RACE, SOCIOECONOMIC STATUS, AND THE PERCEIVED IMPORTANCE OF POSITIVE SELF-PRESENTATION IN HEALTH CARE

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ABSTRACT

Hundreds of studies have documented disparities in medical treatment in the US. These findings have generated research and initiatives intended to understand and ameliorate such disparities. Most approaches implicitly assume that disadvantaged patients' beliefs and attitudes toward health care are at odds with the health care system, failing consider whether patients use particular strategies to overcome providers' potentially negative perceptions of them and/or obtain quality medical care. In this paper, we examine positive self-presentation as a strategy that may be used by disadvantaged groups to improve their medical treatment. Analysis of survey data suggests that both African Americans and lower socioeconomic status persons are more likely than whites or higher socioeconomic status persons to report that positive self-presentation is important for their getting the best medical care. Based on these findings, we suggest several routes for future research that will advance our understanding of patients' everyday strategies for getting the best health care.

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Hundreds of studies have documented disparities in medical treatment in the US (Smedley, Adrienne Y. Stith, and Alan R. Nelson 2003). Furthermore, there is strong evidence that stereotypes associated with sex, age, diagnosis, sexual orientation, sickness, socio-economic status, obesity, and more recently, race/ethnicity influence providers beliefs about and expectations of patients (Bonvicini and Perlin 2003; Douglas, Kalman, and Kalman 1985; Foster et al. 2003; McKinlay, Potter, and Feldman 1996; Najman, Klein, and Munro 1982; Schulman et al. 1999; Shortt 2001; Tait and Chibnall 1997; van Ryn and Burke 2000; Wileman, May, and Chew-Graham 2002). These findings have generated research and initiatives intended to understand and ameliorate such disparities. Most approaches implicitly assume that disadvantaged patients' beliefs and attitudes toward health care are at odds with the health care system. Consequently, work on disparities generally fails to consider whether patients use particular strategies to overcome providers' potentially negative perceptions of them and/or obtain quality medical care.

Are patients who are at greater risk of receiving poor treatment more likely than others to report that strategies for improving providers' perceptions of them are important to getting good medical care? If the experience of unfair treatment and/or observations of inequality have an impact on patient behavior when seeking care, we would expect African American and low socioeconomic status patients to be more likely than their white and high socioeconomic status counterparts to perceive strategies of positive self-presentation as important for obtaining optimal medical care. In this paper, we use survey data to determine whether there are race or socioeconomic status differences in the perceived importance of positive self-presentation to get

the best medical care. The study of strategies for getting the best medical care is important because it can give insight into how patients' social location (e.g., race and social class) influence their approach to health care. In addition, development of interventions to decrease bias in health care, as well as all patient activation interventions, are more likely to be effective if the strategies patients already use are well understood, including sociodemographic variation in strategy use.

BACKGROUND

The 2003 report from the Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* explains that hundreds of studies document racial differences in the use of medical procedures in the US. Whites are more likely than African Americans to receive high technology services as well as basic treatment for medical conditions (Bernabei, Gambassi, and Lapane 1998; Cooper, Yuan, Landefeld, and Rimm 1996; Dunlop, Song, Manheim, and Chang 2003; Escarce, Epstein, Colby, and Schwartz 1993; Palacio, Kahn, Richards, and Morin 2002; Schneider, Zaslavsky, and Epstein 2002). For example, one study finds that African Americans are less likely than whites to receive arthritis related joint replacement, even when controlling for other demographic factors and access to care (Dunlop et al. 2003). While disparities in care due to socioeconomic status is difficult because income and education data are not always collected (Krieger, Chen, and Ebel 1997; Krieger, Williams, and Moss 1997), available evidence suggests that patients with lower incomes have reduced access to care (Himmelstein and Woolhandler 1995; Newhouse and The Insurance Experiment Group 1993) and receive lower quality of care (National Healthcare Disparities Report 2003).

Patients' reports of their care reflect the inequalities in health care. Patient ratings of health care suggest that in at least some instances African Americans and lower socioeconomic

status patients have less positive feelings about the health care system and health care providers (Blendon et al. 1995; LaVeist and Nuru-Jeter 2002; Malat 2001; Ohldin et al. 2004). For example, African Americans are more likely than whites to be dissatisfied with the interpersonal aspects of the medical encounter (Barr 2004). There is some evidence that some patients respond to negative health care experiences by developing strategies to improve future treatment. For instance, perceptions of poor past treatment due to race increase the likelihood of African American patients' preferring a same race health care provider (Malat and van Ryn Unpublished).

