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Racial Identity Safety Cues and Healthcare Provider Expectations

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Although numerous reviews suggest the detrimental influence of healthcare identity threat (i.e., expectations and the experience of identity-based devaluation) on stigmatized group members' experiences in healthcare settings, no experimental research has examined identity safety cues (i.e., identity-relevant cues that signal protection from identity-based devaluation) in healthcare settings. The present 2 studies manipulated the presence or absence of 2 commonly studied identity safety cues on a healthcare provider's brochure (i.e., racial minority representation and diversity statements) and assessed Black and Latinx participants' perceptions of the provider (i.e., the provider's racial bias and cultural competency) and expectations of a visit at that provider's office. Across the 2 studies, Black and Latinx participants (N_{total} = 407) reported greater perceptions of the provider's cultural competence and significantly lower perceptions of the provider's racial bias when the provider signaled having racially diverse clientele compared to all White clientele. Further, participants anticipated having greater comfort and treatment quality when providers had racially diverse clientele. Providers' diversity statements did not have a significant influence on perceptions of providers or anticipated visit quality. Future research should explore how identity safety cues in healthcare settings can influence intentions to visit healthcare providers and consequent health outcomes of Black and Latinx Americans.

Keywords: identity safety, minority representation, minority health, stigma, healthcare identity threat

AQ: 1 *Supplemental materials:* http://dx.doi.org/10.1037/sah0000265.supp

A growing literature documents that Black and Latinx Americans experience identity threat or heightened expectations of being stereotyped and discriminated against in healthcare settings (Grady & Edgar, 2003; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000). Identity threats in healthcare settings, referred to hereafter as *healthcare identity threats*, can impair the physical and psychological health of people of color by reducing the quality of their communication with healthcare providers (Aronson, Burgess, Phelan, & Juarez, 2013; Burgess, Warren, Phelan, Dovidio, & van Ryn, 2010; Phelan, Atunah-Jay, & van Ryn, 2019; Trivedi & Ayanian, 2006) and by reducing healthcare utilization (Van Houtven et al., 2005). Moreover, patients' evaluations of biased treatment lower adherence to providers' health suggestions (Casagrande, Gary, LaVeist, Gaskin, & Cooper, 2007; Dale, Bogart, Wagner, Galvan, & Klein, 2016) and have been associated with further physician distrust and greater negative health outcomes, such as depression and hypertension (Abdou, Fingerhut, Jackson, & Wheaton, 2016; Piette, Bibbins-Domingo, & Schillinger, 2006). Together, healthcare identity threats can have long-lasting and influential effects on the health of stigmatized (i.e., socially devalued, stereotyped, and discriminated against) populations, wherein healthcare identity threats simultaneously predict poor health, poor-quality healthcare visits, and healthcare avoidance.

People of color may be most likely to experience healthcare identity threats when their healthcare provider is White because White providers implicitly and explicitly hold biases against racial minority patients (Chapman, Kaatz, & Carnes, 2013; Hall et al., 2015). In addition, Black and Latinx patients are likely to see White healthcare providers, given that the majority of healthcare providers are White (Public Use Microdata Sample, 2017), despite preferences for racially concordant providers (Chen, Fryer, Phillips, Wilson, & Pathman, 2005; Cooper et al., 2003; Johnson Shen et al., 2018). For example, in 2005 over 75% of Black Americans' and 65% of Latinx Americans' healthcare visits were with racially discordant medical providers (for comparison, only 24% of White Americans had non-White providers; Chen et al., 2005). Additional evidence suggests that high levels of racially discordant healthcare visits persist (Johnson Shen et al., 2018), despite over a decade of movement in recruiting healthcare providers of color. Importantly, these racially discordant provider interactions are shorter and are rated poorly by racial minority patients (see Cooper et al., 2003; Johnson Shen et al., 2018), which oftentimes results in lower levels of seeking healthcare in the future. In the present research, we examined how identity safety cues (i.e., cues that signal that a stigmatized identity is valued) shaped Black and Latinx participants' expectations of an office visit with a White healthcare provider, with the ultimate goal of understanding how

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Please see the Open Science Framework page for all data files, survey materials, and measures (https://osf.io/8ju5z/?view_only=4a123a690b414b46974e4a0fb9542e12).

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the addition of identity safety cues in healthcare settings may contribute to lower experiences of healthcare identity threat and improved provider trust among Black and Latinx Americans.

