that this type of adjustment is burdensome. Political scientist Harris-Perry (2011) contends that Black women must work hard to hold on to their individuality given the ways in which Black women are 'misrecognized,' or denied their common humanity and citizenship, in the American polity and psyche. Theorist Nancy Fraser also notes, 'people can be prevented from interacting on terms of parity in institutional hierarchies of cultural value that deny them the requisite standing: in that case they suffer from status inequality or misrecognition' (Fraser, 2007, p. 20). Chris's analysis of the ways in which her race, class, and gender affect health care suggest misrecognition occurs in that setting as well.

Although Chris acknowledged the impact of the performative elements of connecting with the provider, she also lamented that while she did what she could to minimize potentially negative treatment, there were instances in which nothing affected the outcome. For example, she described a situation in which she and her husband, who is a professor, were referred to a health club to begin an exercise regimen. She stated,

I think that how you present yourself, your education, your educational persona is going to affect how you are going to be received and treated. But then last week at the health club, we went to the health club for the first time. And the people at the desk wanted to know what we were doing there and did we have an appointment and they even called up to the rehab center to make sure that we were legitimate. So even educational level and how you present yourself sometimes doesn't make a darn bit of difference.

Again, Chris's appraisal of the impact of stereotyping is instructive in that Black people continue to face discrimination in their daily lives regardless of their ability to emphasize educational attainment or 'discipline' their bodies through exercise. Her frustration indicates that in spite of her educational 'persona,' she is delegitimized even when attempting to enact a key element of cultural health capital: taking an instrumental approach to one's body (Shim, 2010). In this instance, Chris's cultural capital cannot mitigate prevailing notions of Black illegitimacy.

Another respondent, Ellen, a 60-year-old married woman who works in IT sales, also highlighted the importance of making a personal connection:

... You want that person to care about you as an individual. You want that person not to see you as a piece of meat, but you want them to see you as an individual, see your cares, your concerns. So yes, see me as an individual, not a number ... But I do try to establish that personal connection so that they will put that little extra effort towards caring for me.

Both Chris and Ellen touch on an essential desire to construct an identity or personhood and to be recognized as a human being. These existential concerns are universal, although I would argue that because of the context of the Black experience in the United States, this effort takes on a particular meaning for Black women who must struggle against stereotyping and dehumanization.

'Try to take part in your healing' ... but not too much: women navigate the fine line between engagement and challenge

In keeping with Dubbin's et al.'s (2013) empirical finding on the importance of being able to convey medical information in a succinct and rational manner, study respondents also acknowledged that

conducting research prior to the appointment and demonstrating intelligence were critical to being viewed as a legitimate, credible patient. They strongly expressed the belief that conducting research was a prerequisite for a successful visit. For example, Vanessa stated:

Oh, I think it's important, right up front, so they know then they don't have to waste time trying to tell you, give you instructions on what to do, or whatever. That is gonna set them up, too, to treat you in a certain way, because they know that you're a little more knowledgeable.

Vanessa, 50, divorced, owner of image consulting business

Vanessa's comments illustrate a central tenet of cultural health capital: the ability to communicate in an intelligible and efficient manner. Further, Vanessa hinted at the need to convey medically relevant information quickly and succinctly. Although the contemporary health care context universally pressures patients to act as medical consumers, these pressures may disproportionately affect Black women. Vanessa and other respondents' comments highlight the perceived importance of conveying legitimacy, motivation, and mastery of biomedical discourse.

The importance of doing research prior to the encounter was echoed in the focus groups. One focus group respondent spoke fervently about her efforts to be taken seriously:

I come in so armed with information that you can look at me and want to put me in this box but the minute I start talking about some words that you know you read in a book somewhere it's completely different!

35 year-old single woman who owns a consulting business

Although the respondent did not explicitly name the stereotypes to which she obliquely referred as the 'box', one may interpret her statement as an effort to be viewed as an individual separate from perceptions of Black women. Overall, respondents suggested that they were aware of race and gender stereotypes and explicitly tried to avoid being judged based on them. In keeping with Burgess and colleagues' 2010 study, which emphasized the importance of not 'wasting the provider's time' and demonstrating personal worthiness to quality care, these data suggest Black women are aware of this type of threat and actively resist it.