Nonetheless, most research and intervention programs do not consider that patients may proactively seek to improve their care. Published research on the cause of racial and ethnic disparities in medical treatment has focused on three primary hypotheses. Some of the early studies on the racial disparity focused on differential *financial barriers* by race/ethnicity. While insurance coverage and income account for considerable variance in care provided, disparities in care persist independent of these factors (Smedley et al. 2003). Other studies examined the role of *patient beliefs*, preferences, and refusal of treatment, but found that these patient factors failed to account for the observed disparities in care (Hannan et al. 1999; Hopp and Duffy 2000; Schecter et al. 1996; Shepardson, Gordon, Ibrahim, Harper, and Rosenthal 1999). The third set of studies evaluate the role of *provider bias* with results suggesting that bias and stereotypes, however unintentional, do partially account for differential treatment, at least in some instances (Hannan 1999; van Ryn unpublished). Research on socioeconomic status differences in medical treatment has a longer history (Duff and Hollingshead 1968), finding that access to care, patients' access to information, and health care provider assessments of patients all are influenced by patient socioeconomic status (Anspach 1993; Heimer and Staffen 1998).

Intervention approaches intended to reduce disparities and improve quality of care include increasing the non-white workforce, cultural competence training for providers, and patient "activation" interventions that encourage patients to be more assertive (Adler, McGraw, and McKinlay 1998; Shaffer and Sherell 1995). These approaches, along with most of the discourse on race and medical care encounters, overlook the possibility that patients are attempting their own individual interventions, specifically, applying behavioral strategies to improve their odds of getting quality care.

Self-presentation, a concept developed in social psychology (Goffman 1959), offers one direction for focusing on potentially useful everyday strategies. Self-presentation is a very common form of impression management in which individuals seek to control the image that they project to others (Jones and Pittman 1982). Self-presentation is used to achieve a number of goals, including simply to present a positive image of oneself (Schlenker and Pontari 2000). A positive self-presentation may be particularly important in situations where one is interacting with gatekeepers or other powerful people, both of which generally describe doctors relative to patients.

The extent to which doctors are viewed as expert and powerful relative to patients depends on the social location of the patient, with white and high socioeconomic status patients experiencing a more privileged position. Evidence of their privilege is found in past and present treatment in health care as well as everyday stereotyping by physicians (Anspach 1993; Gamble 1997; Smedley et al. 2003). For instance, African American patients are less likely to be perceived by their providers as intelligent or educated, independent of their actual level of education (van Ryn and Burke 2000). Low socioeconomic status patients are further disadvantaged by having fewer educational resources for communicating with physicians and

fewer material resources for seeking care from an alternate provider. As a result, patients in a disadvantaged social location—specifically here, African American patients and lower socioeconomic status patients—might be more likely to feel the need to employ a strategy of positive self-presentation when seeking health care.

Indeed, there is anecdotal evidence that positive self presentation is an important strategy, at least for some persons, seeking health care.[1] Dr. Risa Lavizzo-Mourey, an African American medical doctor, provided an illustration of using such a strategy when seeking care for her sick daughter (Lavizzo-Mourey 2004). When Dr. Lavizzo-Mourey arrived at the emergency room late at night, she was sleepless from caring for her child. The physician made a quick assessment and told her to take her daughter home. Certain that her daughter needed medical treatment, Dr. Lavizzo-Mourey conveyed that she was educated, in particular about health, by using medical terms. Her efforts were successful, and she gained access to the attending physician, more tests, and her daughter received appropriate treatment for pneumonia. This example provides one example of using a self-presentation strategy to improve care. The analysis in this paper will provide a systematic assessment of the prevalence of the strategy of positive self-presentation among different social groups.

HYPOTHESES

1. African Americans are more likely than whites to report that positive self-presentation is important for receiving the best medical care.

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[1] Other research has suggested that female patients with chronic pain find advantage in a strategy of negative self-presentation, seeming run-down by their disease (Werner and Malterud 2003). This research looks at how gender influences patients with a particular disease experience, while our study focuses on race and socioeconomic status outside of a specific disease context.

2. Low socioeconomic status individuals are more likely than high socioeconomic status individuals to report that positive self-presentation is important for receiving the best medical care.

