

ABSTRACT

South Asian Physician-Patient Interaction (SAPPI)

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This thesis looks at the relationship between South Asian physicians practicing in North America and the possibility of them having an implicit bias preferring South Asian patients as opposed to patients of other races. The first three chapters are literature reviews covering the concepts of the biopsychosocial model of thought, the difference in culture between Eastern societies and Western societies, and the level of cultural comfort for patients in South Asian societies and North American societies. The last chapter of this project will discuss the findings and results of the research done for this study over a randomized group of South Asian physicians who are currently practicing in North America. The goal is to determine if the South Asian physicians who participated in the study's survey show any type of implicit bias that proves significant preference for other South Asian individuals as patients. Overall, the purpose of this research is to determine if South Asian physicians in North America have an implicit bias that shows a preference for patients with a similar race and/or ethnicity as them.

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DEDICATION

To my always loving parents, Tariq Khan and Anita Khan. You both came to this country and endured difficult moments for the sake of your children's futures, even if it may have been less arduous to stay in Pakistan. Thank you for showing me what it means to be a Pakistani-American. In return, I hope to always carry your love, your name, your ethics, and your teachings regardless of where I go.

INTRODUCTION

Discrimination in health care practices can be subtly perpetuated either unconsciously or consciously. Usually, the most identified forms of discrimination are the noticeable outright biased and prejudiced behaviors. However, behavior that is blatantly hurtful and detrimental in the health care practice is not readily tolerated in today's society. Therefore, most of the negative behaviors that patients experience with their care are via subtle instances like microaggressions. Another important fact to note is that not all of the ethnic and racial biases people experience are necessarily negative at first glance. Some of these actions and thoughts can come from feelings of seemingly good will, such as treating patients differently based on shared backgrounds with the physician; however, even these actions and thoughts do not lessen the fact that they ultimately lead to an inherent difference in treatment plans for patients. Overall, these racial and ethnic biases lead to different treatment plans which can affect the patients' perception of their personal value and their overall placement in society. This paper will cover the question regarding if South Asian physicians approach their patients' treatment plans differently based on non-medical factors such as similarity of shared culture and ethnicity, and if this can lead to biased treatments especially concerning communication and understanding between physicians and patients.

Chapter One will introduce the in-depth effects of cultural bias and focus on the biopsychosocial model of thought and its importance when looking at the difference in treatment between South Asian and non-South Asian patients. Some of the introductory

studies will cover how cultural humility is different than cultural competence and how misusing these terms can lead to bias and prejudiced practices no matter if the intentions are good or bad (Trevalon M & Murray-Garcia J, 1998). Chapter One will also introduce other key terms that define the paper's research question, also covering the biopsychosocial model of thought and how a health care treatment is enhanced and modified from a multitude of perspectives other than just a biological approach. Other important factors in a treatment plan are the psychological and social components. This means that health issues cannot be addressed through only one manner. As a result, the presence of racial and ethnic bias can lead to a difference in the social aspect of the model. This can further spiral and change the psychological and biological components as well. Therefore, this chapter will mainly exhibit how the biopsychosocial model of thought can change the relationship and communication between people through the presence of bias and how this can relate to the patient and physician relationship.

The second chapter will focus on cultural differences in the West and the East, and how this cultural difference can apply to a professional setting. The highlighted research will compare the different countries' medical education systems and their effects on medical students. An example of this is Marwat M.'s (2013) paper over "Prevalence of Depression and the Use of Antidepressants Among Third Year Medical Students of Khyber Medical College" which talks about the perception and stigma of mental health in Pakistani society and how this shapes the opinions that medical students bring with them to their future practices. Studies like this will be compared to studies of American medical schools' perceptions of mental health. Therefore, the main topic discussed throughout this chapter will be how differences in culture affect the social thought

process of an individual and how specific mindsets for different groups of people are cultivated. This will lead to the discussion of a probable difference when regarding how physicians interact with their patients through the lens of culture differences between South Asian physicians who received education from a South Asian university and those who received their education from a North American university.

Chapter Three will continue to cover if South Asian patients are more comfortable in communities with more South Asian Physicians or less South Asian Physicians. This section will mostly focus on if having a physician with a similar racial background leads to a more open and honest professional relationship between physician and patient, or if there is greater hesitancy to reveal information and why. An important note for this chapter is that the two communities, South Asia and North America, discussed are vastly different from each other, so culture will play a huge role in determining the type of treatment available to patients. Research like Maan et al.'s (2011) study over "Sexually transmitted infections in Pakistan" will highlight that the homogenous nature of South Asian countries. These nations show a shared culture of modesty that determines how open individuals are in discussing certain kinds of ailments depending on if they are from North America or South Asia. In summary, the research covered here will focus on traditional South Asian communities contrasted with western communities. The goal of this chapter is to see if patients in South Asia report better health and/or health care involvement overall, or if South Asian patients in the West report better health and health care involvement. During this, it is important to understand how the society itself can contribute to the health care experience. This section will compare the two societies to

see if there is a better rating of health care treatment in societies with a larger presence of South Asian physicians or societies with less South Asian physicians.

The last chapter of this paper will focus on the personalized research questions created for this study in particular. The questions will be given as a survey to South Asian physicians in North America contacted through an email list with the nonprofit organization APPNA, Association of Physicians of Pakistani Descent of North America. The main purpose of the survey is to determine the presence of racial and ethnic bias South Asian physicians can have towards South Asian patient communities and non-South Asian patient communities. Chapter Four will statistically analyze and interpret the results of the survey to determine if significant bias is present in order to answer the main question for this paper: do South Asian physicians approach their patients' treatment plans differently based on non-medical factors such as similarity of shared culture and ethnicity, and can this lead to biased treatments especially concerning communication and understanding between physicians and patients? This chapter will tie together the literature studied and reviewed during the previous chapters to come to a definite conclusion regarding the presence and effect of racial and ethnic bias of South Asian physicians toward patients of different ethnicities in North America.

The main goal of this paper is to analyze the overall effect of racial and ethnic bias that physicians can have in their practice, and the effects these outlooks and practices can have on the treatment plans of patients. Then the paper will apply these preexisting studies specifically to the research question regarding South Asian physicians in North America and their personal racial and ethnic biases towards their patients.

CHAPTER ONE

Biopsychosocial Model of Thought

The biopsychosocial model is a concept in psychology that covers the relationship between biology, psychology, and socio-environmental factors. Specifically, it concerns itself with how the three factors affect the appearance, duration, and outcome of wellness and disease in a person's life. When it comes to determining the presence and intensity of diseases and illnesses, socio-environmental factors and psychological factors are just as important as biological factors in predicting the overall level of health. The relationship between these three categories is vital for health and wellness because these factors determine the quality of life one is able to achieve.

It has been covered in multiple studies that people from poor socioeconomic lifestyles are not only prone to being more susceptible to physical diseases but also psychological diseases such as depression and anxiety. In a study done by researcher Luke Allen et al. (2017) over socioeconomic status and non-communicable disease behavioral risk factors in low-income and lower-middle-income countries, the data concluded that "Low socioeconomic groups were found to have a significantly higher prevalence of tobacco and alcohol use than did high socioeconomic groups. These groups also consumed less fruit, vegetables, fish, and fibre than those of high socioeconomic status" (Allen et al., 2017, p. e277). Therefore, this demonstrated lower socioeconomic groups were unable to access the necessary and vital nutrients they would need to develop and strengthen their bodies' responses to the threats of illness and disease.

Furthermore, the study also contributed the conclusion that “[their] tobacco findings mirror the well established inequalities from high-income countries, where low-income groups are the most likely to smoke, start smoking earlier, consume more tobacco, quit less successfully, experience more adverse health effects, and die at a younger age than affluent groups” (Allen et al., 2017, p. e284-285). The low consumption of healthy and nutritious food and higher use of tobacco and alcohol in low socioeconomic groups compared to higher socioeconomic groups contributes to the biopsychosocial model because there are social factors, such as education and income that were noted variables tested in the study, that are linked to the health choices that people are making across socioeconomic stratified groups.

A study concerned with social factors and the propensity for mental illness was conducted in Massachusetts over socioeconomic status and mental illness, testing the social causation and selection hypothesis. Essentially, this study analyzed a statewide database on acute psychiatric hospitalization during the years 1994-2000. The results gathered here showed that there is a negative correlation between socioeconomic status and mental illness. This means that the higher the socioeconomic status, the lower the instances of hospitalization due to mental illness in the community. One of the most significant conclusions gathered was that “whether income, education, or occupational status is considered in relation with overall rates or with schizophrenia or depression in particular, the correlations are moderately to strongly negative, ranging from $-.25$ to $-.70$ ($p < .01$). Similarly, the more economic hardship communities experienced, the higher the rates of hospitalization and reported mental illness were. These have correlations (Pearson’s r) ranging from $.12$ to $.69$, with the most modest relationships involving

housing affordability. Also, the lower the indicators of family fragmentation were, the lower the rates of mental illness were” (Hudson, 2005, p. 9-11). This study further shows that social factors are significant contributors towards health, and this ties into the biopsychosocial model with the psychological and social branches being interconnected with each other.

On the other hand, a study done in South Asia, specifically, that focuses on high socioeconomic status social when looking at the presence and prevalence of illness is over the “Association of hypertension and hyperglycemia with socioeconomic contexts in resource-poor settings: the Bangladesh Demographic and Health Survey.” Like the previously mentioned study conducted in low-income and lower-middle-income countries, this research was focused on low income countries because the risk factors relationship among socioeconomic groups in high-income countries is well documented in established studies. The study determined that “individuals in the richest households were more than four times more likely to have hyperglycemia than individuals in the poorest households” and individuals in the highest wealth quintiles surveyed “had more than twice the likelihood of hypertension” compared to individuals in the lowest wealth quintile (Harshfield et al., 2015, p. 1631). This displayed that increased levels of wealth and education were linked positively to increased levels of both hyperglycemia and hypertension (CVDs). Also, the results did not show a different pattern of relationship in rural compared to urban areas, and BMI was tested as a confounding factor but did not affect the nature of the results gathered. Overall, the goal of this study was not to explain why the relationship between socioeconomic status and CVDs exists, but its main goal

was to display that there is a significantly strong relationship between these two variables.

