Approaches to diversity in family medicine

"I have always tried to be colour blind"

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ABSTRACT

OBJECTIVE To explore family physicians' perceptions of and experiences with patient diversity, including differences in sex, race, ethnicity, social class, sexual orientation, and abilities or disabilities.

DESIGN Semistructured, in-depth, qualitative interviews.

SETTING Halifax metropolitan region, Nova Scotia.

PARTICIPANTS Twenty-two family physicians who ranged in age (25 to 65 years) and in years of practice (<5 to >20). Participants included both sexes, members of racialized minority groups, and those who self-identified as gay, lesbian, or bisexual.

METHODS Physicians were recruited through information letters distributed by mail and through professional networks. Interviews and field notes were recorded, transcribed verbatim, and coded using data analysis software. Weekly team discussions enhanced interpretation and analysis.

MAIN FINDINGS Family physicians employed 5 main approaches to diversity: maintaining that differences do not matter, accommodating sociocultural differences, seeking to better understand differences, seeking to avoid discrimination, and challenging inequities. Quotes from interviews illustrate these themes.

CONCLUSION Most approaches assume that both medicine (as a profession) and physicians are and should be socially and culturally neutral; some acknowledge that the sociocultural background of patients can raise tensions. Most participants in our study seek to treat patients as individuals in order to not stereotype, which hinders recognition of the ways in which sociocultural factors—both patients' and physicians'—influence health and health care. Critical reflexivity demands that physicians understand social relations of power and where they fit within those relations.

EDITOR'S KEY POINTS

- Physicians often struggle with how to best address diversity in their practices. In order to develop appropriate tools and supports, an understanding of how physicians perceive and experience diversity is required.
- Most physicians think family medicine is and should be culturally neutral, and either treat patients as individuals or strive to understand differences in order to avoid stereotyping or discrimination.
- By seeking to avoid bias, physicians might be denying the role of sociocultural influences on patients' health-affecting experiences (eg, racism leading to stress-related hypertension) as well as health care access, treatment, and health outcomes.
- The best approach might to be to acknowledge that both the patient's and the physician's individual sociocultural influences shape health and health care. Self-reflection might allow physicians to be fully aware of both personal biases and those that are rooted in the historical and contemporary social power relations between patient and provider, and employ them effectively in practice.

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Comment aborder la diversité en médecine familiale

«J'ai toujours essayé d'être daltonien»

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RÉSUMÉ

OBJECTIF Déterminer comment les médecins de famille perçoivent la diversité chez les patients, et leurs expériences face à celle-ci, incluant les différences entre les sexes, les races, les origines ethniques, les classes sociales, les orientations sexuelles, et les capacités ou incapacités.

TYPE D 'ÉTUDE Entrevues qualitatives en profondeur semi-structurées.

CONTEXTE Région métropolitaine d'Halifax, Nouvelle-Écosse.

PARTICIPANTS Vingt-deux médecins de famille âgés de 25 à 65 ans, avec une expérience de pratique allant de moins de 5 ans à plus de 20 ans. Le groupe comprenait des participants des 2 sexes, des membres de minorités raciales ainsi que des participants qui se décrivaient comme gais, lesbiennes ou hétérosexuels.

MÉTHODES Le recrutement des médecins s'est fait par lettres explicatives adressées par la poste ou via des réseaux professionnels. Les entrevues ont été enregistrées, transcrites mot à mot et codées à l'aide d'un logiciel d'analyse des données.

PRINCIAPLES OSERVATIONS Les médecins utilisaient 5 stratégies principales pour gérer la diversité: soutenir que la diversité n'a pas d'importance; tenir compte des différences socioculturelles; chercher à mieux comprendre les différences; tenter d'éviter la discrimination; et affronter les iniquités. Quelques citations tirées des entrevues illustrent ces thèmes.

CONCLUSION La plupart des stratégies considéraient que les médecins et la médecine (comme profession) sont et devraient être neutres sur les plans social et culturel; certaines reconnaissaient que le passé socioculturel des patients peut susciter des tensions. La plupart des participants s'efforçaient de traiter les patients comme des individus, de façon à éviter les stéréotypes, lesquels empêchent de voir comment les facteurs socioculturels du patient comme ceux du médecin influencent la santé et les soins de santé. Une réflexion critique exige que le médecin comprenne les rapports de force sociaux et sa propre place dans ces rapports.