METHODS

Data

To test these hypotheses, we used data from the spring 2004 Greater Cincinnati Survey (GCS). The GCS is a telephone survey conducted by the Institute of Policy Research (IPR) at the University of Cincinnati. The survey asks questions on a variety of topics according to the needs of the current GCS clients. The GCS is based on a random digit dial sample of residents of Hamilton County, OH, which includes the city of Cincinnati and the surrounding area. In order to allow sufficient sample size to assess patterns among African Americans, there was an oversample of African Americans. The response rate for the survey was 31 percent, likely due to elsewhere noted response rate problems (Tourangeau 2004). In contrast to conventional wisdom, current empirical research suggests that low response rates are unlikely to bias parameter estimates (Curtin, Presser, and Singer 2000; Keeter, Miller, Kohut, Groves, and Presser 2000; Teitler, Reichman, and Sprachman 2003). The final sample included 689 whites and 510 African Americans.

Positive self-presentation was measured by seven items that used the same question stem. "In order to get the best treatment possible at the doctor's office, how important do you think it is for you, yourself, to wear nice looking clothes to an appointment? Would you say is it very important, somewhat important, not too important, or not at all important?" Other strategies in the series were "look very clean", "arrive on time", "be friendly with the doctor", "be friendly with the office staff", "let the doctor know that you care about your health", and "show that you

are an intelligent person". Factor analyses revealed that these items all load to one underlying factor. Responses were reverse coded and summed to create a scale with a Chronbach's alpha coefficient of .72.

Race, education, income, sex, and age were all measured with standard items. Race includes only African Americans and whites. Socioeconomic status was assessed in the models using education and income. Both education and income were measured in categories and were implemented as continuous variables in the models. Categorical models led to similar results, but are less parsimonious. Over 20 percent of the respondents refused or were unable to provide income information. For this analysis, we imputed the missing values using multiple imputation, which has emerged as a powerful and flexible approach to the problem of missing values (Schafer 1999). We used the UVIS (univariate imputation sampling) Stata module to impute missing income values based on a multiple regression with sex, age, race, and education as predictors.

Analytic Plan

Except when noted, weights were applied to the data presented here. The IPR provided a weight that adjusted for different likelihoods of selection into the sample (due to multiple telephone numbers and number of adults in the household) and to correct for potential sampling biases on age, race, sex, and education, using U.S. Census data. All of the parameters estimates presented in this paper are estimated using the statistical package, Stata version 7.0 (StataCorp. 2001). Stata can adjust standard errors to reflect complex (rather than simple random) survey designs. Stata's "svy" commands were used for these analyses.

Significance values for bivariate associations were determined using Wald tests for equality of means of the categories of the independent variables. Multivariate models were

estimated using ordinary least squares regression. Multiple models assessed relationships among variables. Model 1 included race, but not socioeconomic status, in order to observe the actual effect of race in the sample. Model 2 introduced socioeconomic status indicators to Model 1. Note that the coefficient for race in Model 2 tells us what the effect of race on perceived importance of positive self-presentation would be if all persons had equal income and education. Finally, two additional models tested for possible interactions between race and socioeconomic status indicators. Interactions were tested using multiplicative interaction terms.

RESULTS

Table 1 presents the distribution of the variables. The mean importance of positive self-presentation is 24.4 out of a possible of 28, indicating that most people felt that positive self-presentation is important for receiving the best medical care possible. Table 2 presents the mean importance of positive self-presentation by the independent variables. There is a significant association between self-presentation and all independent variables except insurance coverage. All of the hypothesized relationships are in the expected direction. African Americans, on average, rate positive self-presentation as more important than whites. Those with less education and less income also rate positive self-presentation as more important than their more advantaged counterparts.

The multivariate results are shown in Table 3. As expected from the bivariate distribution, we found that African Americans' average rating is 1.3 points higher than whites', controlling for age, gender, and insurance status (Model 1, $p<.01$). This result indicates that in the existing system of education and income inequality African Americans are more likely than whites to perceive positive self-presentation as very important for receiving the best medical care.