On the psychological branch of the triad, if a person's mental state is hurt and damaged, they are more prone to not only mental illnesses but physical illnesses as well. In a literature review covering the relationship between psychiatric readmission and physical comorbidity, it was determined that "the main body of reviewed studies supported the hypothesis that patients with mental disorders are at increased risk of readmission if they had a co-occurring medical condition, higher Charlson Comorbidity Index score, in and more medical diagnoses" (Sprah et al., 2017). In the study, the Charlson Comorbidity index is one of the most frequently used methods in comorbidity comparative research, and it "predicts the ten-year mortality for a patient in relation to a range of comorbid conditions" (Sprah et al., 2017). Furthermore, in a 2001-2003 US National Comorbidity Survey Replication used in the study it was found that "more than 68% of adults with a mental disorder (diagnosed with a structured clinical interview) reported having at least one general medical disorder, and 29% of those with a medical disorder had a comorbid mental health condition" (Sprah et al., 2017). This shows that there is a distinctly visible relationship that having a mental illness is a probable risk factor for a somatic illness since over fifty percent of those surveyed in the national survey reported that they had a physical illness on top of their psychological illness. Maladies such as depression, schizophrenia, anxiety, and etc. have direct effects on the immune system, and this can cause one's body to be less proficient when protecting against foreign disease carrying antigens when compared to the body of a more neurodivergent individual who is not suffering from psychological illnesses. Another

connection between the three branches of the model reported in the literature review was that “[it was acknowledged] that morbidity burden is influenced not only by health-related characteristics, but also by socioeconomic, cultural, environmental, and patient behavior features. For instance, the study of Mark et al. [2] revealed that social factors have been found to contribute to 39% of admissions in patients with SMI [serious mental illness], followed by factors related to mental and physical disorders (31%) and dangerousness to self or others (20%)” (Sprah et al., 2017). Therefore, there is also a visible connection between the psychological branch and the social/environmental branch of the model. This makes considerable sense when understanding that prolonged admission into hospitals for mental illnesses and/or physical illnesses leads to increased cost and expenses which can affect a person’s lifestyle if their income cannot support the medical expenses.

These studies serve to highlight the interactions within the biopsychosocial model and its ultimate role in health. If the sociological and environmental factors are such that they do not offer someone the proper nutrients and sustenance to be safe, secure, and satiated then a person’s health is capable of declining because their surroundings do not have the appropriate public infrastructure or climate necessary for their bodies and minds to stay healthy. In addition, if a person’s psychological health experiences a decline or disadvantageous event, their physical health can be impacted as well as their social environment should they be unable to interact with others or maintain their quality of life. Biological factors, more easily seen to contribute to poor health and illness, such as physical viral and bacterial infections which invade the body and actively attack the

individual's health. In turn, this can affect their mental health and their surrounding social environment.

The biopsychosocial model is a foundation for this thesis because the interactions between physicians and patients comprise the socio-environmental and psychological branches of the model. The reason for this is that the actual interaction itself is a part of the environment that surrounds the patient and the physician. The hypothesis of this paper is that a South Asian physician's potential bias towards South Asian patients may create biased treatment when considering communication and understanding between the two parties because their relationship stems from a similar cultural background. As a result, when the relationship is altered between a patient and a physician, it contributes to an altered socio-environmental surrounding which affects the overall physical and mental health of the patient given the three branches of the model are interconnected and interdependent.

Cultural Bias Leads to Change in Treatment

Cultural bias is a way of interpreting and judging concepts and situations by standards that are inherent to one's own culture. People can rely on cultural bias either consciously or subconsciously, demonstrating implicit bias. In fact, cultural bias is a way for people to make sense of and categorize what they are interacting with. An example within the scope of this thesis is a physician who sees a patient from the same country as them, and they speak the same language. Compared to a patient from a different cultural background, the patient from the similar background would be able to communicate with the physician in their native tongue. This would, in turn, lead to a more in-depth

communication which would allow the patient and the physician to have a more personal and organic interaction in conjunction with the performative professional interaction. As a result, because there is a more personal relationship, there is a greater chance of the physician being more inclined to consider the patient with the similar cultural background more favorably when compared to the patient who does not share the same cultural relationship. This implicit bias when interacting with people of other cultures can be seen in a study done by Jeff Stone and Gordon B. Moskowitz over non-conscious bias in medical decision making. The paper states that implicit bias is usually unintentional, but “may leak into the way health professionals acquire information on and diagnose and treat minority group patients” (2011, p. 774). This means that when the health care professionals interact with a patient, the interaction can become negative because of the professional’s subconscious stereotyping and assumptions about the patient.

When this happens, there are different interactions present whenever the physician is dealing with the two different types of patients. With the similar patient, the physician is forming a warm and kind environment which in turn feeds into the biopsychosocial model. This means that this patient would be getting a better health care treatment because the physician would be more attentive and focused on the patient and their needs. On the other hand, the patient from a dissimilar culture would have a more cold and stoic environment form around them and the physician, and this could lead to a negative impact on their health when looking at the biopsychosocial model. The reason for this is because the physician could have already stereotyped the patient before talking to them and formed an opinion that would color the rest of the conversation between the patient and physician.

Also, in another study done by Dr. Elizabeth Chapman et al. (2013) over physicians and implicit bias and how doctors unwittingly perpetuate health care disparities, it was found that “the perception of an interaction between White physicians and Black patients was affected by a physician’s implicit race bias, even in the absence of explicit biases. Such negative perceptions could alter their behavior in ways that reduce adherence, return for follow-up, or trust and thus contribute to disparities in care” (2013, p.1507). This means that even if the White physicians were not explicitly biased against the Black patients, there was still an implicit racial bias present. This impacted the overall treatment for those patients because they reported negative experiences with their physicians, so they were less likely to rely on them and go back to them for health care.

The goal of this paper is to show that there is an implicit cultural bias that is present among South Asian physicians where they do not have to be explicitly biased against patients who are not South Asian. Regardless, these biases change the subsequent interaction between physician and patient, and they impact the overall quality of care that the patient is able to receive from the physician. A study that looks at South Asian participation in clinical trials in the UK mentions that there is an underrepresentation of South Asian lay people in clinical trials in the UK. The study looks at possible reasons for this underrepresentation, and one of the reasons offered is that “lack of familiarity with South Asian culture (to the point of being almost fearful) can sometimes lead to the development of cultural myths and stereotypes about the ‘other’” (Hussain-Gambles et al., 2006, p. 157). This shows that there are biases that are subconsciously present because of the fear the clinical trial recruiters may have of offending their patients. However, this fear leads to the propagation of stereotypes and excuses in order to excuse

the reasons for not approaching South Asian patients. This feeds into affecting the treatment for South Asian patients because they are not accurately represented in the necessary clinical trials to determine their responses to different treatment plans and innovations. Some of the reasons offered in the study are that South Asian patients are difficult to bring to clinical trials because they have poor time keeping skills, their elderly women have no interest in research because they are restricted by the men in their families, their large extended families look after their own and they mistrust outsiders, and etc. These stereotypes present a barrier between non-South Asian health care professionals and South Asian patients. One of the main solutions offered in the paper is that “misunderstandings can be overcome by providing training in cultural sensitivity and by deconstructing cultural myths and stereotypes that exist in society” (Hussain-Gambles et al., 2007, p. 163). This would mean that professionals with more understanding of the cultures and the languages should help facilitate a more positive experience for South Asian patients, and, therefore, they would be able to devise a better and more personalized treatment plan than the one they currently give to their patients. The study claims that “practitioners do not only lack the cultural repertoire to accommodate ethnicity difference, but also work in organizational contexts, which fail to prioritize strategies meeting the diverse needs of minority populations” (Hussain-Gambles et al., 2007, p. 163). This proves the lack of personalization and communication between physician and patient keeps the professional relationship between them very formal and bureaucratic. As a result, this hinders the level of trust and faith the patients have for their practitioners, which further affects the overall quality of interaction the two parties can have.

Cultural Humility Compared to Cultural Competency

An important distinction to make for this paper is to understand the difference between cultural humility and cultural competency. Cultural humility is known as understanding that one needs lifelong commitment to introspection and critique in order to readdress power balances (Greene-Moton et al., 2020, p. 142). On the other hand, cultural competence is when one works towards being competent in understanding a culture so that they can work effectively within that culture (Greene-Moton et al., 2020, p. 142). The main distinction between these two concepts stems from the fact that cultural humility pushes a person into a lifelong venture towards learning and self-reflecting when interacting with others while cultural competency makes one assume that the knowledge they know about a certain culture is the only knowledge that they need in order to function efficiently in that environment.

In today's health care field, cultural competency has had a steadfastly popular influence since the 1980s and 1990s. In fact, "Kaiser Permanente's Institute for Culturally Competent Care created and widely distributed easily accessed manuals on culturally competent care with and for use by health professionals with five diverse racial/ ethnic and other groups (e.g., lesbian, gay, bisexual, and transgender populations; people with disabilities)," and this shows that the concept of cultural competency was quickly academicized and distributed to the health care field (Greene-Moton et al., 2020, p. 143). However, this brings to light a controversy because the standardization and implementation of the theory of cultural competency in textbooks and universities means that the message being passed on is that one can gain expertise on someone else's entire

culture with enough resources and seminars. The positive aspects of cultural competency training—direct exposure to other ideas and concepts that are not native to one’s culture—are immensely important for health care workers to obtain as they do not control the kinds of patients they serve. However, the mindset that cultural competency is all someone needs to know regarding a foreign culture, with its own values and customs created over scores of generation, is harmful in the long run because it does not push the health care practitioner into learning more about the culture continuously throughout their practice. As time changes, culture changes as well because there are new customs and trends that become relevant over time. If someone stops learning about these trends, then they may not be able to properly communicate with and understand those who are familiar with the small changes in tradition.

