An Overview of Racism in Medicine

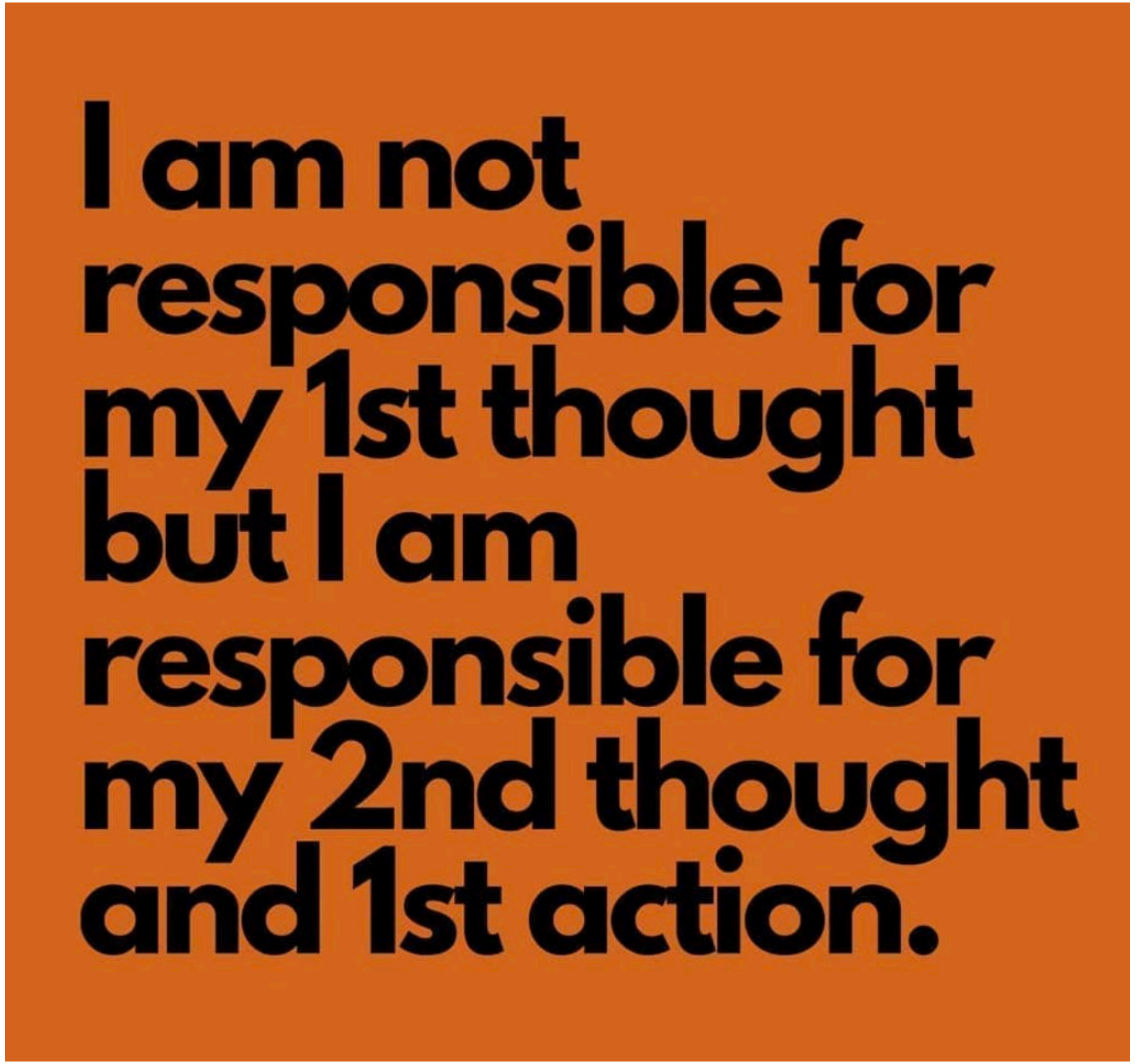
Jessica Huang

Learning Objectives

1. Define race, the different forms of racism, prejudice, and discrimination
2. Understand how racism impacts health outcomes in patients
3. Trace the historical roots of racism in medicine to where we are today
4. Identify actions by which we can combat racism
5. Engage in case-based discussions with thoughtful dialogue about how race and bias impact patient care