Healthcare Identity Threat

Experiences of identity threat are especially common among stigmatized individuals in contexts with known histories of stereotyping and discrimination (Steele, 1997; Steele, Spencer, & Aronson, 2002). Indeed, past experiences of healthcare identity threat and knowledge of historical discrimination influence racial minorities' attitudes toward healthcare providers and visits (Brandon, Isaac, & LaVeist, 2005; Thompson, Valdimarsdottir, Winkel, Jandorf, & Redd, 2004). Importantly, expectations of bias in this context are justified because bias in White providers' treatment of patients of color persists and hinders minority health (van Ryn et al., 2011; van Ryn, Burgess, Malat, & Griffin, 2006). For example, providers' racial bias influences treatment decisions (Chapman et al., 2013; van Ryn et al., 2006) and reduces providers' quality of communication with patients of color (Hagiwara, Slatcher, Eggly, & Penner, 2017; Hall et al., 2015). AQ: 2

A long-standing literature documents identity threats experienced by stigmatized groups in academic and corporate contexts. Identity threats in such contexts elicited greater negative thoughts and anxiety, lower feelings of belonging, lower working memory, and elevated desires to avoid the context (Cohen & Swim, 1995; Inzlicht & Good, 2006; Pietri, Drawbaugh, Lewis, & Johnson, 2019; Schmader, Johns, & Forbes, 2008; Spencer, Steele, & Quinn, 1999). As such, theoretical reviews have discussed the many harms that identity threats may cause within healthcare settings (Aronson et al., 2013; Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008; Dovidio et al., 2008). For instance, healthcare identity threats are suggested to reduce patients' ability to recall providers' treatment decisions (see Burgess et al., 2010), thereby reducing patients' ability to adhere to providers' health suggestions. In addition, healthcare identity threats may reduce patients' accuracy in symptom reporting (Aronson et al., 2013; Cipollina & Sanchez, 2019), consequently reducing providers' ability to provide potentially life-saving treatment decisions.

Although research in the area of healthcare identity threat is growing (e.g., Abdou et al., 2016), only a few studies detail mechanisms through which healthcare identity threats can reduce patients' quality of communication with their providers (Hausmann et al., 2011; Perloff, Bonder, Ray, Ray, & Siminoff, 2006). AQ: 3 For example, during an office visit with a White provider, Black patients who anticipated high provider bias (i.e., high healthcare identity threat) displayed greater negative affect during the visit and were less engaged in the conversation (e.g., asked fewer questions) compared with Black patients who expected less bias (Hausmann et al., 2011). Further, the patients who thought healthcare providers were biased reported that they had more difficulty communicating with the provider and that their healthcare visit was less informative than those with low perceptions of provider bias (Hausmann et al., 2011), suggesting that healthcare identity threat expectations alone can impede the quality of healthcare for stigmatized groups.

As such, expectations of encountering bias in healthcare settings (see Brandon et al., 2005; López-Cevallos, Harvey, & Warren, 2014) may facilitate low levels of comfort and trust during visits with providers (Burgess et al., 2008; Byrne, 2008; Dovidio et al., 2008; Dovidio, Penner, Calabrese, & Pearl, 2017), facilitating a vicious cycle of poorer care (see Penner, Phelan, Earnshaw, Albrecht, & Dovidio, 2018). Indeed, although much research suggests the importance of healthcare bias expectations on healthcare utilization and health outcomes (e.g., Cipollina & Sanchez, 2019; Lee, Ayers, & Kronenfeld, 2009), less research explores the factors that contribute to patients' anticipated healthcare identity threat with a novel provider.

Identity Safety Cues

Individuals with stigmatized identities use identity-relevant situational cues present within potentially threatening contexts to gauge the probability of being devalued in that context (Crocker, Major, & Steele, 1998; Wout, Shih, Jackson, & Sellers, 2009). Indeed, certain identity-related cues facilitate a feeling of identity safety or felt protection from being stigmatized within a setting (Davies, Spencer, & Steele, 2005). Much of the past literature on identity safety has focused on the influence of minority representation on stigmatized group members' outcomes in potentially threatening intergroup contexts. Indeed, this research suggests that if a context lacks representation, minority group members' expectations of poor treatment increases and the desire to engage in the setting decreases (Cohen & Swim, 1995; Murphy, Steele, & Gross, 2007; Pietri, Johnson, & Ozgumus, 2018; Purdie-Vaughns, Steele, Davies, Ditlmann, & Crosby, 2008; Sekaquaptewa & Thompson, 2003). For instance, gender representation cues facilitated women's interest in participating in predominantly male academic fields (e.g., Murphy et al., 2007) and racial minority representation facilitated expectations of fairness in a corporate context among Black Americans (Avery, McKay, & Roberson, 2012; Purdie-Vaughns et al., 2008). Although representation cues can improve expectations of a potentially biased context, cues of a potentially biased individual's affiliations with stigmatized group members have been found to reduce expectations of that individual's bias. For example, Black students expected a better interaction with a White student when they learned that the White student had a racially diverse friend network when compared to an all-White friend network (Wout, Murphy, & Steele, 2010). Although this research suggests that outgroup affiliations may serve as indicators of the potential perpetrators' attitudes toward outgroups, the present studies will be the first to explore how representation/affiliation cues influence perceptions of healthcare providers. Importantly, cues of who a provider serves may be indicative of the provider's racial bias; evidence from a medical student sample suggests that more racially biased students were less likely to want to work with patients of color in their future practices (Phelan, Burke, et al., 2019).