People can never truly be competent in another culture and thinking that they can is harmful for their relationships with others who are of different cultures. Melanie Tervalon et al. (1998) describes in their study over the difference between cultural competency and cultural humility in the health care field that cultural competency is displayed by having understanding that a “Cambodian child who comes in with the linear marks of "coining," a Southeast Asian healing practice, should not be mistaken for the victim of parental child abuse” (1998, p. 118). Knowing this is helpful when seeing children come in with marks like these because not only would there be less of a chance to assume there is something negative happening and understand that it is a cultural practice, but also the health care professional would avoid alienating and offending the patient and their families if they are observant of their cultural values. On the other hand, cultural competency can also have negative impacts on health care workers and patients’

relationships as seen with a nurse who, despite being told by a Hispanic physician to readdress the problem, claimed that “she took a course in nursing school in cross-cultural medicine and “knew” that Hispanic patients overexpress “the pain they are feeling” (Tervalon et al., 1998, p. 118). This shows that the nurse assumed that she knew what was happening without considering the opinions of someone who shares the same culture as the patient. This ultimately led to her being less receptive of her patient’s needs and comfort, and she contributed to alienating her patient.

Consequently, the theory of cultural humility became popularized around the late 2010s. This theory became popular because of its message that one needs to observe a lifelong importance on self-reflection when interacting with others. In the health care field, this is especially important since a physician needs to have humility when interacting with patients because of the stark power imbalances that exist in a physician-patient relationship. When factoring in the possibility that there are cultural differences between physicians and patients, it is important to have humility so as to not make false assumptions and accusations. These assumptions and accusations would alienate the patient and make them less likely to confide in their physician. A patient who keeps information about their health from their physician is not able to receive the best care possible from the health care professional. In the context of this paper, a South Asian patient who is receiving care from a physician of a different cultural background than them may not be able to tell the physician everything they think is wrong with their health. If the physician makes it clear that they are willing to learn and be receptive to their patient, it would help facilitate better communication between the two parties. The reason why the patient may be unlikely to speak freely to their physician is that they may

not trust the physician to understand their considerations. On the other hand, a South Asian physician with a South Asian patient would be able to understand explicit cultural remedies and maladies that may have not made sense to someone of a different culture. This shows that there are intricate aspects of a culture that someone who is a part of that culture would be able to clearly understand. Thus, there needs to be an emphasis on cultural humility so a physician can spend time learning continuously about other cultures they may have to interact with. Compared to the previous South Asian physician example, the opposite can be true as well where a South Asian physician is unable to grasp the full extent of some cultural remedies and treatments if the patients are not of a South Asian background. Consequently, they may remain unable to understand the cultures if they do not venture out to learn more about them and their unique practices. Once again, it is important to understand that cultural humility opens one up towards being more receptive towards their patients while cultural competency maintains a barrier between the patients and the health care practitioner that instills a detrimental mistrust between the two parties.

CHAPTER TWO

Cultural Differences in Thought: East and West

There is a difference in mindset between societies in the East—such as India, Pakistan, Bangladesh, and etc.—and societies in the West—such as America, Canada, and etc. The reason for this dissonance is because of culture. More specifically, this difference is due to the concept of a shame based model of thought and a guilt based model of thought. The East has a shame based model of thought. This means that the majority of Eastern countries view self-denial and humility as ways of restoring social order. Therefore, “in a shame society, the primary device for maintaining social order is the inculcation of shame and threat of ostracism of the individual from the group” (Yakeley, 2018, p. S20). On the other hand, Western societies are guilt based cultures, and they emphasize punishment and forgiveness as a way of restoring moral order. A “guilt society is one in which social control is maintained by creating and reinforcing feelings of guilt and fears of punishment for unacceptable behaviors” (Yakeley, 2018, p. S21). This thinking model is further highlighted by the fact that Eastern societies are more community oriented where the say of the collective community contributes more to the dignity, honor, and pride of the individual. Inversely, Western societies have a more Christian foundation of culture which translates into prioritizing personal salvation, morality, and individuality as being more important and honorable to a person compared to what the community believes to be valuable and important.

Mental Health Differences in East and West

Knowing Western societies place more importance on guilt and individuality while Eastern societies place more importance on the collective community, there is a difference in assigning importance towards different social issues. One example of a social issue is mental health. There is a clear distinction to be made between the stigma of mental health in shame based cultures and the stigma of mental health in guilt based cultures. While both cultures have a stigma of mental health, this stigma displays itself in different ways across societies. In a study done over “Countries and Cultural Differences in the Stigma of Mental Illness: The East-West Divide,” the researchers find that while certain stigmas over mental health disorders are universal, there are a significant amount of cultural differences that lead to different levels of stigmatization over certain disorders. These differences in the study are analyzed through two potential components of stigma—prejudice and discriminatory potential. Essentially, it was found by researchers Krendl and Pescosolido (2020) that prejudice, negative attitudes, and discrimination, negative behaviors, are significantly more pronounced depending on how people perceive the etiology of mental illness. If the mental illness is considered to be a disease, then there is less social stigma associated with the illness. However, if mental illness is considered to be a moral failing, then there is high prejudice and, later, discriminatory behavior towards individuals with mental health issues. Krendl and Pescosolido (2020) found that Eastern countries were more likely than Western countries to “make moral attributes about the etiology of mental illness” (p. 150). This goes hand in hand with the shame based culture in Eastern countries because a moral issue is reflective of the whole collective instead of just representing the individual. Therefore, there is more stigma

regarding mental health, and this translates over into there being greater social distancing between the community and the individual who states that they are ill.

As a result, individuals from Eastern societies are less likely to receive help or treatment for mental health illnesses like anxiety and depression because of the prejudice about mental health and the discrimination against individuals in the community who have mental illnesses. This is highlighted in a study done by Meekyung M. and Pong H. (2015) which shows that Asian American college students in four-year universities not only had more mental health problems than assumed initially based on the “model minority stereotype,” but also they were less likely than their peers of European descent to seek mental health resources despite having similar levels of accessibility to the resources. Furthermore, the study concluded “that acculturation, cultural barriers, and stigma attached to mental health problems are common factors that significantly contribute to Asian American college students’ low mental-health-seeking behaviors” (Meekyung & Pong, 2015, p. 1). This example of mental health stigma highlights the difference in thought between Eastern and Western societies because it shows that the shame based culture of the East leads to individuals from those communities to view failure as being representative of the whole community instead of just the individual. This means that there is a moral failing on the individual’s part instead of there being a problem whose cause is outside the scope of the individual’s control. On the other hand, Western societies, which have a more individualistic approach to culture, recognize many social issues such as mental health as being problems that are outside of the individual’s control; these problems do not stem from moral failures that require a showing of shame,

but instead these issues are due to problems whose causes lie beyond the individual's personal attributes.

Mental Health in South Asia and North America

Because there is such a collectivist approach in Eastern societies when it comes to social issues, there is great pressure on individuals from areas like South Asia to be model individuals who are in charge of representing not only their families but also their entire communities. This fear of failing the community is further heightened in higher education settings such as medical schools. The study done by Marwat M. (2013) over third year medical students in Peshawar, Pakistan showed that through a self-rating depression scale, out of 166 responses, around 17.5% of students had scores which indicated a form of depression. However, only 2.4% of students reported to taking antidepressants such as citalopram, fluoxetine and dothiepin. This demonstrates that when doing a self-rating scale, after being informed of the intent and the anonymity of the study, 17.5% of students recognized that they had signs of depression but only 2.4% of them admitted to seeking help and addressing the illness. Marwat M. also talks about how there are no backup studies to support why only 2.4% of individuals are taking medication even though 17.5% report depression symptoms. The paper claims that this means that there are not enough resources and research done to support the mental health of medical students in Pakistan. In fact, in the recommendations section of the paper, Marwat M. states that they “highly recommend the establishment of student support committee and the initiation of systematic screening and counseling programs for early diagnosis and treatment of emotional ailments to prevent any future complication” which

shows that there are not measures in place by the school that help students with their mental health issues (2013, p. 28).

Another study done in Gujrat, India over medical students and depression reported that out of 331 students surveyed through a 22 question questionnaire to assess depression and different types of stigma—personal, help-seeking, and perceived—there was an overall prevalence of depression among 64% of the students (Vankar et al., 2014). Also, the study claimed that “73.3% students felt that having depression would negatively affect their education, and 52.3% saw depression as a sign of personal weakness” (Vankar et. al., 2014, p. 1). This study lends further support to the earlier claim that Eastern societies see problems such as mental illnesses as personal moral failings which indicate that an individual is causing disgrace and dishonor for the general community. Also, the study found that there is high stigma among students about the causation of depression with there being results that show that students believed that peers would not want to work with depressed peers; 50.9% of females reported this, and 36.2% of the males surveyed reported this as well (Vankar et al., 2014, p.1). In the study, there was stigma about even relaying to friends if one was depressed, and many individuals surveyed reported that someone with depression would be unable to successfully thrive in school and complete their responsibilities with “thirty to 40% students [reporting] that if depressed, other students would respect their opinion less, they won't be able to handle responsibilities, and other students would not work with them” (Vankar et al., 2014, p. 3). Therefore, these two studies further exemplify that there is a mental health stigma in South Asia, an Eastern society when compared to a Western society like America, which is dependent on the community and the overall society's perception of the individual.

Many students in the Gujrat medical school study claimed that they believed a depressed person would be unable to successfully work in society. Furthermore, students who were depressed and taking the survey had more stigmatized opinions of themselves compared to peers who were not depressed. This resembles the claim that the etiology of mental illness in Eastern cultures is that mental illness stems from moral failings as opposed to health failings.