Model 2 introduced indicators for education and income to Model 1. Both education and income were significant predictors of the rating of the importance of strategies ($p<.05$). Persons with less education and more income were more likely than their advantaged counterparts to believe that positive self-presentation is important for receiving the best medical care, which supports the second hypothesis. For example, an individual with a high school degree and $10,000--$20,000 annual income would rate strategies as 1.0 higher than a counterpart with a college degree and $30,000--$50,000 annual income. Of note, the inclusion of indicators of socioeconomic status reduced the coefficient for race, but race remained a significant ($p<.01$) predictor of perceived self-presentation importance. Among the control variables, both age and gender are significant ($p<.05$), with increasing age and being female predicting higher rating positive self-presentation. Finally, additional models tested whether the effect of education and income varies by race. Neither interaction term was significant ($p>.10$, not shown).

DISCUSSION

In this paper we set out to examine whether individuals in disadvantaged social locations—specifically, African Americans and lower socioeconomic status persons—are more likely to feel that positive self-presentation is important for receiving the best medical care. Our findings provide support for this hypothesis. African Americans and lower socioeconomic status persons are more likely to think that self-presentation strategies are important. While other research has documented that African American and low socioeconomic status patients are less likely to receive a variety of forms of medical treatment and that providers' perceptions of patients are influenced by patients' race and sociodemographic characteristics (Anspach 1993; Heimer and Staffen 1998; Smedley et al. 2003; van Ryn and Burke 2000), it is unclear whether differences in use of strategies is due to awareness of inequality in medical care specifically or a

general response to ubiquitous societal inequality. In either case, the analysis presented here provides, for the first time, systematic evidence that African Americans and low socioeconomic status persons more strongly value a particular individual proactive strategy to improve the quality of their health care.

The results showed some notable effects among the control variables. Insurance status did not have an effect on the perceived importance of positive self-presentation. Unfortunately, the measure of insurance coverage used here was not sensitive to variations in physician choice and switching options, precluding tests of whether greater control over physician choice reduces the perceived need for positive self-presentation. Women rated the importance of positive self-presentation higher than men, which is concordant with the notion that lower status persons are more likely to view positive self-presentation as important. Increasing age was also associated with perceiving positive self-presentation as important. While this may reflect patient response to stigma associated with age and/or physician negative perceptions of older patients (Shortt 2001), it may also be attributable to generational differences in approach to doctors as an authority.

Managing one's self-presentation requires extra cognitive and emotional effort. During the medical encounter, patients' efforts to project a positive self-presentation may reduce the cognitive resources available for other tasks such as remembering to ask questions or carefully listening to medication regimens. In the long-term, heightened attention to self-presentation in a variety of environments may be an added stressor for African Americans and low socioeconomic status persons. Research on race and health status suggests that both major stressors and everyday stresses related to racism have an impact on the health of African Americans (Geronimus 1996; Krieger 1996; Williams, Yu, Jackson, and Anderson 1997).

These results importantly contribute to research on disparities in medical treatment in the US. To date, research on disparities has primarily asked how African American and low socioeconomic status patients' beliefs are at odds with health care. This study shows that persons in these social locations are actually more likely than their more privileged counterparts to place importance on at least one active strategy for getting the best medical care. This examination of a particular strategy for getting the best medical treatment is not intended to put responsibility for good care on patients, but to point out that patients are proactive in their approach to health care. These results can also contribute to work on patient activation interventions, which are based on the premise that patient behavior can improve the quality of care received and reduce errors. While these interventions may prove useful, currently there is little evidence regarding which patient strategies work, nor how provider response to patient strategies may differ by the race/ethnicity of the patient.

Much has been made of the rising power of patients as consumers and the possible loss of professional power of physicians (Coburn and Willis 2000). The results presented here suggest that patients' sense of empowerment in the medical encounter may not be equally distributed through society. The potential for a patient to act as a consumer (e.g., making demands on physicians) may depend on the social position of the patient. The present research suggests that some groups of people feel more like consumers entitled to quality treatment and some feel more like supplicants.

There are several limitations of this study. First, the sample is not representative of the US population. The greater Cincinnati area, however, does include urban areas similar to other Midwestern cities as well as standard suburban areas and more rural areas. Another limitation of the present study is that it measured only whether people feel that positive self-presentation is

important, not if they actually take action to this end. This study barely scratches the surface in our understanding of the way patient strategies, race/ethnicity and other non-clinical factors, and provider response interact to influence quality of care. The findings presented here provide impetus for a number of research questions:

1) Do these strategies work? Does patient behavior mediate and/or moderate the observed effects of patient socio-demographic characteristics on providers' perceptions of and behavior towards patients? For example, does an African American patient who communicates interest in their health receive better care than other African American patients? Or does a poor patient who makes an effort to be friendly and look very clean receive better care than other poor patients? These questions may be best answered through factorial experiments using vignettes where only the relevant factors are manipulated.