Across academic and corporate domains, varied types of diversity statements (e.g., diversity-valuing/multicultural statements; Emerson & Murphy, 2014; Plaut, Thomas, & Goren, 2009; Stevens, Plaut, & Sanchez-Burks, 2008; Wilton, Good, Moss-Racusin, & Sanchez, 2015) have been examined as tools to mitigate identity threats. AQ: 4 For example, diversity-valuing philosophy statements on a company brochure improved Black Americans' expectations of a company by reducing expectations of identity threats and improving trust in the company's executive board members (Purdie-Vaughns et al., 2008). However, recent research

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demonstrates that minority group members place low levels of importance on diversity statements, suggesting that diversity statements alone do not translate to better treatment expectations or feelings of identity safety (Apfelbaum, Stephens, & Reagans, 2016; Downey, van der Werff, Thomas, & Plaut, 2015; Wilton, Bell, Vahradyan, & Kaiser, 2020). Instead, diversity-valuing statements may only be effective when viewed in conjunction with other safety cues, such as high levels of minority representation.

Present Research

The current research sought to examine the influence of two widely studied identity safety cues (i.e., minority representation and diversity statements) on anticipated identity safety among Black and Latinx Americans in healthcare settings by manipulating the presence and absence of identity safety cues on a White medical provider's brochure. In Study 1, we recruited Black/African American participants and examined the potential interaction of two identity cues, minority representation and diversity statement, on participant's expectations of a healthcare visit (including treatment quality, comfort, and trust with the provider) because past research demonstrates that diversity statements alone do not facilitate identity safety for some stigmatized groups. In Study 2, we replicated the findings of Study 1 with a younger sample of people of color from an undergraduate research pool, who may have had less experience in healthcare settings when compared to the Mechanical Turk (MTurk) sample recruited for Study 1. Further, Study 2 also expanded racial inclusion criteria to Latinx participants because Latinx individuals also experience considerable healthcare identity threats and discrimination in healthcare settings (Benjamins & Middleton, 2019; Morales, Cunningham, Brown, Liu, & Hays, 1999; Trivedi & Ayanian, 2006). In addition, across both studies, we examined how perceptions of the provider's racial bias and cultural competency may be shaped by minority representation cues to examine two mechanisms through which identity safety cues may translate to better visit expectations. Providers' cultural competence (i.e., their understanding of the structural and cultural factors that influence the health outcomes of diverse groups and desire to promote minority health; Butler et al., 2016) has been related to their patients' health outcomes (Betancourt, Green, Carrillo, & Park, 2005) and may increase minority group members' intentions to seek healthcare from them (see Nápoles-Springer, Santoyo, Houston, Pérez-Stable, & Stewart, 2005).

Thus, the present research tested four hypotheses. First, we anticipated that participants who viewed a provider with racially diverse clientele would anticipate better visit quality when compared with participants who viewed a provider with all-White clientele. Second, we anticipated that participants in the representation condition would perceive the provider to be lower in racial bias and greater in cultural competence compared to providers with all-White clientele. Third, we anticipated that there would be an interaction between diversity statement and representation condition, such that those who saw a provider with a diversity statement would only rate that provider and visit favorably when the provider's clientele was racially diverse. We did not have a specific hypothesis about differences within the high-representation condition by statement condition, although we might expect that the diversity message could have an added benefit if perceived as genuine by the participants. Lastly, parallel-mediation models were used to examine whether perceptions of provider's bias and cultural competency mediated the relationship between safety-cue conditions and anticipated visit outcomes, such that better perceptions of the provider would be facilitated by the presence of representation, which would in turn be associated with greater anticipated visit outcomes.

Study 1

Method

Participants were recruited to participate in a "Choosing a Doctor Study" if they identified as Black/African American, currently resided within the United States, and were between the ages of 18 and 64 years old on TurkPrime's survey platform. Data collection was stopped at 238 participants to achieve a final sample size greater than 200 participants (suggested 199 participants for $d = 0.40$ at 80% power, using G*power a priori power analysis; Faul, Erdfelder, Buchner, & Lang, 2009). According to the agreement with TurkPrime, participants had to pass at least two attention checks to be a part of the analytic sample. Participants were compensated $2.75 for their 15 min of participation and were unaware of inclusion criteria.[1] All participants were treated according to the Institutional Review Board (IRB) protocol, which was granted by a university IRB in the Northeast region of the United States. Fn1

Participants were mostly female ($n = 148$, 62.2% female, $n = 2$, 0.8% other, i.e., nonconforming, genderqueer) and had a mean age of 41.47 (standard deviation [*SD*] = 13.59). Participants self-identified as Black/African American (96.6%, $n = 230$), and 3.4% were biracial or multiracial ($n = 8$). Most of the participants were heterosexual ($n = 214$, 89.9%) and 74.8% ($n = 178$) of the participants reported having been to a primary care office within the past year. The majority of participants had health insurance at the time of participation (74.8%) and eight participants reported never having been to a healthcare provider's office. The present analyses included all participants because covarying for insurance and never-visit status suggested the same pattern of results.