While medical education is stressful and demanding whether it be in an Eastern society or a Western society, there are less stigmas towards gaining help for mental health in Western medical schools. In a study done by Lee J. and Graham AV. (2001) about a program developed by Case Western Reserve University, it was noted that multiple “medical schools in the United States and Canada have initiated health promotion programs and have reported positive results in reducing the negative effects of stress upon medical students' health and academic performance” (p. 652). The students who were enrolled in these courses were told to write essays about their experiences and their intentions with what they learned in the class, and they reported that they largely believed that mental health issues should be prioritized for health care workers. The students also reported that talking to their peers was a useful coping mechanism that the wellness program encouraged them to practice. These students who participated in the program could see that their mental health illnesses were not a product of personal failings, but actually they were a result of the stressful environment of their surroundings. In Europe, another example of a Western society, a study was done over different traditional track and reformed track medical schools and their first year students' perceptions of stress and support from the school. Once again, this study also highlighted

the stressful environment of medical schools. However, Kiessling et al. (2004) emphasized that the increasing presence of reformed curricula showed that when compared to each other's questionnaire responses, "students on the RT [reformed track] felt more supported than students on the TT in terms of study conditions, social support at university, perceptions of their own attitudes and competencies, and living conditions" (p. 504). This shows that once students were given help, the culture of the Western society helped reinforce the idea that mental illness is not a moral failing that cannot be talked about.

In the competitive and stressful sphere of medical education in both the East and the West, there is a clear difference in the help offered to students. The students in the East are not given much help regarding their mental health, and they are left to their own devices where they believe that their illnesses are an indicator of a personal failing that would shame them and their community. On the other hand, Western societies also have some stigma about mental health in medical education, but there are many schools that are taking the first step towards promoting wellness and mental health resources for their students. This shows that the Western schools are viewing mental health as having a disease based origin that should be treated instead of a morality based origin that Eastern medical schools are largely still supporting silently.

How This Translates Into Practice

For the purpose of this paper, I believe that the difference in cultural thought between the East and the West leads to a difference in the medical practice that individuals employ. Because physicians who either lived in South Asia for a majority of

their lives, gained their medical degrees from South Asia, or both would be coming from a society which placed the collective over the individual, they may be more prone to being comfortable around patients who are also from a similar culture. Due to South Asian culture prioritizing the community over the individual, there would be a sense of community developed between the South Asian physician and the South Asian patient which would help foster easier communication and trust between the two parties. Therefore, I predict that, for the results and discussion chapter of this paper, the South Asian physicians surveyed would have a greater preference for other South Asian individuals as patients.

Another reason for this preference could be due to the difference in values between Eastern societies and Western societies. The reason for this is similar to the example of mental health mentioned earlier. There would be a difference in thought between a physician with a predominantly western mindset and a patient with a predominantly South Asian mindset, or vice versa. This would be due to there being a difference in how each party prioritizes certain values and concerns. For example, if the physician is from a South Asian medical school and the patient is from a Western society like America, then the physician could form an implicit bias, that may or may not transverse into discrimination, when hearing the concern of the patient especially if it deals with culturally reliant issues such as mental health. Because it is difficult to change one's cultural upbringing and the lessons learned from it, there could be an initial reaction, no matter how subconscious, where the South Asian physician sees the mental health issue as a personal attribute on behalf of the patient. Even if the physician politely attends to the patient and gives them a prescription, there could still be a bias present that

hinders the physician from favoring and connecting with the Western patient when compared to a South Asian patient. Therefore, I predict that the results of this research will show that South Asian physicians have an implicit bias favoring South Asian patients as opposed to patients of other races. The reasons for this would be that there could be contributions from cultural differences which would affect communication leading South Asian physicians to prefer South Asian patients. Not only do both patient and physician come from a shared culture that they can empathize with and understand each other more intimately with, but they would have similar cultural values which would help make communication in the professional relationship easier and more fluent between both parties. Overall, these factors can lead to South Asian physicians having an implicit bias preferring other South Asian individuals as patients because there is a shared background that makes the communication more understandable and relatable. In turn, this leads to more honesty, trust, and openness during clinical appointments because there is a better understanding between both parties.

CHAPTER THREE

Difference Between South Asia and North America Communities

Based on the previous chapter, there was an explanation regarding the difference in cultural thought in Eastern societies like South Asian countries compared to Western societies like North American countries. It was established that the Eastern countries focus more on the collective while the Western countries focus more on the individual. Therefore, it serves to consider that there may be a difference in how a South Asian patient perceives health care treatment in the West as opposed to health care treatment in the East. In the West, because it is more individualistic, a patient who identifies as being South Asian may feel alienated and uncomfortable in a Western society because it is so much more individualistic than community based. This can, in turn, lead to the patient not trusting their Western physicians and not communicating with them properly about their health concerns due to the lack of comfort. In a study done by Maan et al. (2011) about the prevalence of STI's in Faisalabad, Pakistan, it was reported that there is a lack of STI and general sexual health education in Pakistan. This is due to the Islamic and South Asian culture of the country which shames the topic of sex and related points while promoting modesty and purity virtues, so topics dealing with sex become taboo to talk about. The paper states that there was an issue retrieving data from female participants and that the ones who did participate "were shy about pertinent queries" (Maan et al., 2011, p. 266). Therefore, not only were many patients hesitant to talk about sexual health, but also physicians and other health care professionals did not push them into talking or learning about the topic. While it is true that this is a harmful practice for the majority of society, there is still the fact that both parties did this due to the culture of the society.

On the other hand, the West has a different cultural mindset towards topics like sexual health. In North America, this is not a taboo topic, and it is encouraged that health care professionals educate and work with their patients on this topic. While this is healthy behavior that protects society, a person who identifies as being South Asian would be hesitant to talk about this topic with their physician—as seen by the women in the previously mentioned study who were shy about sharing results. This hesitancy would be dangerous in the relationship between the physician and patient because this means that there is not fully open communication between the two. If there is limited communication between the two parties, for any reason, then it means that the patients are not receiving the best health care possible. These patients may become hesitant about sharing things other than sexual health or related topics with their physicians if they start feeling distant and uncomfortable from their physicians. This would be more harmful than patients in Eastern societies not talking about taboo topics because those patients would still confide in their physicians about other topics since there would not be uncomfortable feelings between the two parties.

Another similar study examines South Asian immigrants seeking health care in the United States for HIV/AIDS. The study states that “In the traditional South Asian context, seeking health care for HIV/AIDS infection or disclosing seropositive status could bring shame on the family and the community. HIV-infected South Asians may thus prefer coping strategies based on the concept of saving face. They may hide the disease, ignore it, or attribute its symptoms to a less-stigmatized cause than HIV/AIDS” (Bhattacharya, 2004, p. 108). If the patients are uncomfortable discussing the disease, it is true that this would be harmful in either the West or the East. However, what sets it apart

here is that these patients are in a Western country, and they feel alienated from the extensive South Asian social network they would be used to while in South Asia; they are alienated without the large South Asian community in a non-South Asian country. This could be a stressor that contributes to their illness and exacerbates it because the article also states that the immigrants may be more vulnerable in the West compared to the East because they delay seeking health care not only because of the lack of knowledge but also because “the willingness to seek health care, particularly for HIV/AIDS, involves personal judgments in the context of extended social units. South Asians may perceive substantial personal and social costs, such as cultural stigma, family abandonment and shame, and deportation on the basis of undocumented immigration status” (Bhattacharya, 2004, p. 111). Therefore, South Asian patients in Western societies would feel alienated because of barriers like different cultural backgrounds and language differences.

Another barrier to health care would be ethnicity. The reason for this is that some physicians in America, who do not identify as being South Asian, could lump all South Asian patients as being of similar backgrounds. A study done by Pfeffer (1998) over “Theories of race, ethnicity, and culture” emphasizes that while it is true that there are cultural similarities among the South Asian countries, there are still differences that are present based on language, region, and religion. For example, even though both a Bangladeshi-American and an Indian-American identify as South Asian, their nationalities are different, and it may be hard for a non-South Asian physician to not only recognize this but understand how to respectfully differentiate between the two nationalities. Furthermore, there are also many different ethnicities present in each of the South Asian countries. In Pakistan alone, there are six major ethnic groups and even more

minor ethnic groups recognized by the government of Pakistan. Members of these groups would identify their nationalities as being Pakistani, however, there are clear differences present in minor aspects of their culture that other Pakistanis know to recognize and respect depending on which ethnic groups the individuals belong to. Therefore, someone in the West, who does not identify as South Asian, risks grouping together South Asians on a false basis of homogeneity even though individuals who identify as South Asian would understand there are cultural differences based on ethnicity. These South Asian individuals would know how to act respectfully towards the different native cultures without alienating the other South Asian individuals.

Overall, in Western societies, the barrier for South Asian health care is that there can be a difference in treatment between South Asian patients and non-South Asian patients. Another study that exemplifies this is over a pap-test screening clinic in Vancouver, Canada. The study noted that there was a pap testing clinic developed explicitly for South Asian women because of a community-initiated response to high rates of cervical cancer. The research done showed that there were cultural barriers to cancer screening because of “many South Asian women's strong beliefs about cancer as a stigmatizing, painful, and untreatable disease,” and also the study claims that “participation in screening in the absence of symptoms does not readily fit with South Asian women's holistic views of health and health promotion” (Grewal et al., 2004, p. 413). This calls for there to be a different approach that Western health care professionals need to make when addressing the needs of South Asian individuals in the community. The creation of the pap-test screening clinic is one successful example of an approach made because the nurses in charge of this clinic worked to determine how to successfully

overcome language communication problems, and they actively worked with the South Asian patients when addressing cultural concerns. This shows that in a Western society, if there is not a lot of conscious effort made by non-South Asian physicians and other health care workers, then there is the risk of alienating South Asian patients from receiving the best possible treatment that they could receive. In a South Asian society, these patients would not be alienated, so they would report a more comfortable experience with their health care providers as there would be no barriers due to culture or language between the professionals and the patients.