POINTS DE REPÈRE DU RÉDACTEUR

- Les médecins se demandent souvent comment aborder la diversité dans leur pratique. Il importe de connaître la perception et l'expérience qu'ont les médecins de la diversité si on veut développer des outils et des aides appropriés pour y faire face.
- La plupart des médecins pensent que la médecine familiale est, et devrait être, neutre sur le plan culturel et qu'elle devrait traiter les patients comme des individus ou s'efforcer de comprendre les différences afin d'éviter les stéréotypes et la discrimination.
- En voulant éviter des biais, le médecin pourrait oublier l'influence des facteurs socioculturels sur certaines expériences qui affectent la santé du patient (p. ex. le racisme qui entraîne une hypertension causée par le stress) mais aussi l'accès aux services de santé, le traitement et les issues de santé.
- La meilleure approche est probablement de reconnaître que les influences socioculturelles propres au patient comme au médecin façonnent la santé et les soins de santé. En y réfléchissant, le médecin devrait pouvoir identifier ses biais personnels comme ceux qui sont ancrés dans les rapports de force historiques et contemporains entre patient et soignant, pour ensuite les utiliser efficacement dans sa pratique.

Cet article a fait l'objet d'une révision par des pairs.
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Health disparities are well documented in the United States and Canada. Patient race,[1,2] ethnicity,[3-8] sex,[9-11] socioeconomic status,[12,13] and sexual orientation[14-16] have all been shown to influence health outcomes and health care. Patient factors (eg, health care utilization), health system factors (eg, access to services), and health professional factors (eg, stereotyping and discrimination) all contribute to inequitable health outcomes.[1] Even when patient access and utilization are controlled, inequities arise from inherently subjective patient-provider interactions. Health care providers often act out of unconscious biases, such that preconceptions and unexamined values unknowingly influence their practices.[11,17-22]

The dominant response to health disparities within and among populations has been the establishment of cultural competence training, which generally examines cultural sensitivity (focusing on awareness and attitudes), multicultural understanding (focusing on knowledge about particular groups), or cross-cultural interactions (focusing on tools and skills).[1] Yet such approaches have been soundly criticized for encouraging stereotyping; for emphasizing individual attitudes rather than social context and power relations; for overemphasizing knowledge of "other" minority groups and underemphasizing critical self-reflection; and for entrenching the notion that only those from minority groups have "culture" or "diversity," while the dominant group is "normal" and therefore not in need of examination.[17,21] In contrast, social scientists argue that medicine itself has a culture; the objective practice of medicine is not socially and politically neutral, but rather the norms and values of the dominant society are embedded within it.[23,24] In fact, all knowledge claims, including those of science, "bear the fingerprints of the communities that produce them."[25]

These arguments fly in the face of established notions of objectivity and neutrality.[21] It is generally assumed that neutrality is desirable—and possible—in medicine[18,26]: "Doctors are taught that their own personal background, and the characteristics of the patient and the clinical setting, should be excluded from consideration in the formulation of clinical decisions."[2] The tension between this emphasis on neutrality and the pressure toward culturally competent practices leaves physicians struggling to know how best to address diversity. It is crucial to understand how physicians perceive diversity in their practices, as well as the implications of their perspectives, in order to develop appropriate educational tools and supports. In this qualitative study, using semistructured interviews, we sought to understand how Canadian family physicians approached diversity in their everyday practices.

METHODS

The study was exploratory, using qualitative methodology in an ethnographic tradition. Ethics approval was granted by Dalhousie University's Research Ethics Board. Participants were recruited through announcements in hospital newsletters and circulars and through letters sent to all family physicians in the Halifax, NS, metropolitan area. Interested physicians contacted the researchers. Twenty-two family physicians, of diverse ages and practice experience, participated (**Table 1**). Although most self-identified as white, others were of Greek, South Asian, African, and Asian descents. Similarly, while most self-identified as heterosexual, 4 self-identified as gay or lesbian. All had been in family practice for at least 3 years. Recruitment continued until new ideas were no longer generated (conceptual saturation) in the primary areas of interest. The focus on diversity represents a portion of a larger study of everyday practice dilemmas. A range of physicians participated, many of whom did not identify diversity as a particularly pressing issue. In other words, we deliberately recruited a sample of "average" family physicians.

One research assistant interviewed all participants at convenient times and in convenient locations. Interviews followed a semistructured interview guide and were 60 to 90 minutes in length. They were later transcribed verbatim. Transcripts were coded inductively using ATLAS.