Procedure and Materials

Following procedures used in past research on identity safety cues (see Purdie-Vaughns et al., 2008), participants were randomly assigned to one of four brochures using a randomized control design. The brochures, detailed in the following section, depicted the same provider but varied the provider's diversity statement and racial diversity in office clientele using a 2 (Minority Representation: Present or Absent) × 2 (Diversity Statement: Present or Absent) design. After viewing the brochure, participants completed a set of questions about the brochure (including manipulation checks) and indicated their perceptions of the provider's cultural competence, their reaction to the depicted office (i.e., provider trust, anticipated treatment quality, anticipated comfort), and their perceptions of the provider's racial bias, among other

[1] Participants who failed a single attention check (Study 1 = 20, Study 2 = 26) in the following studies were retained in the presented analyses because removing them did not alter the results.

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filler items (e.g., whether this provider would treat women fairly), in this order.

Brochures. All brochure materials were pretested to ensure that the representation condition was perceived as more diverse than the no-representation condition. The materials were also pretested to ensure no significant differences in attractiveness, intelligence, and friendliness between conditions (see the online supplemental materials). The final brochure contained an image of eight people who were all White (i.e., no-representation condition) or an image with four Black and four White clients (i.e., representation condition). Half of the brochures had generic statements that might appear in a provider's statement, whereas the other half had inserted mention of valuing diversity and minority groups (see the Appendix). All brochure materials and survey measures are included on the Open Science Framework site. Participants were instructed to read over the brochure and indicate their impressions of the brochure with filler items about font and text readability. As manipulation checks, participants had to correctly identify part of the provider's statement and a grouping of four people from the brochure. If participants failed these checks, they repeated the manipulation-check questions among filler items. All participants correctly identified the message text and image before moving forward in the survey.

Anticipated visit quality. Using a Likert scale from 1 (*Strongly disagree*) to 7 (*Strongly agree*), participants reported their agreement with statements related to their anticipated treatment quality and comfort in the depicted healthcare setting. Participants first reported on their trust in the provider and staff at the provider's office with five items (adapted from Thompson et al., 2004). These items included statements such as, "I trust that this doctor's office would have my best interests in mind" and "I trust that this doctor's office would take my opinion/input seriously," followed by eight items on the anticipated quality of treatment that they would receive from that provider (e.g., "I think this doctor would listen to me carefully" and, "explain things clearly to me"; items created from Stewart, 1995). Lastly, participants rated five items assessing their perceptions of comfort interacting with the provider and their anticipated sense of belonging at the office (adapted from Purdie-Vaughns et al., 2008; e.g., "I would feel comfortable going to this medical office"). These three measures (i.e., trust, anticipated treatment, and comfort) were intended to be explored as different outcome measures, but exploratory factor analyses revealed that all items loaded onto one factor, explaining 74.88% of the variance. In addition, the subscales were highly correlated ($rs > .81$, $ps < .001$), and the composite scale of 18 items (mean [M] = 5.70, SD = 1.07) had excellent reliability (a = .98).

Perceived cultural competence. Participants' perceptions of the provider's cultural competence were rated with eight items (adapted from Doorenbos, Schim, Benkert, & Borse, 2005) on a Likert scale from 1 (*Strongly disagree*) to 7 (*Strongly agree*). The items (e.g., "This doctor would be aware of health issues of minority groups" and "This doctor would have staff training regarding delivery of culturally appropriate services") loaded onto one factor explaining 73.29% of the variance and had high reliability, a = .95 (M = 5.23, SD = 1.25).

Perceived provider racial bias. On a Likert scale from 1 (*Not at all likely*) to 7 (*Very likely*; M = 2.95, SD = 1.35), participants indicated their perceptions of the provider's racial bias with four items created by the principal investigators (e.g., "How likely is it that this provider holds racist beliefs?" and "How likely is it that this provider feels negatively toward African Americans?"). The four items loaded onto one factor explaining 74.02% of the variance. The items had high reliability (a = .88) and were averaged, such that higher values indicate greater racial bias.

Results

A series of 2 × 2 analyses of variance (ANOVAs) was conducted to examine the influence of minority representation and diversity statement on participants' perceptions of the healthcare provider and anticipated visit quality (see Figure 1 for means and standard errors). There was a main effect of representation on anticipated visit quality, $F(1, 234) = 12.87$, $p < .001$, $d = 0.47$, such that those who saw the balanced-representation brochure reported significantly higher anticipated visit quality than those who did not see minority representation. No significant effects were found for diversity statement on anticipated visit quality, $F(1, 234) = 0.88$, $p = .35$, $d = 0.13$, or the interaction between

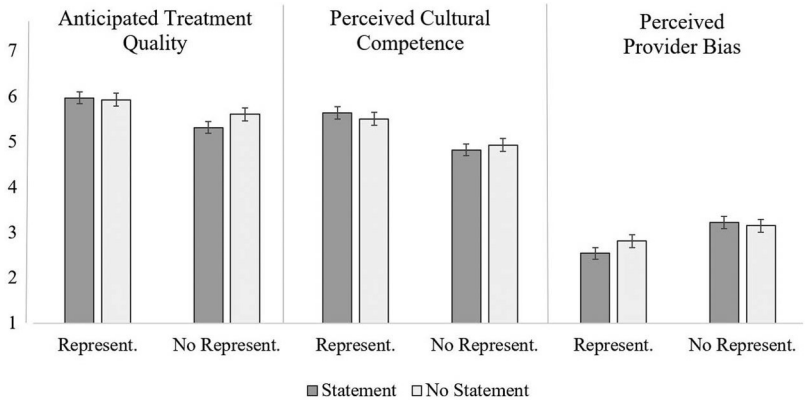

Figure 1. Results from the series of 2 (Minority Representation: Present or Absent) × 2 (Diversity Statement: Present or Absent) analyses of variance (ANOVAs), indicating a significant effect of representation across all outcome variables.