In the context of this paper, because South Asian patients have reported more comfort and convivence in South Asian communities, it may be that South Asian physicians also feel a similar sort of cultural comfort with South Asian patients. Because there are certain cultural practices that are easier to understand within cultures, there would be a more fluent flow of conversation between a physician and a patient if they were both from similar cultures. Furthermore, language barriers are a tremendous issue when it comes to proper communication and trust in a professional relationship. Unless there are either active efforts made on the part of the physician to ensure the patient does not feel uncomfortable and humiliated or fluent interpreters are easily accessible, the best option for an open and honest conversation would be if the physician was from the same cultural region and spoke the same language as the patient. Therefore, South Asian physicians may have an implicit bias preferring other South Asians as patients because there could either be shared cultural backgrounds, or languages, or even both between the two parties. This would essentially help foster clear and honest communication and trust

between physician and patient which would allow the South Asian patient to receive the best health care treatment possible.

CHAPTER FOUR

Research Introduction

For this project, I conducted a study over South Asian physicians in North America. The main methods for this study were that I created an online survey that I distributed to a group of South Asian physicians through an organization that is called Association of Physicians of Pakistani Descent of North America (APPNA). This organization is a nonprofit medical organization where the majority of the members are South Asian physicians who are practicing in North America. I contacted the organization and emailed the research survey and the consent form to APPNA members on the group's email list. The main goal of the study was to obtain around 88 results in order to be a sample size able to properly represent the APPNA population.

Survey Questions

The survey had around twenty-three questions where twenty of the questions were asking information about whether or not the physicians were aware of their place of employment's policies on recording race and ethnicity and if the physicians knew whether their places of employment used interpreters for patients who could not speak English. The purpose of questions like these were to see if the participants were aware of the fact that some of their patients may have difficulties understanding them, and, therefore, it would impact on their ability to receive proper health care, if that is the case. In a study done over cancer patients in minority ethnic groups living in the UK and being in the care of primarily white health care professionals, there were issues with language communication because of the participants varying levels of English comprehension

(Thomas, 1997, p. 136). If there is not a way to record what ethnicity or culture patients are from, and if physicians are not aware that their patients have trouble understanding them it means that the patients are not receiving the best health care that they probably can. Based on earlier chapters, this means that patients would also feel unwelcome and they would be hesitant to reach out with more questions and concerns about their health. In a sense, a physician not being cognizant of the fact that their patients have communication issues based on language and culture differences would imply that the physicians, whether unknowingly or not, are helping to perpetuate microaggressions against their patients.

Some of the other twenty questions were also identifying questions in the sense that, without recording names or email addresses as the survey was confidential and nonbinding, the participants were asked where they obtained their medical license and what their own race and ethnicity were. These questions were important because it would help establish if the physicians actually identified as being South Asian. Also, these questions helped explain where the physicians completed their medical education which ties in with CHAPTER TWO of this thesis about there being a difference in mindset and thinking among the eastern and western cultures.

The last three questions were presented as Likert scale questions that measured a physician's response to three different categories of patients: patients with a clear South Asian accent, patients with an American accent, and patients with a non-South Asian and non-American accent. The purpose of these questions was to gauge how the physicians responded to and interacted with patients who were seemingly from different areas of the world. The questions were measured on a 1 to 5 scale with one being the least likely

option and 5 being the most likely option; this meant that 3 was the neutral option in the questions, 2 was slightly unlikely, and 4 was slightly likely. The types of categories across all three Likert scale questions were the exact same in order to determine how answers varied across the three accent categories.

Likert Scale Questions and Reasoning

Overall, there were ten sub questions in each Likert scale question. The first question was asking how likely physicians were to complement a person's English. This question was in place to measure microaggression against a patient since someone with an accent would take it as a backhanded compliment in the situation of the medical appointment. This is so because in the case of the appointment, commenting on a patient's English, even if it is meant to be assuring if there is an obvious non-American accent, can potentially harm the patient's confidence and willingness to trust the doctor. The reason for this is because this backhanded compliment is implying that there is an obvious difference in language capabilities to be able to bring up a complement mentioning them in the first place. Therefore, there should be no need to bring up the fact that a patient's English is good because this kind of assurance would be unnecessary, and it would sound condescending in the context of the appointment since it is deemed by the healthcare professional that the English is jarring enough to render a compliment. For the purpose of this research this question would imply a bias towards South Asian patients if the South Asian physicians were more likely to comment options 4 or 5 of the scale to patients with a non-South Asian accent compared to patients with a South-Asian accent.

If the scaled choices were equal across all three categories, it would imply that there would not be a considerable bias for any one group.

Question two asked the physicians how likely they are to ask someone where they are from during an appointment. Similarly, to the previous survey question, this question also implies a type of microaggression if the patient is of a different race and ethnicity compared to the physicians. Even if this is meant to be small talk during the appointment, this could be perceived as rude as the patients are being singled out as not being a native citizen in America. On the other hand, if the physician is a South Asian physician, as was the case in this study, then asking a patient with a South Asian accent where they are from could be a way of connecting with the patient in order to find similar backgrounds and experiences based on a possible cultural connection. When looking at the category for patients with a South Asian accent, if the physicians were more likely to choose choices 4 and 5 for this question as opposed to the other two accent categories, it would help show that physicians had an implicit bias towards other South Asian accents and were trying to bond and connect to their patients in order to make the medical appointment more comfortable.

Question three stemmed from question two because it asked physicians how likely they were to try and find a similar topic of conversation different from the professional conversation of the appointment. With South Asian physicians and patients with South Asian accents, this would help show an implicit bias preferring patients from a similar ethnic and cultural background in the sense that physicians may be trying to find a topic to talk about that both parties can connect to. With the other two accent categories, the higher value choices would show that the physicians are trying to connect

to their patients in order to make the appointment more comfortable and the communication more forthcoming. However, if this question is equally chosen through options 4 and 5 or options 2 and 1 across all three categories, then it would imply that the physicians are not looking to make small talk with any specific set group of patients, and they are also not likely to try and connect, outside of the parameters of the treatment plan, to their patients during the appointment. If the categories with South Asian accents reports higher choices of 4 and 5, however, then this would imply that the South Asian physicians are displaying a slight implicit bias preference for other South Asian patients.

Question four was meant to see how likely physicians are to identify with a patient's experience if they are not from the same culture or ethnicity as the physician. This question was designed with the American accent and the non-South Asian accent and non-American accent categories in mind. The reason for this is that if the South Asian physicians were shown to consistently choose higher value options for these two categories when compared to the South Asian accent category, then it would mean that they are not showing an implicit bias favoring other South Asian patients as they are trying to be more communicative and interactive with patients who are from a different race and culture from them. However, if physicians were to vote options 1 and 2 (in the case that the South Asian accent category was not also consistently rated 1 and 2) meant that physicians were showing a slight bias towards other South Asian individuals when they try to connect more to the South Asian individuals through shared experiences stemming from racial and cultural similarities.

Question five was asking the physicians how likely they are to spend over 15 minutes with a patient not the same ethnicity as them. The reason why the time limit is 15

minutes or more is because according to a study over time allocations in primary care office visits in America, the “average length of visits was 17.4 minutes. The median length of visits was 15.7 minutes” (Tai-Seale et al., 2007, p. 1879). This means that if physicians choose to leave faster than 15 minutes, if they chose options 1 or 2, for patients with an American accent and a non-South Asian accent and non-American accent, then they were spending less than the average amount of time and median amount of time with patients who are not from the same racial, ethnic, or cultural background as them. Furthermore, if physicians were more likely to select choices 4 and 5 for the category with patients with a South-Asian accent then it would further imply that there is a slight implicit bias that is contributing to the physicians spending more time on average with their patients from similar cultural backgrounds as them.

Question six was similar to Question three because this question was asking how likely the physicians were to keep a purely medical approach to their appointment with patients. This question was meant to serve as a counter to Question three in order to make sure participants were paying attention to the survey questions. If participants were to answer similarly within categories between Question three and Question six then it would imply that they were skewing the results by not properly taking the survey since these two questions cannot have similar option categories unless the predominant choice is 3, neutral.

Question seven, Question eight, and Question nine were designed to be similar in the sense that the questions each ask about the physician’s likeliness to give a patient medicine compared to patients in a different category. This means that the South Asian category would ask how likely the physicians are to give pain medication to patients with

South Asian accents compared to non-South Asian accents (this includes both the American accents and the non-South Asian and non-American accent categories). Similarly, the other two categories would compare the possibility of patients receiving medication compared to the South Asian patient categories. The reason why there are three separate questions is because they are addressing the three different age groups of patients: Question seven covers young adults (18-35 years old), Question eight covers middle aged patients (36-55 years old), and Question nine covers elderly patients (above 55 years old). The reason why this is divided into subcategories is to determine if there is a difference in pain medication allocation among age groups. There is a stigma with pain medication that is an implicit bias on its own. According to a study done over “Patients with Pain Need Less Stigma, Not More,” “Stigma—shaming and shunning—continues to befall patients with chronic pain, as do inequities in access to care. Tragically, people with the fewest resources to resist pain’s debilitating effects—minorities, the very young or very old, those with HIV, cancer, or substance abuse, the poor or homeless—are also marginalized by society” (Carr, 2016, p. 1391). This is prevalent to this study because minorities, the young, and the old are stigmatized against when it comes to pain medication. Therefore, it is most uncommon to give pain medication to those groups. In each of the three accent categories, I would expect to see the most favorable options for pain medication allocation for the middle-aged adult categories, then this can be compared among the three accent categories to see if there is a preferential treatment for patients with South Asian patients when compared to other patients. Question seven and Question nine can also be compared among the accent categories to see if the South

Asian physicians are more likely to give pain medication to those who have a South Asian accent.

The last question in the Likert scale questions was asking physicians how likely they are to spend more than five minutes speaking to a nurse and PA in the room. According to the previously mentioned study about time allocation in primary care appointments, the average time a physician spends speaking to a patient is around 5.3 minutes, the average time a patient speaks to a physician is also 5.3 minutes, and the average time that neither speak is around 55 seconds (Tai-Seale et al., 2007, p. 1879). This means that if a physician spends more time on average speaking to their nurse or PA when the average time for an appointment is around 15 minutes, the physician would either end up talking to the patient for less than an average amount of time or the patient would not be as open and talkative to the physician and would talk less than average, if the appointment is assumed to take the average amount of time.