GROUND RULES

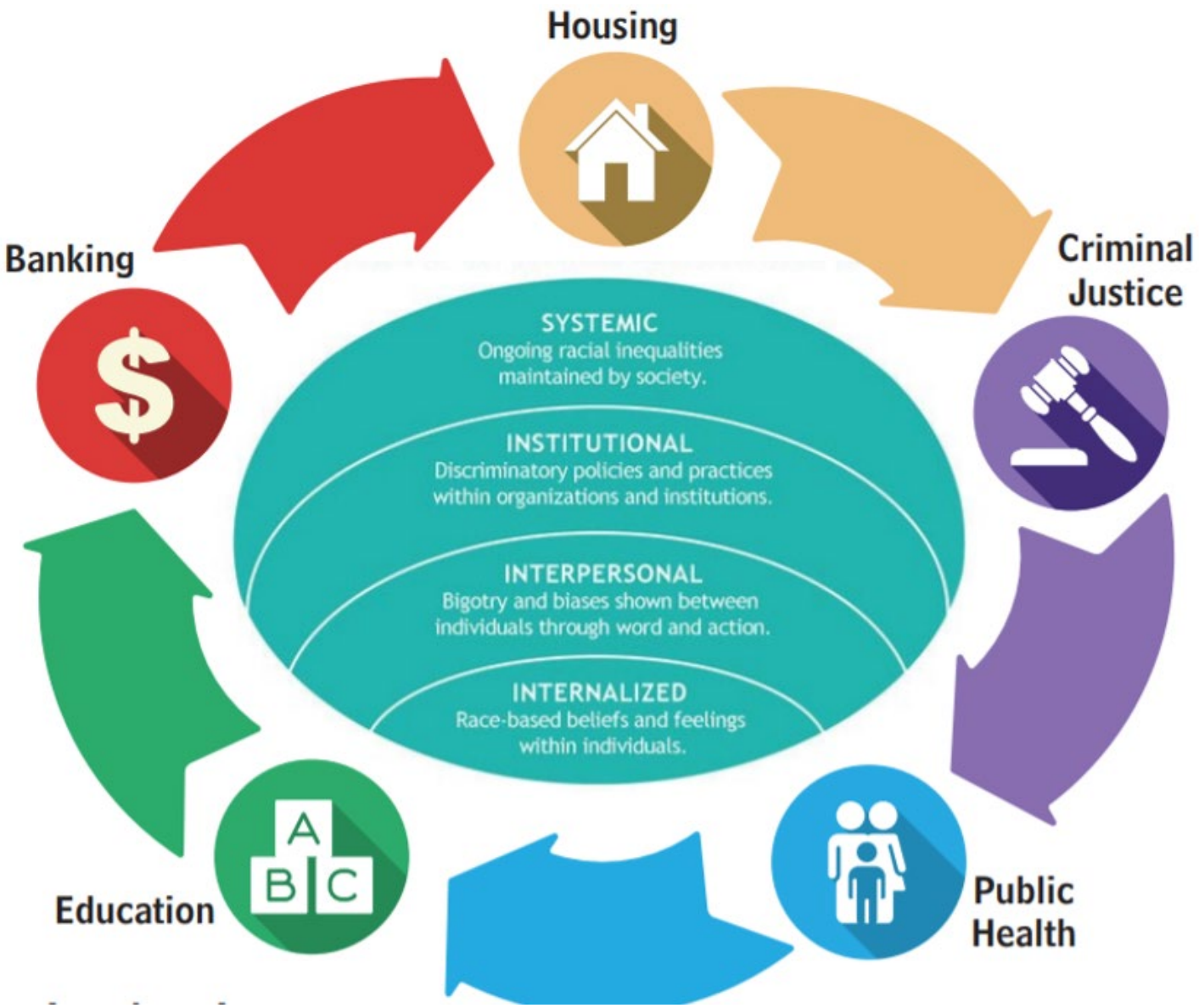
1. RESPECT EACH OTHER – no personal attacks
2. No judgement zone
3. Vegas rules
4. “I” statements – speak from your own experience
5. Be brave