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diversity statement and representation, $F(1, 234) = 1.41$, $p = .24$, $d = 0.16$.

There was a main effect of representation on cultural competence, $F(1, 234) = 19.94$, $p < .001$, $d = 0.59$, such that those who saw the balanced-representation brochure rated the provider as significantly more culturally competent than those who did not see representation. There was not a significant effect of statement, $F(1, 234) = 0.002$, $p = .97$, $d = 0.00$, or an interaction of conditions, $F(1, 234) = 0.56$, $p = .46$, $d = 0.09$. There was a main effect of representation on perceptions of racial bias, $F(1, 234) = 8.63$, $p = .004$, $d = 0.39$, such that those who saw the brochure with representation reported significantly lower perceptions of provider bias compared with those who did not see representation. There was not a significant effect of diversity statement, $F(1, 234) = 0.34$, $p = .56$, $d = 0.06$, or an interaction with representation on perceptions of bias, $F(1, 234) = 0.98$, $p = .32$, $d = 0.13$. Analyses were also conducted using the three subscales of the composite and revealed the same pattern of results (see the online supplemental materials).

Next, a parallel-mediation analysis was conducted to examine the indirect effects of representation condition on anticipated visit quality via both perceptions of provider bias and cultural competency. All presented mediation analyses controlled for diversity statement condition to account for the 2 × 2 study design, although removing this covariate did not alter the pattern of results. Using Hayes's (2012) best practices and the PROCESS macro for Statistical Package for the Social Sciences (SPSS), the parallel-mediation analysis revealed a significant indirect effect of representation via both perceived racial bias ($B = 0.04$, $SE = 0.02$, 95% confidence interval [CI: 0.01, 0.09]) and cultural competency ($B = 0.20$, $SE = 0.06$, 95% CI [0.10, 0.31]). The significant indirect effects indicate that minority representation was associated with both lower perceptions of the provider's bias and greater perceptions of the provider's cultural competence, which, in turn, were associated with anticipating a better visit quality (see Figure 2). The total effect of condition on anticipated visit quality was significant ($B = 0.24$, $SE = 0.07$, 95% CI [0.11, 0.38]), whereas the direct effect of representation condition on anticipated visit quality when removing the influence of the mediators was no longer significant ($B = 0.007$, $SE = 0.05$, 95% CI [−0.08, 0.10]).

Discussion

Study 1 found the first evidence that Black participants' expectations of a healthcare visit with a White provider were influenced by minority representation cues. Specifically, Black participants who viewed a provider's brochure with a balanced representation of Black and White clientele perceived the provider as lower in racial bias and higher in cultural competence and reported greater anticipated visit quality when compared with participants who viewed a provider's brochure with no racial minority representation. Contrary to our expectations, the presence of a diversity statement did not influence perceptions of the provider or visit quality, even when combined with minority representation cues. Mediation analyses revealed that representation on a provider's brochure improved Black participants' anticipated visit via reducing perceptions of the provider's racial bias and increasing perceptions of the provider's cultural competency.

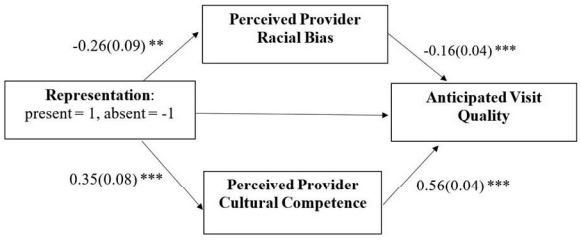

Figure 2. Parallel-mediation model displaying the indirect effect of representation on anticipated visit quality through perceptions of cultural competence and provider race bias with a sample of Black/African American participants (Study 1). ** represent $p < .01$; *** represent $p < .001$.