2) Do these strategies ever backfire, for example exacerbating the activation of stereotypes associated with low status individuals? While there is some evidence that assertiveness may improve quality of care for black, but not white, patients (Krupat et al. 1999), we know nothing about the impact of impression-management strategies on characteristics of medical encounters and quality of care. For instance, social class is communicated very subtly (Bourdieu 1984), perhaps making positive self-presentation more effective for high social class persons of color than lower social class individuals who do not possess the resources to effectively manage their self-presentation to a provider. As a result, a patient's effort to reduce perceptions of social distance by speaking formally could be thwarted by a single non-standard usage.

3) Are provider characteristics associated with response to patient self-presentation and race/ethnicity? For example, does provider social location (e.g., race, gender) or practice factors (e.g., specialty or location) influence response to patients? Research that allows us to tease out the relationship between behavior and both patient and provider sociodemographic characteristics could answer these questions about the efficacy of self-presentation efforts.

4) What other strategies do patients use to improve the quality of their medical treatment? How do these strategies work? For instance, research in the sociology of education finds that parents' ability to advocate for their children's educational needs depends, in part, on information obtained from their social network (Lareau 2000). A future study of patient strategies might examine how patients use social networks to try to obtain to the best medical care. The benefit provided by accessing social networks depends on the degree to which the network contains the relevant resources (e.g., contacts, knowledge, experience). Working class and poor people's social networks include fewer persons, including medical doctors, who can provide information based on either experience or professional knowledge (Lareau 2003).

5) What are patients' perspectives on using strategies of self-presentation? For instance, do patients feel that they successfully implement these strategies? What is the link between intention and behavior? How do the exigencies of the medical encounter limit patients' ability to put forward a positive self-presentation? For example, do time limitations and patients' inability to control the conversation limit patients' ability to demonstrate that they care about their health? In addition, how does the nature of visit

(e.g., for a serious condition vs. a routine check-up) or the duration of the relationship with the provider affect the perceived importance of self-presentation strategies?

6) Why are there differences in the perceived importance of self-presentation strategies? For instance, do higher socioeconomic status patients feel that positive self-presentation is less necessary to receive optimal care or does adherence to standards of positive self-presentation more strongly accord with their daily personal and professional strategies (e.g., wearing professional attire, comfort with persons of professional status) making special efforts unnecessary? Other methodological techniques, such as ethnography and semi-structured interviews, would provide greater insight into patients' thinking about positive self-presentation in health care.

7) Are patients successful in conveying the impression they desire? For example, a patient who intends to show interest in her health may be perceived as overly aggressive by the doctor. Or a patient who purposively intends to demonstrate that he is intelligent simply may not be perceived as such by the doctor. A study that measures patients' intentions and matches them with doctors' perceptions of patients could answer such questions.

8) Are there regional or urban/rural differences in perceived importance of impression management strategies? Factors like the degree of homogeneity of the population, or the extent of anonymity in the community might influence the perceived importance of positive self-presentation. In a rural white community with a single clinic staffed by few providers, making a positive impression may be less important because the provider is likely to know they patient as well as their relatives. Answering these questions will require larger and more representative samples than available here.

CONCLUSION

The findings presented here indicate that many patients believe that positive self-presentation is important for getting care, and that this belief is both more prevalent and strongly held among African American and low status patients. These findings provide support for the need for further investigation of patient self-presentation strategies. Furthermore, those developing and implementing patient-directed interventions should be aware that patients may already be implementing a number of strategies of their own, and that these strategies may or may not be consistent with the intervention's objectives.

REFERENCES

Anspach, Renee. 1993. *Deciding Who Lives: Fateful Choices in the Intensive-Care Nursery*. Berkeley: University of CA Press.

Barr, Donald A. 2004. "Race/Ethnicity and Patient Satisfaction: Using the Appropriate Method to Test Perceived Differences in Care." *Journal of General Internal Medicine* 19:937-43.

Bernabei, Roberto, Giovanni Gambassi, and Kate Lapane. 1998. "Management of Pain in Elderly Patients With Cancer." *Journal of the American Medical Association* 279(23):1877-82.

Blendon, Robert J., Ann C. Scheck, Karen Donelan, Craig A. Hill, Mark Smith, Dennis Beatrice, and Drew Altman. 1995. "How White and African Americans View Their Health and Social Problems: Different Experiences, Different Expectations." *Journal of the American Medical Association* 273(4):341-46.