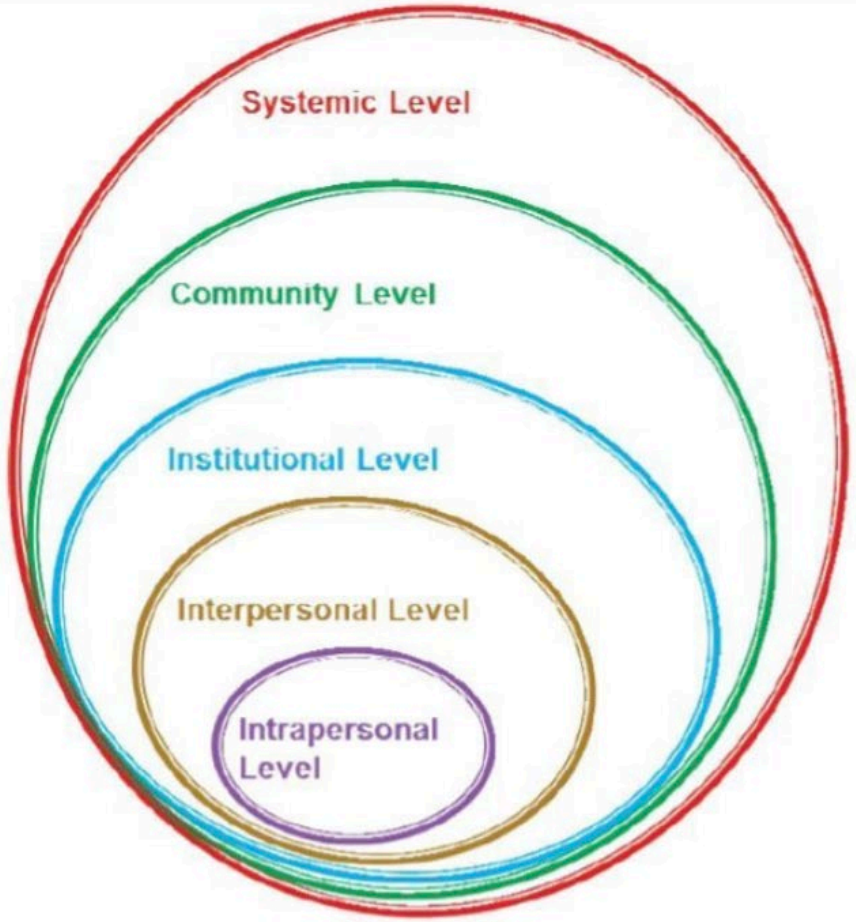

I am not
responsible for
my 1st thought
but I am
responsible for
my 2nd thought
and 1st action.

Definitions

- **Race** is the classification of humans into groups based on physical traits, ancestry, and social relations, or the relationships between them
- **Racism** is a system of structuring opportunity and assigning value based on the social interpretation of race.
- **Prejudice** is differential assumptions about the abilities, motives, and intentions of others according to their race
- **Discrimination** is differential actions toward others according to their race

Jones CP. *Am J Public Health*. 2000;90(8):1212-1215.
Jones CP. *Med Care*. 2014;52:S71-S75.