Discussion and conclusion

This study considered Black women's efforts to resist discrimination in health care settings. All study respondents acknowledged the pervasiveness of stereotypes of Black women, and the importance of adopting certain behaviors to mitigate discrimination.

In addition to the fact that respondents acknowledged implementing specific strategies to resist stereotyping, they also reflected on the social inequities, i.e. race and gender bias, which led them to believe they should do so. As such, this finding implicates a larger system of inequality and does not imply that women should have to engage in these behaviors to receive adequate medical care. I do not argue that employing cultural health capital should be thought of as an intervention to reduce health disparities. Rather, the findings should serve as a critique of the social arrangements that give rise to such disparities and the strategies women use to mitigate them.

Similar to Goffman's (1959) conceptualization of the importance of self-presentation in everyday life, study respondents emphasized the need to carve out a space for themselves as individuals, which may be understood as a way to resist pervasive stereotyping. Prior to the visits, women described conducting extensive research in an effort to be an informed, competent health care consumer. Although many women had positive experiences with providers, they all noted that it was important to demonstrate their cultural health capital. Demonstrating elements of cultural health capital, like the scientific rationality conveyed by conducting research prior to the health care encounter, was particularly salient.

In addition, although the respondents are not as vulnerable as lower income African Americans, their stories implicate the ongoing significance of race and gender in shaping health care. For the women in this study, emphasizing their cultural health capital skills was a form of self-advocacy in the context of an asymmetrical patient-provider relationship. For racial and gender minorities, the power asymmetry

may be that much more acute. As a result, Black women, regardless of their class status, feel the need to perform, jockey, or otherwise fight for recognition. At least for Black middle-class women, they possess more resources to bring to bear on the encounter. The fact that Black, American, middle class women, with their relative privileges, continue to face these challenges certainly does not bode well for other groups with multiple disadvantages, including the poor, patients who do not communicate well in English, undocumented patients, etc. In this manner, these stories serve as a litmus test for the health care system's ability to successfully treat society's most vulnerable.

Moreover, executing these strategies requires significant effort and may exact an emotional and cognitive toll. Malat et al. (2006), Geronimus (1996), Krieger and Sidney (1996), Clark, Anderson, Clark, and Williams (1999), and others have described this type of exertion as an additional stressor or burden that is linked to poor health among African Americans. These stressors likely exert a cumulative physiological effect (McEwen & Seeman, 1999), which may explain why African Americans have worse health outcomes at every level of income and education compared to their White counterparts. Further, a growing body of literature on health-related stereotype threat confirms that stereotyping in health care settings may lead to increased anxiety, physiological arousal and subsequent difficulty communicating with the provider (Burgess, Warren, Phelan, Dovidio, & Van Ryn, 2010).

In spite of the contributions of this work, I acknowledge the study's limitations. First, study respondents were drawn from a purposive sample based in one large US city. Second, women with poor health may have been more likely to participate in the study. These factors may limit the generalizability of the findings. However, as is the case with qualitative research, transferability (and not generalizability) is the criterion upon which the research should be evaluated (Denzin & Lincoln, 2011). Third, the study includes women of various ages with different underlying health status and levels of physical activity. As such, it is possible that their experiences with health care providers differed based on their health status. In spite of these differences, respondents reported remarkably consistent experiences of stereotyping and use of cultural health capital techniques. Thus, the empirical findings suggest that the necessity to emphasize certain skills to get better care is important regardless of health status or physical activity.

In sum, the Black middle-class women in this study highlighted the ongoing need to resist stereotyping and discrimination in health care settings. Study respondents acknowledged the importance of adopting certain behaviors prior to, and during, the clinical encounter to improve the patient-provider interaction. However, although respondents indicate cultural health capital is critical to forging a productive relationship with a health care provider, these resources are differentially distributed in society. As such, although these strategies may facilitate a positive relationship with a provider, they may also reinforce social inequities.

The findings also bring our attention to the durability of race and gender discrimination in health care settings. This should prompt us to consider possible interventions to ameliorate discrimination, particularly provider bias. To that end, a group of physician scholars have recently elaborated a 'fundamental cause' approach first advanced by Link and Phelan (1995) and later taken up by physicians, social scientists, and critical theorists (Metzl & Hansen, 2014). The fundamental cause framework theorizes social problems in the context of social structures, e.g. structural racism and gender discrimination, that ostensibly give rise to health care inequities, provider-level bias, stereotyping and differences in treatment. The framework emphasizes the antecedent structural causes of social problems and does not remain solely at the individual level of the patient and provider.