Study 2

Study 2 sought to examine the influence of minority representation on Black and Latinx participants' expectations of a White male healthcare provider. By recruiting both Black and Latinx undergraduate participants, we sought to generalize the findings of Study 1 to a Latinx and younger population. Because no effect of diversity statement was found in Study 1, we dropped the diversity message condition in Study 2. In addition, we purposefully included a balanced representation of Black clientele on the brochure to examine how representation cues directed at one group (in this case, Black Americans) would also facilitate identity safety for other stigmatized group members (in this study, Latinx Americans). According to past research on the transfer of identity cues (Chaney & Sanchez, 2018; Chaney, Sanchez, & Remedios, 2016; Sanchez, Chaney, Manuel, Wilton, & Remedios, 2017), identity cues directed at one stigmatized group can signal to other similarly stigmatized groups how they will be treated. Specifically, learning that an organization treats other disadvantaged racial minority group members well was sufficient to make White women feel as though they, too, would be valued at that organization. Thus, we predicted that Latinx participants who viewed a healthcare provider with Black clientele would have better perceptions of the healthcare provider and greater anticipated visit quality when compared with Latinx participants who viewed a provider with all-White clientele. We did not anticipate a participant race effect (i.e., that Black participants would report greater responsiveness to representation cues than Latinx participants) because past research suggests that identity safety cues directed at one group influence stigmatized ingroup and outgroup members similarly (e.g., Chaney & Sanchez, 2018).

Method

Following the procedures of Study 1, participants were recruited to participate in the "Choosing a Doctor Study" if they identified as Black/African American or as Latinx/Hispanic in the introductory psychology subject pool prescreen survey. The minimum sample size was determined using a priori power analysis for a 2-cell between-subjects design, suggesting 156 participants for $d = 0.40$ at 80% power (Faul et al., 2009). Participants ($N = 172$) were compensated with partial course credit, were treated according to IRB protocols, and were unaware of inclusion criteria. Participants who failed two or more attention checks ($n = 3$) were removed from the present analyses because of questions about the validity of their responses.

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The final analytic sample was 169 participants, with $n = 88$ (52.1%) exposed to the no-representation brochure and $n = 81$ (47.9%) exposed to the balanced-representation brochure. Participants were mostly female ($n = 116$, 67.4% female) and had a mean age of 19.00 ($SD = 1.84$). The majority of participants identified as Latinx/Hispanic, 60.4% ($n = 102$), with 32.6% identifying as Black/African/Caribbean American ($n = 55$) and 7.1% as biracial or multiracial (i.e., Black and/or Latinx; $n = 12$). Most of the participants were heterosexual ($n = 158$, 93.5%), and all participants reported having been to a healthcare provider's office in their lifetime.

Procedure and Materials

Participants were randomly assigned to one of two brochures that varied in the presence of racial minority representation and completed the same (or adapted to sample) measures from Study 1. Using the same brochure representation manipulation as Study 1, participants in the representation condition saw that the provider either had all-White clientele displayed on the brochure or a clientele that had balanced Black-to-White representation. Unique to Study 2, no diversity statements or other mentions of diversity were present. Participants had to complete the same representation manipulation check from Study 1 (i.e., identifying a grouping of people on the brochure) among fillers. Before debriefing, participants were able to comment on the brochure, and some mentioned the lack of diversity (including the lack of Asian or Latinx representation). No participants indicated suspicion of the study materials, and no comments indicated awareness of an experimental design.

Anticipated visit quality ($M = 5.57$, $SD = 0.99$, $a = .96$) and perceived cultural competence ($M = 4.81$, $SD = 1.30$, $a = .94$) were measured with the same items from Study 1. Because the participant sample in Study 2 included Black and Latinx Americans, we included two additional provider bias questions that pertained to Latinx populations, which resulted in a six-item scale (e.g., "How likely is it that this provider holds racist beliefs" and "How likely to unfairly judge Latino Americans is this provider?"; $M = 3.18$, $SD = 1.35$). The six items loaded onto one factor (explaining 88.26% of the variance) and had high reliability ($a = .97$).

Results

Before conducting planned analyses, a series of 2 (Minority Representation Condition) × 2 (Participant Race) ANOVAs was conducted to probe for unexpected participant race differences or interactions. As expected, there were no significant differences between Black and Latinx participants on all dependent variables (Fs = 0.01–0.68, ps = .92–.47) and no significant Race × Condition interactions (Fs = 0.24–1.75, ps = .62–.19). A series of independent-samples t tests was conducted. The results revealed a significant effect of minority representation on anticipated visit quality, $t(152.78) = 3.64$, $p < .001$, $d = 0.56$, such that those in the representation condition reported greater anticipated visit quality ($M = 5.84$, $SD = 0.75$) than those in the no-representation condition ($M = 5.31$, $SD = 1.12$). Participants in the representation condition reported significantly lower perceived provider racial bias ($M = 2.73$, $SD = 1.14$) when compared to those in the no-representation control ($M = 3.59$, $SD = 1.40$), $t(167) = 4.39$, $p < .001$, $d = 0.68$. Lastly, participants in the representation condition perceived the provider to be significantly more culturally competent ($M = 5.17$, $SD = 0.99$) than those in the control condition ($M = 4.28$, $SD = 1.41$), $t(156.53) = 4.79$, $p < .001$, $d = 0.73$.