Survey Results

According to the survey, out of the 85 people surveyed, 70.5% completed their medical education in South Asia, 18.4% completed their education in Asia (aside from South Asia), 9.2% completed their medical degrees in North America, 1.1% completed their degrees in Europe, and 1.1% completed their degrees in South America. This means that around 88.5% of the participants came from an Eastern culture. Compared to those who completed their degrees in North America, Europe, and South America, these people would have a different mindset from those in the western societies as the east and the west have different cultural values. Also, because these physicians completed their

education in a culture which greatly values in-group loyalty and prioritizes the community over the individual (Yakeley, 2018, p. S20). This means that according to these results, most of the physicians taking this survey are from eastern societies, which means that they have a strong sense of community alliance. This would imply that during the statistical analysis of the Likert scale questions, there should be results that largely highlight this preference for other South Asian patients.

Where did you complete your medical education:
88 responses

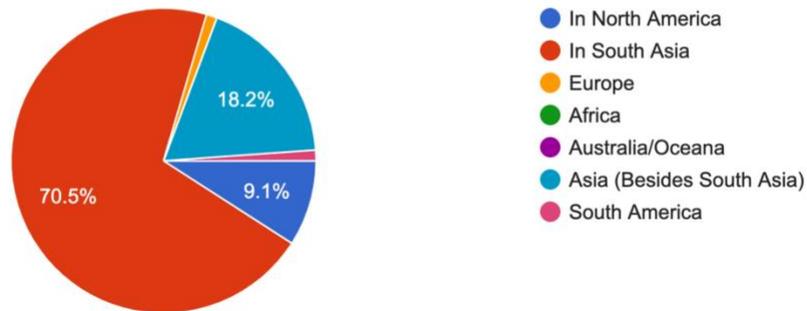


Figure 1: Survey question over place of medical education completion.

This is also further reinforced by the next survey question which asks physicians to identify their nationality based on their ethnicity. Out of the 88 participants, 87.5% claimed to be Pakistani and 12.5% claimed to be Indian. This further reinforces the cultural background of the participants, and there should be a significant preference for other South Asian patients in the Likert scale analysis.

If Yes to Question 7, How Would You Classify Your Nationality?

88 responses

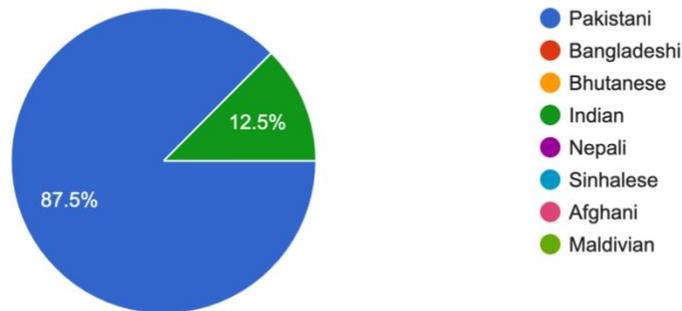


Figure 2: The nationality and ethnicity of patients; responding to Question 7 which was asking if participants identify as South Asian

Two more questions asked were, first, whether the participant knew if their place of employment collected information of a patient's race. The second was asking if the participants knew if their employment place collected information on patients' ethnicities. According to the results in Figure 3 and in Figure 4, over 20% of participants did not know if their places of employment collected racial and ethnic information about participants. This is significant because it means that the physicians themselves are not aware of the racial and ethnic background of the patient and this could have dangerous effects if the patient assumes that there is some sort of cultural dissonance or neglect on the physician's part for being unaware. This could essentially lead to communication problems between patients and physicians.

Does your hospital or clinic collect information on the race of patients (This would generally involve classifying patients as White, Black/African American...d Native Hawaiian or other Pacific Islander, etc.)?

88 responses

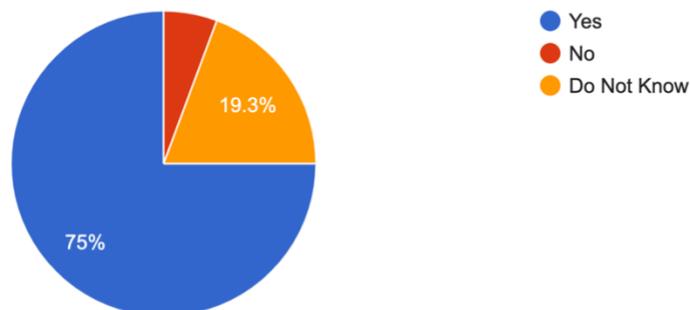


Figure 3: Collection of race classification

Does your hospital collect information on the ethnicity of patients?(This would involve classifying patients as Hispanic/Latino, or non-Hispanic/non-Latino)?

88 responses

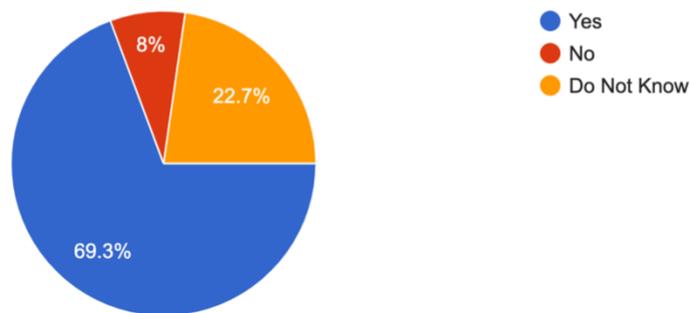


Figure 4: Collection of ethnicity classification

This is further reinforced by Figure 5 below where physicians claim to not know how to report the quality of care for their patients across different racial/ethnic/tribal groups. A bit over 70% of the physicians knew that their places of employment recorded and compared quality of care among patients of different groups. On the other hand, the small 28.4% of participants who recorded either no or “do not know” are unaware of whether or not the quality of health care is different among different racial/ethnic/tribal groups.

This is problematic because this means that these 28.4% of participants are not cognizant of the fact that because health care treatments are different for different racial/ethnic/tribal groups and not everyone is subjected to the same treatment plan whether it be due to miscommunication based on language or cultural differences, there needs to be an appraisal of data in order to secure the best treatment plans for a variety of patients. Inability to do would mean that there are people who do not have access to the best healthcare that they can obtain.

Does your hospital use race/ethnicity/tribal affiliation data to assess and compare quality of care among patients of different population groups?

88 responses

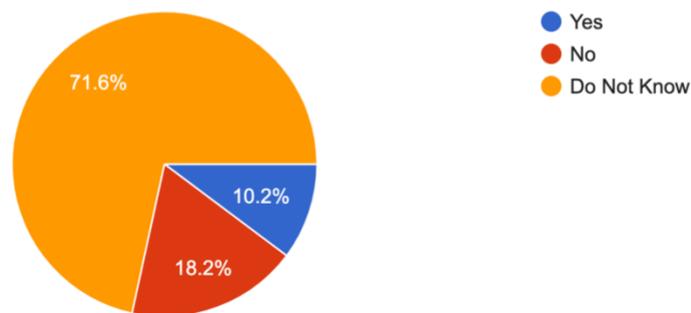


Figure 5: Quality of care assessment over different racial/ethnic/tribal affiliations survey question

Also, for the questions about primary language and interpreters, Figures 6 and 7 show that a majority of the participants are aware that their place of employment collects information about a patient's native language and their place of employment also employs interpreters in case of language comprehension issues. However, even in this situation, some physicians are either unaware of whether their places of employment do note primary languages or employ interpreters, or they state that their places of employment do not do one or the other or both. This further highlights the idea of there

being a possibility of miscommunication between physicians and patients which could lead to patients being less forthcoming towards physicians about the truth of their health and wellness because there is a language barrier between the parties.

Does your hospital collect information on patients' primary language?
88 responses

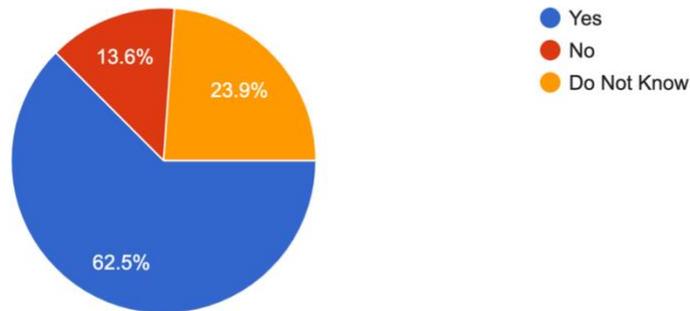


Figure 6: Information on primary language collection

Does your hospital employ interpreters (either full-time or part-time)
88 responses

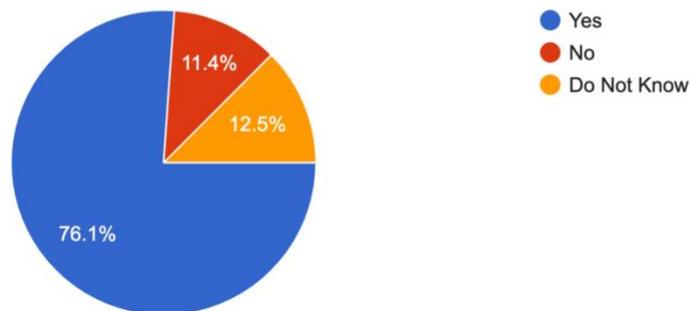


Figure 7: Information on employment of interpreters

Another question that measured how much time, on average, physicians spent with patients, around 75% of participants claimed to spend 15 minutes or more with patients, which is around the average and median time for a clinic appointment. On the other hand, only 25% claimed to spend less than 15 minutes with patients.

How much time do you spend with your patients usually on average?