Bonvicini, Kathleen A. and Michael J. Perlin. 2003. "The Same but Different: Clinician-Patient Communication With Gay and Lesbian Patients." *Patient Education and Counseling* 51(2):115-22.

Bourdieu, Pierre. 1984. *Distinction: A Social Critique of the Judgement of Taste*. Cambridge, MA: Harvard University Press.

Coburn, David and Evan Willis. 2000. "The Medical Profession: Knowledge, Power, and Autonomy." Pp. 377-93 in *Handbook of Social Studies in Health and Medicine*, Gary L. Albrecht, Ray Fitzpatrick, and Susan C. Scrimshaw (eds). Thousand Oaks, CA: Sage Publications.

Cooper, Gregory S., Zhong Yuan, Seth Landefeld, and Alfred A. Rimm. 1996. "Surgery for Colorectal Cancer: Race-Related Differences in Rates and Survival Among Medicare Beneficiaries." *American Journal of Public Health* 86(4):582-86.

Curtin, Richard, Stanley Presser, and Eleanor Singer. 2000. "The Effects of Response Rate Changes on the Index of Consumer Sentiment." *The Public Opinion Quarterly* 64(4):413-28.

Douglas, C J., C M. Kalman, and T P. Kalman. 1985. "Homophobia Among Physicians and Nurses: an Empirical Study." *Hospital and Community Psychiatry* 36(12):1309-11.

Duff, Raymond S. and August B. Hollingshead. 1968. *Sickness and Society*. New York: Harper & Row.

Dunlop, Dorothy D., Jing Song, Larry M. Manheim, and Rowland W. Chang. 2003. "Racial Disparities in Joint Replacement Use Among Older Adults." *Medical Care* 41(2):288-98.

Escarce, Jose J., Kenneth R. Epstein, David C. Colby, and J. S. Schwartz. 1993. "Racial Differences in the Elderly's Use of Medical Procedures and Diagnostic Tests." *American Journal of Public Health* 83(7):948-54.

Foster, Gary D., Thomas A. Wadden, Angela P. Makris, Duncan Davidson, Rebecca S. Sanderson, David B. Allison, and Amy Kessler. 2003. "Primary Care Physicians' Attitudes About Obesity and Its Treatment." *Obesity Research* 11:1168-77.

Gamble, Vanessa N. 1997. "Under the Shadow of Tuskegee: African Americans and Health Care." *American Journal of Public Health* 87(11):1773-8.

Geronimus, Arline T. 1996. "Black/White Differences in the Relationship of Maternal Age to Birthweight: a Population-Based Test of the Weathering Hypothesis." *Social Science and Medicine* 42(4):589-97.

Goffman, Irving. 1959. *The Presentation of Self in Everyday Life*. Garden City, NY: Doubleday and Company.

Hannan, Edward L., Michelle van Ryn, Jane Burke, Danice Stone, Dinesh Kumar, Djavad Arani, Walter Pierce, Shahrokh Rafii, Timothy A. Sanborn , Samin Sharma, James Slater, and Barbara A. DeBuono. 1999. "Access to Coronary Artery Bypass Surgery by Race/Ethnicity and Gender Among Patients Who Are Appropriate for Surgery." *Medical Care* 37(1):68-77.

Heimer, Carol A. and Lisa R. Staffen. 1998. *For the Sake of the Children: The Social Organization of Responsibility in the Hospital and the Home*. Chicago, IL: University of Chicago Press.

Himmelstein, David U. and Steffie Woolhandler. 1995. "Care Denied: US Residents Who Are Unable to Obtain Needed Medical Services." *American Journal of Public Health* 85(3):341-44.

Hopp, Faith P. and Sonia A. Duffy. 2000. "Racial Variations in End-of-Life Care." *Journal of the American Geriatrics Society* 48(6):658-63.

Jones, Edward E. and Thane S. Pittman. 1982. "Toward a General Theory of Strategic Self-Presentation." Pp. 231-62 in *Psychological Perspectives on the Self* Jerry M. Suls. Hillsdale, N.J. : Lawrence Erlbaum Associates.

Keeter, Scott, Carolyn Miller, Andrew Kohut, Robert M. Groves, and Stanley Presser. 2000. "Consequences of Reducing Nonresponse in a National Telephone Survey." *The Public Opinion Quarterly* 64(2):125-48.