Metzl and Hansen (2014) have suggested that graduate medical education adopt the fundamental cause approach in its training of new physicians. In so doing, they call for medical training to emphasize the structural causes of individual medical problems. Metzl and Roberts take this further to integrate the notion of structural competency with an explicit focus on racism in medical settings. Finally, Rich, Hansen, and Link (2016) have conceptualized a 'fundamental interventions' approach that addresses the fundamental causes of disease in clinical settings. These theoretical perspectives are critical to generating actionable interventions that situate the problem of health inequities at the structural, and not only, individual level.

Finally, this study highlights the power relations inherent in the health care encounter. It reminds us of the ongoing struggle to assert one's humanity in the face of persistent race, gender, and class stereotypes. Certainly, the women's stories illustrate the strategies they use to avoid stereotyping while simultaneously implicating the larger system of social inequity that forces such adaptations. It is my hope that by explicitly naming the individual and structural forces that affect the health care encounter, we may begin to finally eliminate differences in treatment.

Note

1. The codes and analytic strategy were developed in consultation with a qualitative methods working group at the University of Chicago.

Disclosure statement

No potential conflict of interest was reported by the author.

Funding

This work was supported by Fahs-Beck Fund for Research and Experimentation.

References

- Aronson, J., Burgess, D., Phelan, S. M., & Juarez, L. (2013). Unhealthy interactions: The role of stereotype threat in health disparities. *American Journal of Public Health, 103*, 50–56.
- Auerbach, C., & Silverstein L. B. (2003). *Qualitative data: An introduction to coding and analysis* (1st ed.). New York, NY: New York University.
- Braveman, P. A., Cubbin, C., Egerter, S., Chideya, S., Marchi, K. S., Metzler, M., & Posner, S. (2005). Socioeconomic status in health research. *JAMA, 294*, 2879–2888.
- Burgess, D. J., Fu, S. S., & Ryn, M. V. (2004). Why do providers contribute to disparities and what can be done about it? *Journal of General Internal Medicine, 19*, 1154–1159.
- Burgess, D. J., Warren, J., Phelan, S., Dovidio, J., & Van Ryn, M. (2010). Stereotype threat and health disparities: What medical educators and future physicians need to know. *Journal of General Internal Medicine, 25*, 169–177.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.
- Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*, 805–816.
- Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. New York, NY: Routledge.
- Corbin, J., & Strauss, A. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. (S. Oaks, Ed.). Thousand Oaks, CA: Sage.
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*, 1241–1299.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. (2nd ed.). Thousand Oaks, CA: Sage.
- Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Dubbin, L. A., Chang, J. S., & Shim, J. K. (2013). Cultural health capital and the interactional dynamics of patient-centered care. *Social Science & Medicine, 93*, 113–120.
- Farmer, M. M., & Ferraro, K. F. (2005). Are racial disparities in health conditional on socioeconomic status? *Social Science & Medicine, 60*, 191–204.
- Fraser, N. (2007). Re-framing justice in a globalizing world. In T. Lovell (Ed.), *(Mis)recognition, social inequality and social justice: Nancy Fraser and Pierre Bourdieu* (pp. 17–35). Abingdon: Routledge.
- Geronimus, A. T. (1996). Black/White differences in the relationship of maternal age to birthweight: A population-based test of the weathering hypothesis. *Social Science & Medicine, 42*, 589–597.
- Goffman, E. (1959). *The presentation of self in everyday life*. New York, NY: Anchor.
- Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., & Eng, E. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health, 105*, e60–e76.
- Harris-Perry, M. (2011). *Sister citizen: Shame, stereotypes, and Black women in America*. New Haven, CT: Yale University Press.