88 responses

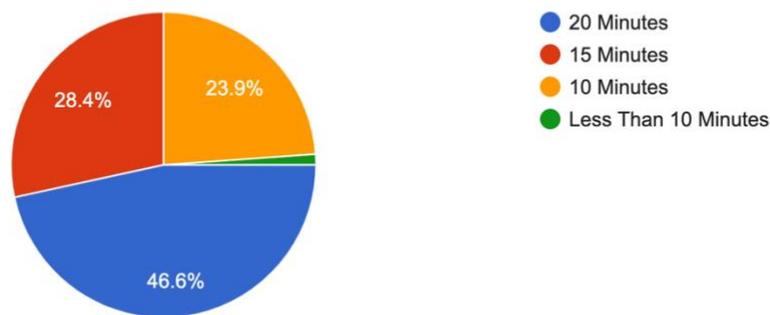


Figure 8: Time spent with patients on average

These survey results show that while there are some physicians who are uninvolved with knowing the racial, ethnic, and cultural background of their patients, the majority of those surveyed knew that there were differences present. They were also cognizant of the fact that there need to be measures in place to counter those differences in order to ensure proper treatment for all patients.

Likert Scale Analysis

The analysis used for the Likert scale questions was the Wilcoxon Signed Rank test because it measures an independent variable which is an independent categorical variable, the accent categories for patients, and a dependent variable which can be an ordinal variable, the Likert scale questions. Also, this test is appropriate because there is no independence in observation among the three categorical variables as the same participants complete the survey for each category. Furthermore, normality cannot be assumed for this research because the assumption is that there will be difference in sum scores to show that there is a bias among South Asian physicians regarding the race

and/or ethnicity of their patients. As a result of not being able to assume a normal distribution, the Wilcoxon Signed Rank test is appropriate to use. The null hypothesis for these questions was that there is no significant difference in the medians of the choices for both the South Asian accent and non-South Asian accent groups and the South Asian accent and American accent groups. The alternative hypothesis is that there is a significant difference in the medians of the choices between the South Asian accents and non-South Asian and non-American accents and the South Asian accents and American accents. The p-value for searching significance was $p = 0.05$.

Results

The Wilcoxon signed rank test showed that when South Asian physicians took a survey about observing their interactions with patients with South Asian accents, patients with American accents, and patients with non-American and non-South Asian accents, there was a significant difference in the implicit bias towards South Asian accent patients when measured against both the non-South Asian and non-American accent patients and also the American accent patients groups ($Z = -2.189$, $p = 0.029$; $Z = -2.899$, $p = 0.004$, respectively). Furthermore, when looking at the medians for each category through Figure 9 and Figure 12, the South Asian accent group had a median score of 28.0, the non-South Asian and non-American had a median score of 28.0, and the American accent group had a median score of 27.0. This means that there were total scores around 28.0, 28.0, and 27.0 that were the median total scores for each accent category.

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum	25th	Percentiles 50th (Median)	75th
Asianacc	88	28.3750	4.21904	18.00	38.00	25.2500	28.0000	31.0000
nSAnAacc	88	27.7273	3.86772	20.00	38.00	25.0000	28.0000	30.0000

Figure 9: Asian Accents and Non-South Asian and Non-American Accents Descriptive Statistics Table

Ranks

		N	Mean Rank	Sum of Ranks
nSAnAacc – Asianacc	Negative Ranks	43 ^a	35.56	1529.00
	Positive Ranks	25 ^b	32.68	817.00
	Ties	20 ^c		
	Total	88		

a. nSAnAacc < Asianacc

b. nSAnAacc > Asianacc

c. nSAnAacc = Asianacc

Figure 10: South Asian Accents and Non-South Asian and Non-America Accents Rank Table

Test Statistics^a

nSAnAacc – Asianacc	
Z	-2.189 ^b
Asymp. Sig. (2-tailed)	.029

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

Figure 11: Asian Accents and Non-South Asian and Non-American Accents Z-Scores and p Values

Because the South Asian accent group and the non-South Asian and non-American accent group had similar medians, it seemed as if there would not be a

significant difference between the medians which would reject the null hypothesis. However, according to Figure 10, there were 43 participants who had higher sums of choices in the Asian accent group while there were only 25 participants who had higher sum of choices in the non-South Asian and non-American accent categories. This means that out of the 88 participants who took the survey for both categories, there were almost double the number of participants who chose more favorable options for the Asian accent category in the survey options. Then looking at Figure 11 solidified the evidence that there was a significant difference among the difference of medians across the two categories for Asian accents and non-South Asian and non-American accents because the Z-score was -2.189 which is less than the Z-score associated with a p-value of 0.05, -1.96. Furthermore, the p-value for these two categories was determined to be p-value = 0.029 which is less than the p-value of 0.05. Looking at the difference between the South Asian accent and non-South Asian and non-American accent, it can be concluded that we can partly deny the null hypothesis.

Descriptive Statistics								
	N	Mean	Std. Deviation	Minimum	Maximum	25th	Percentiles 50th (Median)	75th
Asianacc	88	28.3750	4.21904	18.00	38.00	25.2500	28.0000	31.0000
Ameacc	88	27.1477	4.21693	19.00	38.00	24.0000	27.0000	30.0000

Figure 12: South Asian Accents and American Accents Descriptive Statistics Table

Ranks

		N	Mean Rank	Sum of Ranks
Ameacc – Asianacc	Negative Ranks	47 ^a	37.88	1780.50
	Positive Ranks	24 ^b	32.31	775.50
	Ties	17 ^c		
	Total	88		

- a. Ameacc < Asianacc
- b. Ameacc > Asianacc
- c. Ameacc = Asianacc

Figure 13: South Asian Accents and American Accents Rank Table

Test Statistics^a

		Ameacc – Asianacc
Z		-2.899 ^b
Asymp. Sig. (2-tailed)		.004

- a. Wilcoxon Signed Ranks Test
- b. Based on positive ranks.

Figure 14: South Asian Accents and American Accents Z-Scores and p Values

The second of the null hypothesis can be rejected if the p-value of the differences in medians between the South Asian accents and the American accents is also less than $p = 0.05$. Looking at Figure 13, initially, it can be observed that there are 47 participants out of 88 who had higher sums for their survey choices when it came to the South Asian accent category. On the other hand, 24 of the participants had a total sum of

choices that were higher in the American accent category than they were in the South Asian accent category. Similarly to the previously mentioned category pair—the South Asian accent and the non-South Asian and non-American accent—there are almost double the number of participants who have higher total sums of favorable choices in the South Asian category when compared to the American accent category. Then looking at Figure 14, it is shown that the Z-score for this pair of categories is also less than the Z-score associated with a 0.05 p-value: the Z-score here is -2.899. Also, the p-value for this category is less than the significant p-value of 0.05, and the p-value here is $p = 0.004$. This shows that the null hypothesis can be fully rejected because both categories of American accents and non-South Asian and non-American accents have a significantly smaller sum of total favorable choices in the survey when compared to the South Asian accent category.

Discussion

Because the null hypothesis is rejected, this means that the alternate hypothesis is accepted: there is a significant difference in the sum of medians for the American accent and South Asian accent categories and the non-South Asian and non-American accent and South Asian accent categories. Because there were consistently more participants who chose higher ranking values for the survey questions for the South Asian accent category compared to each of the other two categories, that means that the physicians had an implicit bias that favored the South Asian patients compared to other patients. The entire purpose of the Likert scale questions was to ask physicians questions which would invoke them to consider how they interact with their patients. The nature of the questions

was such that they were designed so that higher ranking values displayed that the physicians were more perceptive and open towards communicating with their patients. Even if subconsciously, when physicians chose their options for the questions, they were displaying an implicit bias towards in-group members that viewed them through a more favorable and preferential point of view.

According to the survey, all 88 participants identified as South Asian, so their in-group preference would be towards other individuals with South Asian accents. A research article over “The Neural Substrates of In-Group Bias” states that “classic minimal-group studies found that people arbitrarily assigned to a novel group quickly display a range of perceptual, affective, and behavioral in-group biases” and it also claims that “the value humans place on group membership is illustrated by the ease with which humans form groups and favor in-group members” (Van Bavel et al., 2008, p. 1131). This means that when South Asian physicians see a South Asian patient, they would likely start associating them as being a part of a shared cultural, racial, or even ethnic group. This would lead into the physicians already interacting with the patients through a more favorable mindset that would allow the physicians to be more attentive and communicative with the South Asian patients. As seen in the survey, this openness to communication can be seen in multiple questions in each category such as the one asking physicians how likely they are to spend 15 minutes or more with patients or even the question asking how likely physicians are to finding a topic of conversation that is not strictly medical—this shows that the physician is taking time out of their busy schedule to talk to the patient, to maybe try and empathize with and understand them, or even to find a similar shared background or experience that would allow the patients to trust the

physicians more and open up more willingly about their health and wellness.

Miscommunication is dangerous when it comes to the healthcare field, and even if physicians are not being outright malicious to their patients, a detached and seemingly disinterested physician can deter a patient from wanting to tell the professional the full extent of their health concerns.

While the survey does show that there is a significant difference in the survey question choices across categories to be able to claim that there is an implicit bias at play during the South Asian physicians' interactions with South Asian patients, it is also important to consider that there may be other factors that influenced the survey questions. For example, a flaw I noticed in this study that maybe impacted the results was that the Likert scale questions were asking about accent categories. However, there could be South Asians that have American accents or even non-American and non-South Asian accents because they may have grown up in America or abroad in an area besides South Asia. As a result, these South Asian patients could fit into the categories of American accents and non-South Asian and non-American accents. This aspect of the research was misleading information because it failed to consider that accents can vary across place. However, something that does help lesson this error into making it more believable that the results are significant is that there are specific questions within the Likert scale question that specifically address possible shared ethnicities, races, and cultures between the physicians and the patients: questions such as the ones asking for the possibility of discussing shared similar experiences are an example of this. Furthermore, Question 7, Question 8, and Question 9 specifically ask for either South Asian individuals or non-South Asian individuals when comparing the possibility of giving out pain medication, so

this explicitly addresses the issue with labelling the independent variable of this reasearch as being dependent on specific accents.