Table 1. Characteristics of study participants: *N* = *22.*

CHARACTERISTIC	N (%)
Sex	
• Male	7 (32)
• Female	15 (68)
Ethnicity	
• White	17 (77)
• Racialized minority	5 (23)
Sexual orientation	
• Heterosexual	18 (82)
• Gay, lesbian, or bisexual	4 (18)
Length of time in practice, y	
• < 5	2 (9)
• 5-9	4 (18)
• 10-14	7 (32)
• 15-19	2 (9)
• ≥ 20	7 (32)
Age, y	
• 25-35	6 (27)
• 36-45	7 (32)
• 46-55	6 (27)
• 56-65	3 (14)

ti, qualitative data analysis software. Codes were developed and refined by the research assistant and the team during ongoing weekly discussions that explored individual transcripts, highlighted contradictions and patterns, and searched for commentary that challenged emerging analyses. A summary of the preliminary analysis was sent to participants for feedback.

RESULTS

Five themes emerged from what participants said about approaches to diversity: (1) differences do not matter, (2) accommodating differences, (3) understanding differences, (4) avoiding discrimination, and (5) challenging inequities. Most participants described taking more than 1 of these approaches in their practices.

Differences do not matter

Nearly half of participants stated that patients' race, class, sexual orientation, and other sociocultural differences did not raise any tensions in their practices (**Table 2**). Some suggested that people are simply not that different in ways that matter to the practice of medicine. Others noted that while sociocultural factors might indeed differentiate people, they see few such differences in their practices in Halifax, where the population is relatively homogeneous. Still others noted that sociocultural differences are relevant in relation to genetic and physiologic mechanisms (eg, predisposition to certain illnesses or responses to certain medications) rather than to social concerns. Overall, these participants described an ideal of neutral family physicians, seeing few patients from diverse sociocultural groups with little or no tension arising when they did.

Accommodating differences

In contrast, more than half of participants noted that some tensions do arise in practices with diverse patient groups (**Table 3**). Language barriers were considered the most challenging, yet that issue was readily addressed when translators were available. Tensions also arose when patients' values and beliefs differed from those of physicians, challenging the way physicians practised medicine. Some participants commented on cultures in which women could not be examined by men, specific interventions were forbidden, or cultural rules dictated who could be told what within families. Most of these participants ultimately accommodated patients' values when those values were explicitly articulated. As one physician explained, "If I can find an alternative solution to meet the patient's needs, I will. I think most people do." Participants described an ideal in which family medicine is a neutral, value-free enterprise, readily adaptable to patients' diverse values and needs.

Table 2. Examples of participant comments suggesting that sociocultural differences do not matter

SUBTHEME	COMMENTS
Conflict is individual	"Race is never an issue for me. It's more personality that sometimes can create conflicts ... that ha[ve] nothing to do with their race, or [patients'] ethnic background."
Differences are not important	"I don't think there [are] a whole lot of differences with what we generally want. You know, we want to have a comfortable home, whatever your choice of a comfortable home is, and we want to have the best for our children. We want not to have to worry about food. I don't think we want a whole lot of different things .... I don't think there is difference—[well], there is difference, but there's not."
Diversity occurs elsewhere	"There aren't a lot of cultural differences in Halifax. I think that's Toronto [Ont]. I think that's where it's coming from, with huge numbers of people from all over the world. Halifax is pretty homogeneous."
Diversity is biological	"There are certain diseases that are more common in one race or culture than another and those things come up just as medical facts ... [and] not anything that's social."

Table 3. Examples of participant comments on accommodating sociocultural differences

SUBTHEME	COMMENTS
Diverse needs create challenges in medicine	"Language is probably one of the biggest problems, although ... I can book a little more time if I have a patient with a translator." "What I find the most challenging ... is cultural differences, particularly when working with people who are from cultures [that are] significantly different [or who] have perhaps immigrated. It can be a challenge sometimes to try to figure out how to respect those cultural needs or beliefs, or whatever, especially if you don't know the culture well, yet continue to practise medicine in a way that you know how."
Medicine is neutral	"You can [practise family medicine] around the world and with not too much effort, probably even manage to do it in another language that you didn't know. It's very transportable, family medicine."