Krieger, Nancy. 1996. "Racial Discrimination and Blood Pressure: The CARDIA Study of Young Black and White Adults." *American Journal of Public Health* 86(10):1370-1378.

Krieger, Nancy, Jarvis T. Chen, and Gregory Ebel. 1997. "Can We Monitor Socioeconomic Inequalities in Health? A Survey of U.S. Health Departments' Data Collection and Reporting Practices." *Public Health Reports* 112481-91.

Krieger, Nancy, David R. Williams, and Nancy E. Moss. 1997. "Measuring Social Class in US Public Health Research: Concepts, Methodologies, and Guidelines." *Annual Review of*

Public Health 18:341-78.

Krupat, Edward, Julie T. Irish, Linda E. Kasten, Karen M. Freund, Risa B. Burns, Mark A. Moskowitz, and John B. McKinlay. 1999. "Patient Assertiveness and Physician Decision-Making Among Older Breast Cancer Patients." *Social Science and Medicine* 49(4):449-57.

Lareau, Annette. 2000. *Home Advantage: Social Class and Parental Intervention in Elementary Education*. Lanham, MD: Rowman & Littlefield Publishing.

———. 2003. *Unequal Childhoods: Class, Race, and Family Life*. Berkeley: University of California Press.

LaVeist, Thomas A. and Amani Nuru-Jeter. 2002. "Is Doctor-Patient Race Concordance Associated With Greater Satisfaction With Care?" *Journal of Health and Social Behavior* 43(3):296-306.

Lavizzo-Mourey, Risa. 2004. *The Robert Wood Johnson Foundation Making a Difference: Annual Report 2003*.

Malat, Jennifer. 2001. " Social Distance and Patients' Rating of Healthcare Providers." *Journal of Health and Social Behavior* 42(December):360-72.

Malat, Jennifer and Michelle van Ryn. Unpublished. "African American Preference for Same Race Healthcare Providers: The Role of Healthcare Discrimination." .

McKinlay, John B., Deborah A. Potter, and Henry A. Feldman. 1996. "Non-Medical Influences on Medical Decision-Making." *Social Science and Medicine* 42(5):769-76.

Najman, J M., D Klein, and C Munro. 1982. "Patient Characteristics Negatively Stereotyped by Doctors." *Social Science and Medicine* 16(20):1781-9.

Newhouse, Joseph P. and The Insurance Experiment Group. 1993. *Free for All? Lessons From the RAND Health Insurance Experiment*. Cambridge, MA: Harvard University Press.

Ohldin, Andrea, Bessie Young, Ann Derleth, Mary McDonell, Paula Diehr, Catarina Kiefe, and Stephan Fihn. 2004. "Ethnic Differences in Satisfaction and Quality of Life in Veterans With Ischemic Heart Disease." *Journal of the National Medical Association* 96(6):799-808.

Palacio, Herminia, James G. Kahn, T A. Richards, and Stephen F. Morin. 2002. "Effect of Race and/or Ethnicity in Use of Antiretrovirals and Prophylaxis for Opportunistic Infection: a Review of the Literature." *Public Health Reports* 117(3):233-51.

Schafer, Joseph L. 1999. "Multiple Imputation: A Primer." *Statistical Methods in Medical Research* 8:3-15.

Schecter, Alison D., Pascal J. Goldschmidt-Clermont, Glenda McKee, Donna Hoffeld, Mary

Myers, Roseann Velez, Julieta Duran, Steven P. Schulman, Nisha G. Chandra, and Daniel E. Ford. 1996. "Influence of Gender, Race, and Education on Patient Preferences and Receipt of Cardiac Catheterizations Among Coronary Care Unit Patients." *American Journal of Cardiology* 78(9):996-1001.

Schlenker, Barry R. and Beth A. Pontari. 2000. "The Strategic Control of Information: Impression Management and Self-Presentation in Daily Life." *Psychological Perspectives on Self and Identity*, A. Tesser, RB Felson, and JM Suls (eds). Washington, DC: American Psychological Association.

Schneider, Eric C., Alan M. Zaslavsky, and Arnold M. Epstein. 2002. "Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care." *Journal of the American Medical Association* 287(10):1288-94.