Systemic Level
- Immigration policies
- Incarceration policies
- Predatory banking

Community Level
- Differential resource allocation
- Racially or class segregated schools

Institutional Level
- Hiring and promotion practices
- Under- or over-valuation of contributions

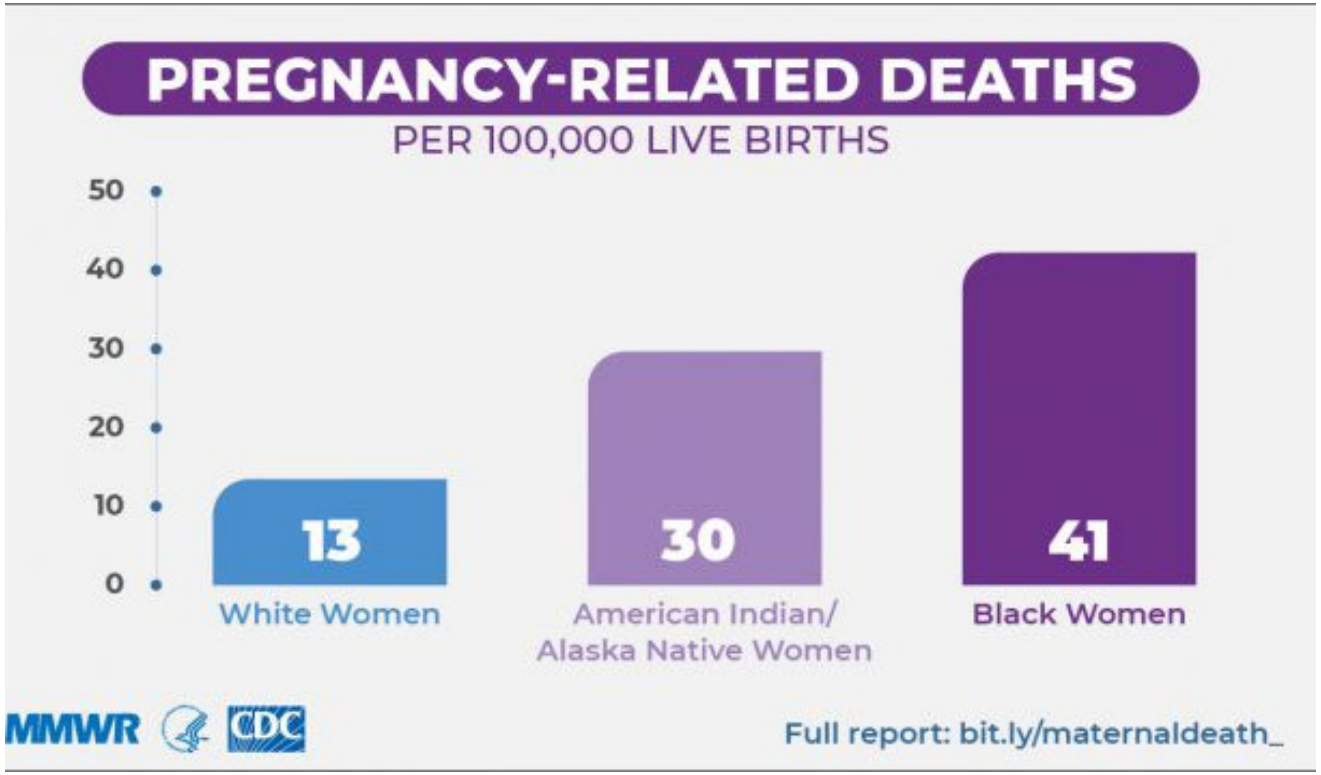
Interpersonal Level
- Overt discrimination
- Implicit bias

Intrapersonal Level
- Internalized racism
- Stereotype threat
- Embodying inequities

Why does this matter?

- School districts in 2000 were more segregated than in the 1970 due to the resegregation that occurred in the 90s. This leads to inner-city minority schools lacking decent buildings, being overcrowded, and generally lacking resources. Lower education leads to lower health literacy
- Minority Americans are less likely than whites to get many effective medical and surgical services across a variety of clinical settings:
  - Black patients 22% less likely to receive pain medication than white patients
  - Lower rates of revascularization procedures for acute MI
  - Fewer prescriptions for beta-blockers after MI
  - Less timely administration of antibiotics for pneumonia
  - Less optimal care for diabetes
  - Fewer prescriptions for inhalers in children with asthma
  - Fewer cancer screening tests