Understanding differences

The patient-physician connection is not just about a common language; even with accurate translation, cultural nuances can be omitted.[5,27] Nor is it even simply about the explicit values patients are able to articulate. Some participants were aware that they lacked a broader understanding of other sociocultural groups (**Table 4**). One participant explained that such a lack of understanding can occur because of physicians' "cultural blinders," their predisposition to see—and not see—the world in certain ways, as a result of the influence of their own sociocultural and professional backgrounds. If participants are not knowledgeable about certain cultures, they might inappropriately impose their own assumptions; thus, some participants sought to learn more about specific cultural groups. Others sought to make no assumptions about any of their patients, learning from each person as an individual.

Avoiding discrimination

Many participants feared that recognizing patients' sociocultural backgrounds meant they were stereotyping. People repeatedly said, "I don't mean to generalize, but ...." Participants often conflated generalization with stereotyping and discrimination, expressing concern that if they noticed a patient's race or culture or class they were inherently enacting prejudice. The most common behavioural response when confronted with this fear was to "retreat into professionalism," striving for neutrality (**Table 5**). This meant trying to put feelings and values aside, aiming to be colour-blind or nonjudgmental, and attempting to provide the best care possible regardless of personal responses.

Some participants went further, using conflicts with patients as opportunities to reflect on their own values and assumptions: "Why do I respond in a certain way? What are my 'assumptions' and 'biases?'"

Table 4. Examples of participant comments on understanding sociocultural differences

SUBTHEME	COMMENTS
Awareness of a lack of understanding	"In terms of race, I think I've become even more conscious that I'm going to have great difficulty understanding [certain people's] experience because it's so different from mine, and that they may not feel all that comfortable with me, or they may feel that I have the inability to understand. I guess I sort of had a view of myself as a fairly open person so maybe I think I should be okay, when maybe I'm not."
Awareness of acting out of assumptions	"You have blinders to certain things that you do culturally. You always do [them], and occasionally you'll trip. I guess I just do what I always do, which is I say what I've just done. I say, 'Okay, I guess I did this,' then try and talk about it." "I mentioned to somebody, 'Are you sexually active?' And the person said, 'Yes.' I asked, 'What are you using for birth control?' And she just kind of looked at me, and there was a very awkward silence. I can't remember how it came out, but she was a lesbian. It was one of those things; again, I felt very uncomfortable. And I said, 'I'm sorry for the assumption.' And, you know, you learn from your mistakes."
Learning about others	"Continuing education, teaching yourself things about cross-cultural medicine, is very important. There are really good articles that will give you a different [perspective]. Educating yourself on other races is really important."
Focusing on the individual	"I try to stay focused on the patient, and to try and attend to how they are and what they're needing."

Table 5. Examples of participant comments on avoiding discriminating

SUBTHEME	COMMENTS
Striving for professional neutrality	"I try and have always tried ... to be colour blind." "You're human, and you have to make an extra effort in order to put things aside." "You have to [adopt] a nonjudgmental attitude, keep [up] the empathetic side of you." "I treated [the patient] as best I could, but I was constantly aware that I had to just be my ordinary doctor-self and not let my biases get in the way, and I don't think they did."
Reflecting on the self to set aside biases	"It took me a while to think [it] through ... why did I react so strongly to that [patient's decision]? It just made me aware that I have a certain cultural sense, and she had quite a different one. That was just one of those gaps between us; I guess they're differences. So, I guess, if I sense that kind of difference, my goal is usually to try to retreat into professionalism, if you will, and do the best I can, at the same time reflecting [on] why and what is it that's going on here."

This extends the desire to avoid discriminating from treating all patients as individuals to critically examining the self (reflexivity) as someone bearing sociocultural influences and personal values. Participants paid attention to their own feelings of discomfort with patients, as well as to patients' discomfort with them. One participant, for instance, described a patient who, in disclosing that he was gay, seemed to become "a little defensive." This prompted the physician to reflect that perhaps he had unknowingly "given off vibes of disapproval" or had been unapproachable about sexual orientation. This approach uses reflexivity in order to maintain professional neutrality—examine the self in order to set biases aside.

Challenging inequities

In the approaches outlined above participants either assumed professional neutrality or strove for neutrality. A few participants, however, proposed an alternative by acknowledging that neither physicians nor patients are neutral: both experience different life chances and "deal with different realities depending on … age, race, ethnicity, sex, sexual orientation, [and] ability." These participants recognize the power they wield as physicians (**Table 6**) and also the potential power that they accrue simply because of their membership in a particular social group (eg, race, culture, class). They were conscious that social status inevitably affected how they interacted with patients as well as how patients interacted with them, without anyone being intentionally discriminatory. Some explained how they drew upon aspects of their own identities, particularly their personal experiences of marginalization or disadvantage, to better understand their patients' experiences.