CONCLUSION

This project considered the question of whether South Asian physicians have an implicit bias that prefers South Asian patients as opposed to patients of other races. It was found after extensive literature review that effective health care consists of more than just a medical approach to treatment. In fact, there are social and psychological factors that have just as much of an influence as biological factors in the kind of health care treatment that a patient has access to. Together, these three factors make up the biopsychosocial model of thought. If any of these three factors are lacking, then the treatment the patient is receiving is lacking in its efficacy. Furthermore, since social and psychological factors play a huge role in health care, this paper also established that culture is a factor which extensively contributes to the two branches of the biopsychosocial model of thought. As a result, there are certain barriers to health care that closely follow cultural differences. These cultural differences play a significant role in what kind of treatment a patient receives. Considering how different a shame-based South Asian society is from a guilt-based North American society, it is understandable that there are certain topics that some South Asian immigrants are hesitant to speak about with their physicians. If the physician is not aware that this hesitancy may be due to cultural differences, a lack of cultural education can worsen the issue. If the physician pushes too much and does not consider the hesitation a patient may hold regarding certain topics, the physician-patient relationship would be hindered and potentially cause strife between the two parties. If there is little trust between or any miscommunication, then the patient would not seek out the health care professional because they do not feel comfortable.

Because a South Asian physician has many similarities based on either cultural backgrounds, ethnic backgrounds, religious backgrounds, and/or language backgrounds, there would be an easier flow of communication between the physician and a South Asian patient. This easy flow of communication would translate into there being a greater amount of trust between both parties. The most vital aspect of a physician and patient relationship is trust because if this is damaged then the physician risks alienating their patients, which would be counterproductive towards gaining a better understanding of a patient's health and treatment. The question asked in the beginning of this paper asked if South Asian physicians approach their patients' treatment plans differently based on non-medical factors such as similarity of shared culture and ethnicity, and if this can lead to biased treatments especially concerning communication and understanding between physicians and patients. Combined with the literature review, the research done for this paper shows that there is significant evidence towards South Asian physicians having an implicit bias that shows a preference towards patients who identify as South Asian as opposed to patients who do not identify as being South Asian. This preference can lead to biased treatments such as physicians spending slightly more time with patients who are South Asian as seen by the fact that this was one of the questions asked on the survey passed out to the South Asian physicians who participated in this study.

Going Forward

This paper can be used to understand that there is a difference between individuals who identify as being South Asian and individuals who identify as being non-South Asian. In the West, there is not a lot of research done over health care that focuses

on South Asian patients, therefore, these individuals are underrepresented in health care research. The goal of this study was to understand if there was a clear difference on how South Asian physicians interact with patients who are South Asian and patients who are not South Asian. Because this preferential treatment could be due to a shared culture, religion, ethnicity, and/or language, there needs to be active measures taken to ensure that physicians understand that there are cultural differences they need to address when they interact with patients of different cultural, religious, ethnic, and/or linguistic backgrounds. The South Asian physicians show a significant implicit bias favoring South Asian patients, requiring the need to address their biases to ensure that they would not show preference for any one race of patients in their future interventions. While there are certain diversity trainings present in health care fields, there needs to be a specific training made for South Asian physicians because they may have different cultural mindsets and values compared to the Western physicians who are the main target audience for these training sessions. The future interventions for South Asian physicians could include training videos showing different cultural backgrounds of non-South Asians to help South Asian physicians familiarize themselves with patients who are culturally and racially different from them. The interventions can also include training exercises like mock clinicals which help South Asian physicians interact with patients from different situations addressing concerns that are culturally based so that they become more aware of how to ask for and look for signs that a patient has a certain concern that is not easily communicable through language alone. The main action that this study calls for is that South Asian physicians need to reflect on their practice, and

understand how they can address the needs of patients from different cultures without accidentally alienating them from seeking out health care.

APPENDICES

Survey Questions: South Asian Physician-Patient Interaction (SAPPI)

Directions:

Please answer each question to the best of your ability. If a particular question makes you uncomfortable, you may choose to skip it. Please note that once you go to the next question, you will not be permitted to return to previous questions.

- 1) Please enter your age:
- 2) What year did you complete your medical education?
- 3) Where did you complete your medical education:
 - a. In North America.
 - b. In South Asia.
 - c. Somewhere Else
If Somewhere Else, Where:
 - a. Europe
 - b. Africa
 - c. Australia/Oceania
 - d. Asia
 - e. South America
- 4) What year did you start practicing medicine in the United States?
- 5) What specialty do you practice?
- 6) Would you classify yourself as being South Asian: Yes or No
If Yes, how would you classify your race:
 - Pakistani
 - Bangladeshi
 - Bhutanese
 - Indian
 - Nepali
 - Sinhalese

Bangladeshi
Afghani
Maldivian

If No, how would you classify your race:

American Indian/Alaskan Native
Black/African American
Hispanic/Latino
White
Native Hawaiian/Other Pacific Islander

7) Do you believe race and ethnicity are two different concepts:

- a. Yes
- b. No
- c. Do not Know

8) Does your hospital or clinic collect information on the race of patients (This would generally involve classifying patients as White, Black/African American, American Indian

or Alaska Native, Asian and Native Hawaiian or other Pacific Islander, etc.):

- a. Yes
- b. No
- c. Do not Know

9) Does your hospital collect information on the ethnicity of patients?(This would involve

classifying patients as Hispanic/Latino, or non-Hispanic/non-Latino):

- a. Yes
- b. No
- c. Do not Know

10) How does your hospital primarily collect patient race/ethnicity/tribal affiliation?

- a. Verbally ask the patient
- b. Patient fills out this information on a form
- c. The registration staff observes the physical characteristics of the patient
- d. The hospital does not collect this information
- e. Do not know

11) Does your hospital use race/ethnicity/tribal affiliation data to assess and compare quality of

care among patients of different population groups?

- a. Yes
- b. No
- c. Do not know

12) Does your hospital collect information on patients' primary language?

- a. Yes
- b. No
- c. Do not know

13) Does your hospital employ interpreters (either full-time or part-time)?

- a. Yes
- b. No
- c. Do not know

14) Where would you classify your work:

- a. Academic medical center
- b. Managed Care Group
- c. Solo Practice (Go to q 16)
- d. other (Go to q 15)

15) Where would you classify your practice taking place:

16) Is your solo practice in a rural, suburban, or urban area:

17) How much time do you spend with your patients usually on average?

- a. 20 minutes
- b. 15 minutes
- c. 10 minutes
- d. less than 10 minutes

18) On a scale of 1 to 5 with 1 being very unlikely, 2 being slightly unlikely, 3 being neutral, 4 being slightly likely, and 5 being very likely rate the following-

If you meet a patient who has a South Asian accent:

How likely are you to complement them on their English:

How likely are you to ask where they are from in casual conversation:

How likely are you to try and find a similar topic of conversation different from the professional conversation:

How likely are you to identify with a patient's experience related to culture and ethnicity if it is not the same ethnicity and culture as yours:

How likely are you to spend over 15 minutes with a patient not the same ethnicity as you:

How likely are you to talk about a purely medical approach to treatment:

How likely are you to prescribe pain medication to a young adult (18-35 years) compared to a non-South Asian young adult patient:

How likely are you to prescribe pain medication to a middle age (36-55 years) compared to a non-South Asian middle age patient:

How likely are you to prescribe pain medication to an older adult (above 55 years) compared to a non-South Asian older adult patient:

How likely is it that when you are with a patient, you address your nurse or PA for more than 5 minutes:

19) On a scale of 1 to 5 with 1 being very unlikely, 2 being slightly unlikely, 3 being neutral, 4 being slightly likely, and 5 being very likely rate the following-

If you meet a patient who has a non-American and Non-South Asian accent:

How likely are you to complement them on their English:

How likely are you to ask where they are from in casual conversation:

How likely are you to try and find a similar topic of conversation different from the professional conversation:

How likely are you to identify with a patient's experience related to culture and ethnicity if it is not the same ethnicity and culture as yours:

How likely are you to spend over 15 minutes with a patient not the same ethnicity as you:

How likely are you to talk about a purely medical approach to treatment:

How likely are you to prescribe pain medication to a young adult (18-35 years) compared to a South Asian young adult patient:

How likely are you to prescribe pain medication to a middle age (36-55 years) compared to a South Asian middle age patient:

How likely are you to prescribe pain medication to an older adult (above 55 years) compared to a South Asian older adult patient:

How likely is it that when you are with a patient, you address your nurse or PA for more than 5 minutes:

20) On a scale of 1 to 5 with 1 being very unlikely, 2 being slightly unlikely, 3 being neutral, 4 being slightly likely, and 5 being very likely rate the following-

If you meet a patient who has an American accent:

How likely are you to complement them on their English:

How likely are you to ask where they are from in casual conversation:

How likely are you to try and find a similar topic of conversation different from the professional conversation:

How likely are you to identify with a patient's experience related to culture and ethnicity if it is not the same ethnicity and culture as yours:

How likely are you to spend over 15 minutes with a patient not the same ethnicity as you:

How likely are you to talk about a purely medical approach to treatment:

How likely are you to prescribe pain medication to a young adult (18-35 years) compared to a South Asian young adult patient:

How likely are you to prescribe pain medication to a middle age (36-55 years) compared to a South Asian middle age patient:

How likely are you to prescribe pain medication to an older adult (above 55 years) compared to a South Asian older adult patient:

How likely is it that when you are with a patient, you address your nurse or PA for more than 5 minutes:

At End Of Survey: Thank you for taking the time to complete this survey. The undisclosed information mentioned earlier was that this survey is testing if South Asian physicians have any implicit bias or preferential attitudes towards South Asian patients and if this can affect treatment plans. Thank you for answering the questions to the best of your abilities and for contributing to this study.

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