The planned parallel-mediation analysis revealed a significant indirect effect of minority representation via both perceived racial bias ($B = 0.09$, $SE = 0.04$, 95% CI [0.04, 0.17]) and cultural competency ($B = 0.20$, $SE = 0.05$, 95% CI [0.10, 0.31]), such that representation resulted in lower perceptions of provider bias and greater perceptions of cultural competency, which, in turn, were associated with greater anticipated visit quality (see Figure 3). The total effect was significant ($B = 0.27$, $SE = 0.07$, 95% CI [0.12, 0.41]), whereas the direct effect ($B = -0.03$, $SE = 0.05$, 95% CI [−0.13, 0.08]) was no longer significant. F3

Discussion

Study 2 provides additional evidence that Black participants of a younger age used ingroup racial representation of the office's clientele as an identity safety cue. In addition, racial outgroup members, in this study, Latinx participants, also received identity safety from Black clientele representation. Specifically, a healthcare provider with a brochure that included Black clientele was rated by both Black and Latinx participants as less likely to be racially biased and more likely to be culturally competent compared with a provider who had all White clientele. Replicating the findings of Study 1, we found additional evidence that minority representation in a provider's clientele improved anticipated visit quality via both greater perceived provider cultural competence and lower perceived provider racial bias.

General Discussion

Across two studies, we found evidence that the identity safety cue of minority representation in healthcare settings improved Black and Latinx participants' anticipation of healthcare identity threat at a novel White healthcare provider's office. Specifically, participants anticipated better-quality healthcare visits (including better treatment, anticipated comfort, and trust in the provider) with providers who displayed racially diverse clientele compared with providers with all-White clientele. Moreover, representation cues signaled greater identity safety and treatment by reducing

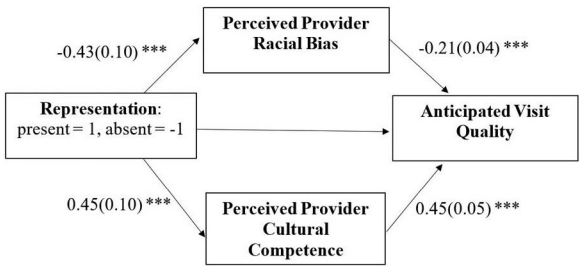

Figure 3. Parallel-mediation model displaying the indirect effect of representation on Black and Latinx participants' anticipated visit quality via perceptions of cultural competence and provider race bias (Study 2). *** represent $p < .001$.

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perceptions of the provider's racial bias and by increasing perceptions of the provider's cultural competency (including the provider's knowledge of barriers to care and willingness to accommodate diverse groups). Thus, the present research displays the first experimental evidence demonstrating that an identity safety cue (specifically, minority representation) increased Black and Latinx Americans' expectations of healthcare visits and White healthcare providers.

In addition, the present research suggests that participants did not place much weight on a diversity statement put forth by the provider; we found no significant influence of diversity statement on expectations of visit quality or perceptions of the healthcare provider. This is consistent with research suggesting that diversity messages require evidence (e.g., effective past actions or policies) in order to create identity safety for stigmatized groups (Wilton et al., 2020). The diversity statement in the present research included a reference to the provider having a diverse clientele, which may be a particularly ineffective type of diversity message when paired right next to an image of a all White clientele compared with a cue referencing the provider's training or certificates to serve marginalized groups. As such, providers' diversity statements that discuss actual protocols or policies put in place by their offices to better serve diverse clientele (e.g., a standing policy to have an English translator on staff or past aid given to underserved racial communities; see Phelan, et al., 2019) may be better suited to improving racial minorities' expectations of visits with White healthcare providers (see Cipollina and Sanchez [2019] for review of varied identity safety cues in the healthcare context).

The present research also expands on past research on the importance of cultural competence within healthcare settings (e.g., Betancourt et al., 2005) by indicating that certain identity safety cues (i.e., minority representation) influenced perceptions of a provider's cultural competency, which, in turn, improved visit expectations among Black and Latinx participants. In addition, this research documented the relatively strong effect (*ds* = 0.47–0.56) of representation cues on anticipated healthcare visit quality among both older (Study 1, M_{age} = 41.47) and younger (Study 1, M_{age} = 19.00) Black and Latinx participants with varying degrees of experience in healthcare settings. The present research adds insight into how healthcare providers' materials (e.g., their brochures or websites) with visual representations of the diversity of their clientele signal protection from healthcare identity threat to future patients. Importantly, with Study 2, we add to the literature on the transfer of identity safety cues (e.g., Chaney et al., 2016) by documenting that Latinx participants received identity safety from minority representation cues directed at racial outgroup members because the racial minority representation on the present brochures only consisted of Black clientele.

Although not directly tested in the present research, we anticipate that future research may find that identity safety cues can improve healthcare utilization because research suggests that anticipated treatment quality and expectations of encountering bias in medical visits influence healthcare-utilization intentions (Jones et al., 2013; Stewart, 1995). In addition, it is unclear whether expectations created by identity cues presented *before* healthcare visits will translate to better visit quality, although research on patients' expectations of racial bias would suggest that perceptions of bias can influence healthcare visit quality (e.g., Hausmann et al., 2011). Future research should examine how safety cues within medical offices may also increase comfort in talking about health behaviors and symptoms or the likelihood of asking questions of providers (see Burgess et al., 2010) because identity threats may reduce comfort in discussing symptoms, which can be related to stereotypes (e.g., being unhealthy or uneducated; Aronson et al., 2013).