A few participants spoke of taking an extra step to actively question unwarranted assumptions, judgments, and actions, using their own power to challenge colleagues and even patients. Overall, these participants did not shy away from being political. In fact, they insisted on the inevitability and necessity of taking a political stance in their professional roles. They denied the possibility of neutrality, describing family medicine as embedded in politics.

This final approach to diversity does not aim to be neutral. The focus is on awareness of personal "biases," including situations in which physicians experience power or disadvantage, and the conscious employment

Table 6. Examples of participant comments on challenging inequities

SUBTHEME	COMMENTS
Recognizing power—privilege and disadvantage	"[Doctors are] in a position of power…. I think anybody that's coming in for a problem is in a position of vulnerability." "I have the privilege of doing an examination on somebody … so right away, from history-taking, people are delving into very confidential issues, psychologically or organically. Not many people will allow other people to touch their body except maybe a physician or a partner. [It is] a huge privilege. Also, because we're professionals, people will respect our opinions, and what we say goes a long way." "There are privileges I've had as a white, employed woman that have not necessarily had anything to do with being a doctor. And there's privilege that I have that goes along with being a doctor … [that] comes from the dominant paradigm that I participate in to a greater or lesser degree. [There] are also parts of who I am that connect me with people who don't have the privileges that I have. So I often call on that experience to share anger [or] to hear rage."
Addressing structural roots of inequities	"I think we have to get [further] down to the roots of the problems. People don't choose to be impoverished, it's what happens to them through their lives, and … that is so closely linked to a person's health. If our society is sick … we're not going to solve those issues. And I don't know if that's where we should put the funding or if we should put it toward health care and meet those needs more directly. In an ideal world, we'd do both." "I've always felt that you [address] things within your practice on a one-on-one basis, and [address] things on a large[r] scale [with respect to] social policy and challenging education and that kind of thing. So my practice has been involved in that way."
Directly addressing discrimination	"Occasionally we've had inpatients who've absolutely refused to have [international] residents provide care. When they're unwell, our feeling is that's not the time to challenge them, so we tend to have the staff physician take over the role. But we will not let them leave the hospital without discussing how inappropriate their behaviour was."
Medicine as inherently political	"As a family physician you are the gatekeeper. If you don't have any idea about how that [the politics of health care] works, you are going to become a puppet …. They talk about a 2-tiered system—it's already here. If I want to send somebody for physiotherapy, a single mother on welfare, there's no way that she can go for physiotherapy the next day. She has to wait 6 weeks. That's politics."

of these aspects of self when working across sociocultural boundaries. Rather than seeking to neutralize "biases," this approach uses reflexivity to explore and challenge privilege and disadvantage; to connect with individual patients across difference; to understand the generalized experiences of sociocultural groups; and to work for change.

DISCUSSION

It is important to understand how physicians think about and approach diversity in their everyday practices, and the implications of these varying perspectives, in order to develop appropriate education and supports. The family physicians in this study approached sociocultural diversity in a variety of ways. Some argued that such differences mattered very little, while others focused on ways to accommodate differences. These approaches assume that medicine itself is culturally neutral, and that skilled practitioners are also socially and culturally neutral.[18,28] They also fail to recognize that medicine itself has a culture—eg, values, beliefs, assumptions, norms, language—that directly affects how physicians practise.[23,24] Furthermore, as one participant stressed (**Table 5**), physicians are human beings who are as affected by their own race, class, culture, sex, and sexual orientation as their patients are.[18]

Suggesting that differences do not matter denies the effects of diversity; accommodating differences and understanding differences acknowledges that sociocultural factors might have influence. Physicians who focused on accommodating differences emphasized patients' sociocultural values, while physicians who focused on understanding differences pointed to the effects of their own sociocultural backgrounds, recognizing that they were limited by cultural blinders that made it difficult to comprehend certain things. Participants responded to these foci in 1 of 2 ways: trying to learn more about other sociocultural groups or treating each patient as a unique individual, with no assumptions at all. (Of course this is impossible.[25]) Again, the intent was neutrality: recognizing biases to set them aside.