Schulman, Kevin A., Jesse A. Berlin, William Harless, Jon F. Kerner, Shyrl Sistrunk, Bernard J. Gersh, Ross Dube, Christopher K. Taleghani, Jennifer E. Burke, Sankey Williams, John M. Eisenberg, Jose J. Escarce, and William Ayers. 1999. "The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization." *The New England Journal of Medicine* 340(8):618-26.

Shepardson, Laura B., Howard S. Gordon, Said A. Ibrahim, Dwain L. Harper, and Gary E. Rosenthal. 1999. "Racial Variation in the Use of Do-Not-Resuscitate Orders." *Journal of General Internal Medicine* 14(1):15-20.

Shortt, S. 2001. "Venerable or Vulnerable? Ageism in Health Care." *Journal of Health Services Research & Policy* 6(1):1-2.

Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson (eds.). 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press.

StataCorp. 2001. *Stata Statistical Software: Release 7.0*. College Station, TX: Stata Corporation.

Tait, Raymond C. and John T. Chibnall. 1997. "Physician Judgments of Chronic Pain Patients." *Social Science and Medicine* 45(8):1199-205.

Teitler, Julien O., Nancy E. Reichman, and Susan Sprachman. 2003. "Costs and Benefits of Improving Response Rates for a Hard-to-Reach Population." *The Public Opinion Quarterly* 67(1):126-38.

Tourangeau, Roger. 2004. "Survey Research and Societal Change." *Annual Review of Psychology* 55775-801.

van Ryn, Michelle and Jane Burke. 2000. "The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients." *Social Science and Medicine* 50(6):813-28.

Werner, Anne and Kirsti Malterud. 2003. "It Is Hard Work Behaving As a Credible Patient:

Encounters Between Women With Chronic Pain and Their Doctors." *Social Science and Medicine* 57(8):1409-19.

Wileman, Lindsey, Carl May, and Carolyn A. Chew-Graham. 2002. "Medically Unexplained Symptoms and the Problem of Power in the Primary Care Consultation: a Qualitative Study." *Family Practice* 19(2):178-82.

Williams, David R., Yan Yu, James S. Jackson, and Norman B. Anderson. 1997. "Racial Differences in Physical and Mental Health: Socioeconomic Status, Stress, and Discrimination." *Journal of Health Psychology* 2(3):335-51.

Table 1. Weighted percentage and unweighted frequer
distribution of variables

	Percentage (mean)	Unweighted n
Dependent variable		
Strategies importance	(24.39)	1189
Race		
White	75.28	695
Black	24.72	510
Socioeconomic status		
Education		
Less than high school	19.19	94
High school	27.40	306
Some college	27.74	411
College graduate	25.68	393
Income		
under $10,000	19.30	170
$10,000 - $19,999	20.19	261
$20,000 - $29,999	20.84	261
$30,000 - $49,999	10.76	144
$50,000 and over	28.91	343
Controls		
Sex		
Male	45.16	391
Female	54.84	814
Age		
18-19	24.75	241
30-45	28.65	360
46-64	24.59	382
over 65	22.00	197
Insurance coverage		
Have insurance	87.98	1057
No insurance	12.02	147

Table 2. Strategies mean importance by independent variables

	Sum of strategies importance
*Race***	
White	24.06
Black	25.42
Socioeconomic status	
Education**	
Less than high school	25.81
High school	24.57
Some college	24.22
College graduate	23.33
Income**	
Less than $10,000	25.29
$10,000 - $19,999	25.10
$20,000 - $39,999	24.48
$40,000 - $59,999	23.55
More than $60,000	23.50
Controls	
Sex**	
Male	23.96
Female	24.75
Age**	
18-19	23.38
30-45	24.24
46-64	24.46
over 65	25.63
Insurance coverage	
Have insurance	24.38
No insurance	24.40

* $p < .05$, ** $p < .01$ for adjusted Wald test

Table 3. OLS regression models predicting importance o positive self-presentation

	Model 1	Model 2
Race		
Black race	1.33	0.95
	(0.22) **	(0.23) **
Socioeconomic status		
Education		-0.40
		(0.14) **
Income		-0.24
		(0.09) **
Controls		
Male	-0.66	-0.53
	(0.24) **	(0.23) *
Age	0.69	0.62
	(0.12) **	(0.11) **
Have insurance	-0.21	0.20
	(0.37)	(0.38)
Constant	22.87	24.50
	(0.46) **	(0.60) **
Observations	1163	1163
R-squared	0.1	0.14

Standard errors in parentheses
* p < .05, ** p< .01