Experienced/perceived discrimination



- Associated with poorer health outcomes:
  - Hypertension and poor sleep quality in African Americans
  - Increased frailty in Asian Pacific Islander and Latino elderly
  - Black, American Indian, and Alaska Native (AI/AN) women are two to three times more likely to die from pregnancy-related causes than white women – and this disparity increases with age

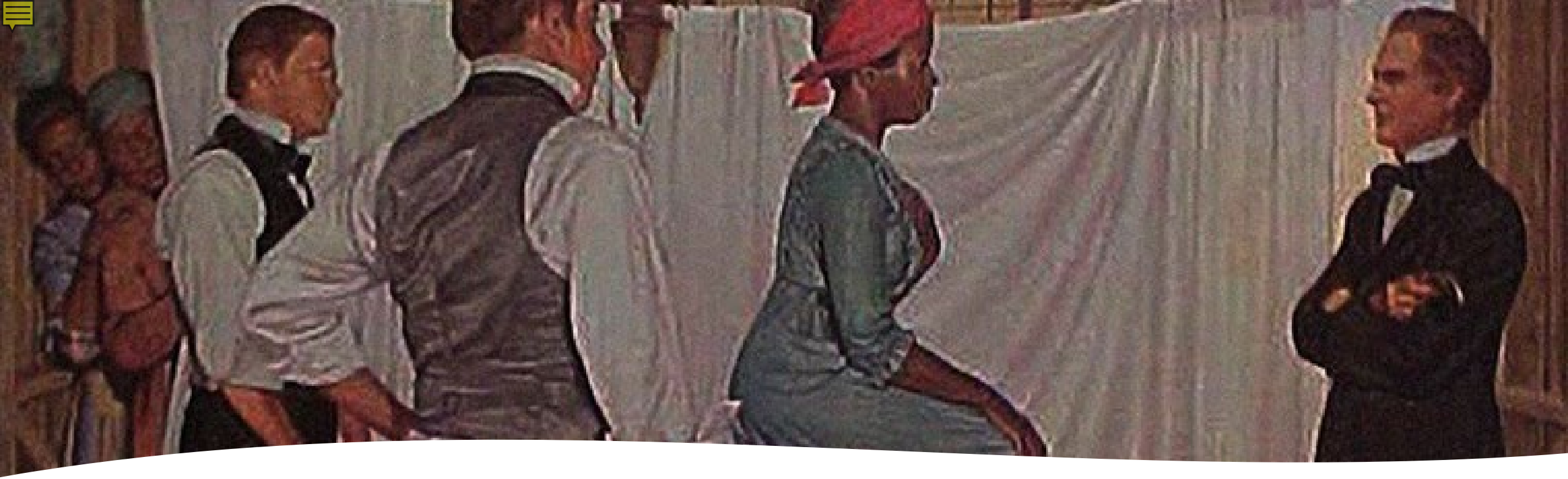
Personally-mediated racism

- Can be intentional or unintentional
- Manifests as:
  - Lack of respect
  - Suspicion
  - Devaluation
  - Scapegoating
  - Dehumanization