Importantly, research on safety cues which examines the role of mistrust in the medical community (e.g., Thompson et al., 2004) or past experience of discrimination in healthcare contexts (e.g., Benjamins & Middleton, 2019) may help to improve healthcare utilization and quality among people of color who are at great risk of healthcare avoidance and, potentially, most vulnerable to the pernicious outcomes associated with healthcare identity threat. Nevertheless, this research should also be extended to other stigmatized populations (e.g., overweight people, sexual minorities) to document the potential nuances in cue effectiveness across stigmatized groups. Future research should also explore the influence of diversity-related cues on White patients' expectations of healthcare settings. According to past research, White women, or sexual minority men, may anticipate better treatment on the basis of their gender or sexual orientation from a provider who is perceived as low in racial bias because this provider would be perceived as also having lower sexism and sexual prejudice (see Chaney, Sanchez, Himmelstein, & Manuel, 2020; Chaney et al., 2016; Sanchez, Chaney, Manuel, & Remedios, 2018; Sanchez et al., 2017). Yet, it is unclear how White heterosexual men would react to racial identity safety cues in the healthcare context. The work to date suggests that they may also come to see their medical provider as more culturally sensitive and less racially biased (Chaney et al., 2016) but that this would have little effect on other healthcare outcomes unless an intergroup threat was present (see Dover, Major, & Kaiser, 2016).

Although the present research examined the potential interaction of minority representation and diversity statement on a provider's brochure, the present research did not manipulate the presence of threat cues (e.g., providers with bad reviews from minority clients), which are likely inherent in ecologically valid settings. Past research on conflicting cues indicates that safety cues' influence is diminished when another threatening cue is present (Purdie-Vaughns et al., 2008; Wout, Murphy, & Barnett, 2014; Wout et al., 2009). As such, future research should consider both safety and threat cues (e.g., actual provider bias) present within healthcare settings. In addition, other individual psychological differences, such as stigma consciousness (i.e., a trait-level anticipation of being evaluated because of one's stigmatized identity; Pinel, 1999) or identity centrality (Sellers, Rowley, Chavous, Shelton, & Smith, 1997), may influence attention to and receipt of identity safety cues in healthcare settings (see Pietri et al., 2018)[2]. Importantly, Fn2
research on individual differences may help explain the influence of diversity messages that vary in concreteness (e.g., diversity-valuing statement vs. a policy) on anticipated visit outcomes or healthcare utilization.

Lastly, some research suggests that safety cues (e.g., inclusive policies) can improve attitudes toward diversity (Stevens et al., 2008). As such, the display of identity safety cues may aid in

[2] The online supplemental materials describe other potential moderating variables that were included within the online surveys. These analyses were not sufficiently powered and are not presented within the article.

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identifying healthcare contexts where racial bias is low, but the presence of safety cues does not always indicate a safer context. Indeed, some identity safety cues may be viewed as dishonest (Wilton et al., 2020) or can create a false perception of inclusivity (Kirby, Kaiser, & Major, 2015), and providers should not advertise safety cues without taking steps to become a more inclusive practice. Ultimately, the quality of treatment that stigmatized patients receive in healthcare visits will be the greatest indicator of experienced identity safety and predictor of visit outcomes.

Conclusion

There are critical differences in the utilization of healthcare between Black and Latinx Americans and their White counterparts (Burgess et al., 2008; Jones et al., 2013; Lee et al., 2009), which are influenced by perceptions of providers' racial bias and expectations of healthcare identity threats (e.g., Abdou et al., 2016; Lee et al., 2009). The present research documented that minority representation cues (i.e., racial minority representation in the clientele of an office) resulted in greater anticipated treatment quality, comfort, and trust with a White healthcare provider, among Black and Latinx participants, compared with White providers with all-White clientele. In addition, providers with diverse clientele were viewed as less racially biased and more culturally competent, which may translate to greater healthcare utilization. Future research into the impact of such identity safety cues in improving visit quality and healthcare utilization is needed to better understand how identity safety cues in healthcare settings can reduce experiences of healthcare identity threat and reduce disparities in the health of Black and Latinx Americans.

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(*Appendix follows*)

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Appendix

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Study 1 Manipulated Brochure Text

The diversity statement brochure text was as follows:

> Dr. Mayhew's office holds the belief that great patient–provider care results from discussions between the physician and patients who have different experiences, perspectives, and cultural backgrounds. We have spent years working on our abilities to be a medical office that meets the needs of our diverse community. To better serve our clients . . . we strive to . . . attract, promote, and maintain a relationship with diverse clientele . . . and encourage strong discussions with our patients from diverse backgrounds, cultures, and ethnicities.

The no-diversity-statement brochure text was as follows:

Dr. Mayhew's office holds the belief that great patient–provider care results from discussions between the physician and patients. We have spent years working on our abilities to be a medical office that meets the needs of our community. To better serve our clients . . . we strive to . . . attract, promote, and maintain a relationship with clientele . . . and encourage strong discussions with our patients.

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