- Hudson, D. L., Neighbors, H. W., Geronimus, A. T., & Jackson, J. S. (2016). Racial discrimination, John Henryism, and depression among African Americans. *Journal of Black Psychology, 42*, 221–243.
- Jackson, P. B., & Cummings, J. (2011). Health disparities and the Black middle class: Overview, empirical findings, and research agenda. In B. A. Pescosolido, J. K. Martin, J. D. McLeod, & A. Rogers (Eds.), *Handbook of the sociology of health, illness, and healing* (pp. 383–410). New York, NY: Springer.
- Jones, C., & Shorter-Gooden, K. (2003). *Shifting: The double lives of Black women in America*. New York, NY: Harper Collins.
- Krieger, N., & Sidney, S. (1996). Racial discrimination and blood pressure: The CARDIA Study of young Black and White adults. *American Journal of Public Health, 86*, 1370–1378.
- Kwate, N. O. A., & Meyer, I. H. (2011). On sticks and stones and broken bones. *Du Bois Review: Social Science Research on Race, 8*, 191–198.
- Lacy, K. R. (2007). *Blue-chip Black: Race, class, and status in the new Black middle class*. Berkeley, CA: University of California Press.
- Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior, 35*, 80–94.
- Malat, J. R., van Ryn, M., & Purcell, D. (2006). Race, socioeconomic status, and the perceived importance of positive self-presentation in health care. *Social Science & Medicine, 62*, 2479–2488.
- McEwen, B. S., & Seeman, T. (1999). Protective and damaging effects of mediators of stress: Elaborating and testing the concepts of allostasis and allostatic load. *Annals of the New York Academy of Sciences, 896*, 30–47.
- Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine, 103*, 126–133.
- Morgan, D. L., & Krueger, R. A. (1998). *The focus group tool kit*. Thousand Oaks, CA: Sage.
- Omi, M., & Wyant, H. (1994). *Racial formation in the United States: From the 1960s to the 1990s* (2nd ed.). New York, NY: Routledge.
- Padgett, D. K. (2008). *Qualitative methods in social work research* (S. Oaks, Ed.). New York, NY: Routledge.
- Penner, L. A., Dovidio, J. F., West, T. V., Gaertner, S. L., Albrecht, T. L., Dailey, R. K., & Markova, T. (2010). Aversive racism and medical interactions with Black patients: A field study. *Journal of Experimental Social Psychology, 46*, 436–440.
- Rich, L. E., Hansen, H. B., & Link, B. G. (2016). “Born Like This / Into This”: Tuberculosis, justice, and futuristic dinosaurs. *Journal of Bioethical Inquiry, 1–5*.
- Renwick, T., & Short, K. (2014). *Examining the middle class in the United States using the lens of the supplemental poverty measure*. U.S. Census Bureau Working Paper. Retrieved from https://www.census.gov/hhes/povmeas/publications/other/renwick_short-SPM.pdf
- Ryn, V., Michelle, S., & Fu, S. A. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health?. *American Journal of Public Health, 93*, 248–255.
- Samuels, G. M., & Ross-Sheriff, F. (2008). Identity, oppression, and power: Feminisms and intersectionality theory. *Affilia, 23*, 5–9.
- Shavers, V. L. (2007). Measurement of socioeconomic status in health disparities research. *Journal of the National Medical Association, 99*, 1013–1023.
- Shim, J. K. (2010). Cultural health capital a theoretical approach to understanding healthcare interactions and the dynamics of unequal treatment. *Journal of Health and Social Behavior, 51*(1), 1–15.
- Unequal treatment: Confronting racial and ethnic disparities in healthcare*. (2002). Washington, DC: National Academies Press.
- Williams, D. R. (1999). Race, socioeconomic status, and health the added effects of racism and discrimination. *Annals of the New York Academy of Sciences, 896*, 173–188.
- Williams, D. R. (2006). Race, socioeconomic status, and health the added effects of racism and discrimination. *Annals of the New York Academy of Sciences, 896*, 173–188.
- Williams, D. R., & Collins, C. (1995). US socioeconomic and racial differences in health: Patterns and explanations. *Annual Review of Sociology, 21*, 349–386.
- Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status, and health: Complexities, ongoing challenges, and research opportunities. *Annals of the New York Academy of Sciences, 1186*, 69–101.
- Williams, D. R., Priest, N., & Anderson, N. B. (2016). Understanding associations among race, socioeconomic status, and health: Patterns and prospects. *Health Psychology, 35*, 407–411.