History of racism

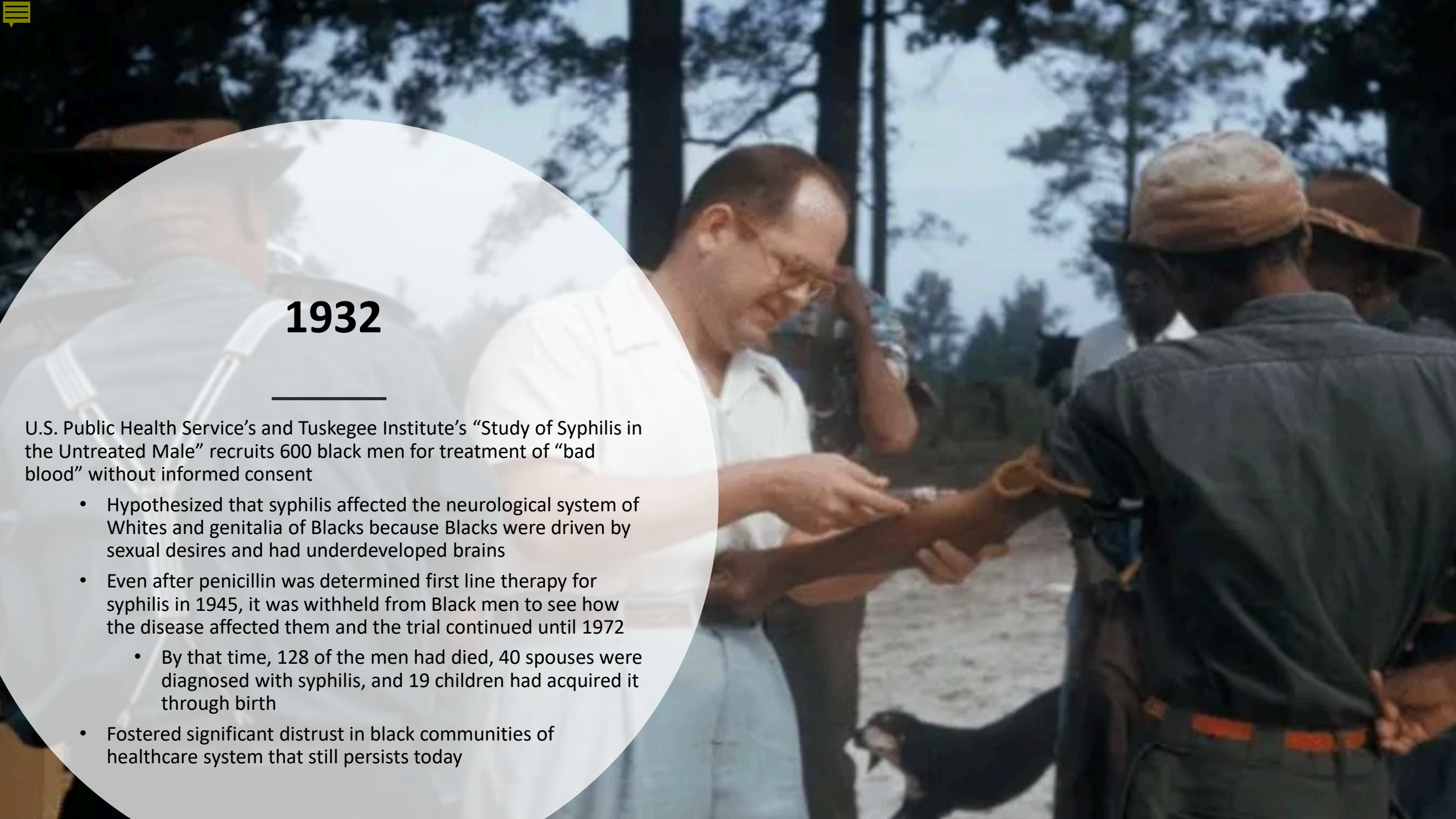
- 336 years of slavery and legal segregation, making up 85% of United States history
- Today, white Americans have accumulated socioeconomic resources over 20 generations from ancestors who benefited from slavery and racial oppression

TRIGGER WARNING



A painting of Dr. James Marion Sims, by American artist Robert Thom from the 1950s, is the only known representation of Lucy, Anarcha and Betsey, three enslaved women who Sims operated on, according to the American Historical Association.

- **1850:** James Marion Sims (father of gynecology, inventor of the speculum, and pioneer of vesicovaginal fistula repair) conducts experiments on female slaves and neonates without anesthesia
  - **Anarcha** (17 yo F) was experimented on for *four years* without anesthesia while he attempted to fix her vesicovaginal fistula, requiring multiple men to hold her down
  - Believed Black people were less intelligent than White people because their brains were compressed by skulls that grew too quickly
    - Operated on Black children to pull their bones apart and loosen their skulls
  - Believed Black people did not feel pain



1932

U.S. Public Health Service's and Tuskegee Institute's "Study of Syphilis in the Untreated Male" recruits 600 black men for treatment of "bad blood" without informed consent