Treating patients as individuals reflects the most common approach to diversity discerned in our study: avoiding discrimination or stereotyping. This is, in fact, the dominant response to diversity in Canada as a whole,[29] and arises from a genuine desire to not treat others badly.[30] In this approach, sociocultural differences are recognized not only as important aspects of both patients and physicians, but also as a basis for discrimination. However, in seeking not to discriminate, physicians aim to neither see sociocultural differences nor apply generalizations at all and inevitably fail to acknowledge generalized social patterns in experiences, life chances, and influences on health.[1-16] Striving to not notice someone's skin colour is unhelpful when it causes patients to experience racism on a regular basis, leading to hypertension and health-related behaviour.[21,22,26] In New Mexico, Quinterro and colleagues found that treatment providers denied any generalization stemming from cultural differences ("all families are prone to substance abuse"), preferring a "color-blind approach to service delivery" in which they asserted neither race nor ethnicity should affect treatment. Participants were well intentioned, seeking to avoid bias and recognize diversity within cultural groups as well as among groups; yet the consequence of their position was "a denial of the role that racism and cultural variation play in shaping differential patterns of help seeking and access to treatment as well as the experience and outcome of these processes."[22] In other words, in striving to not notice differences, practitioners denied the effects of shared experiences that arose from historical and contemporary power relations—experiences of racism, for example. All of the approaches discussed so far reject the idea that social factors influence people's lives in systematic ways.[21]

The final approach, challenging inequities, acknowledges that social realities shape patients' health and health care, as well as physicians' values, assumptions, and ways of practising. This approach accepts that the sociocultural differences related to health inequities are not reducible to individual biases or prejudices, but rather are rooted in historical and contemporary social power relations. In this approach, participants employed reflexivity (critical examination of their own values and assumptions), not to neutralize biases but to be more fully aware of them and employ them effectively in practice.[19,22] Physicians asked themselves hard questions about what assumptions they were making; where those assumptions came from; how their assumptions connected to structural inequities, such as racism and classism; and how they might counter these assumptions. They also asked themselves if and when they personally experienced marginalization; drawing upon their own feelings of difference, disadvantage, or not belonging could help them better connect with patients from other sociocultural groups.

This tricky balance of questioning biases while drawing upon biases is part of the art of medicine. While the easy response to sociocultural differences might be to treat all patients in the same way (aspiring to equity through neutral objectivity), the artful responses allow subjectivity: both patients and physicians are seen as individuals who are constantly influenced by their sociocultural contexts. These responses take the whole of the patient and the whole of the physician into account. Engaging in such artful practices when confronted with diversity asks that practitioners strive less for objective neutrality and more for reflexive self-examination to accomplish equitable outcomes. Future research should

explore the extent to which the approaches we have identified among this small group of family physicians are general patterns among family physicians across Canada, as well as exploring which approaches to diversity in fact improve patient experiences.

Limitations

This study is limited by a small sample size of family physicians from 1 city. Moreover, the method relied on participant reports about their respective practices rather than assessment of actual practices. Without empirical evidence, there is no way to know how participants' beliefs and understandings translate to health care outcomes. This study, rather, provides evidence about the varying ways physicians conceptualize and rationalize their interactions with culturally diverse patients. Further, the focus on diversity represents a portion of a larger study of everyday practice dilemmas. Therefore, the self-selected sample did not comprise "experts" on diversity, or even physicians concerned about diversity. Although this is a limitation of the sample population, at the same time it means the study was less affected by self-selection than usual.

Conclusion

The family physicians interviewed for this study indicated that they employed a range of approaches to sociocultural diversity in their everyday practices. The predominant stances emphasized physicians' own sociocultural neutrality as an ideal. In contrast, some participants acknowledged diversity in their patients, but did not recognize that they too were affected by their own sociocultural realities. Although other participants did recognize their own sociocultural identities, they responded to diversity by striving to set aside assumptions and focus on patients as individuals, again aiming for neutrality. This reflects the most common response in this study: the desire to not stereotype. Only when physicians were able to distinguish between generalizing and stereotyping could they express an understanding that they and their patients were affected by social factors that influenced life experiences, life chances, and, ultimately, health outcomes in patterns that can and should be taken into account in family practice.

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Contributors

Dr Beagan and **Ms Kumas-Tan** contributed to the concept and design of the study; data gathering, analysis, and interpretation of the results; and preparing the manuscript for submission.

Competing interests

None declared

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