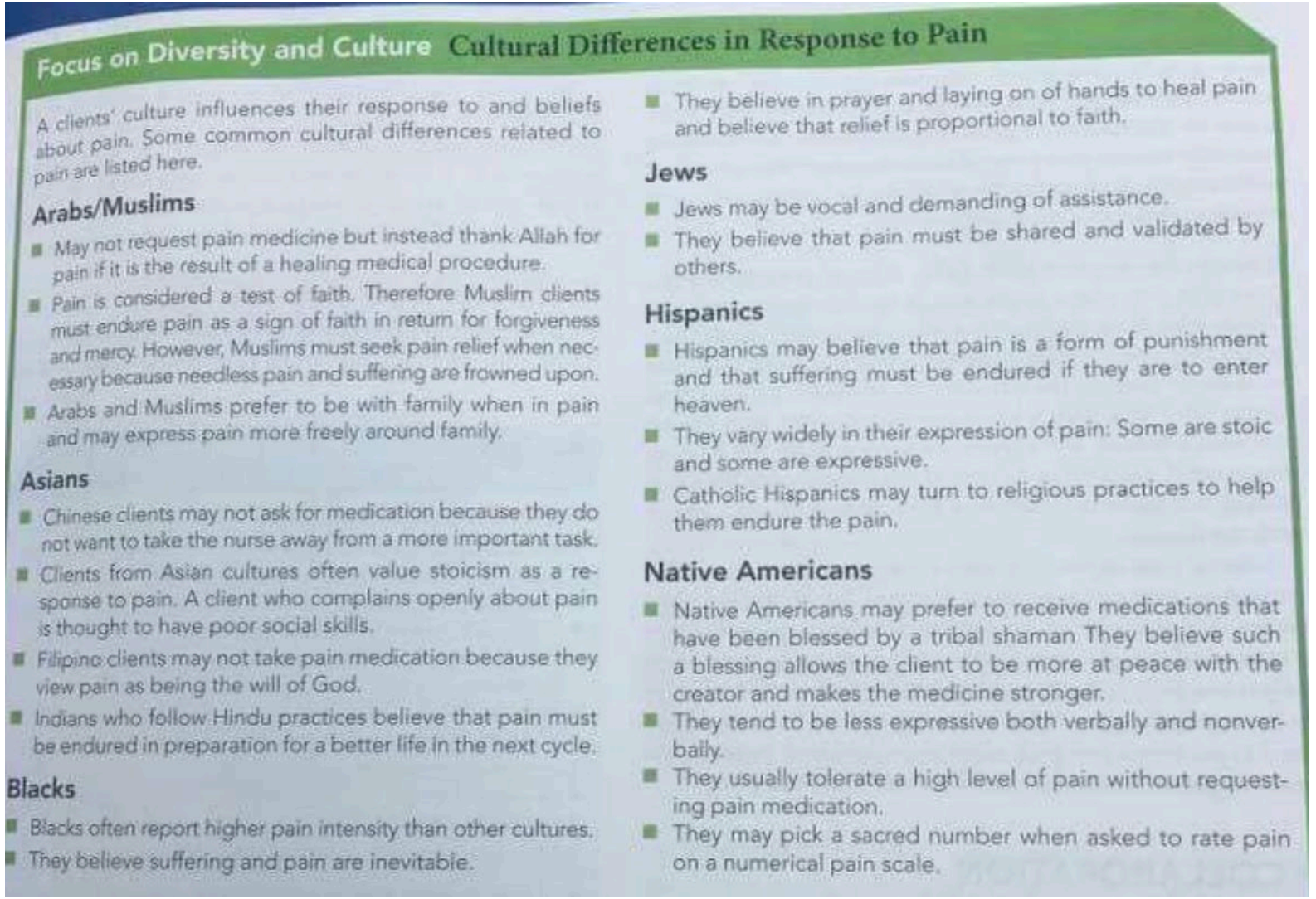
- Hypothesized that syphilis affected the neurological system of Whites and genitalia of Blacks because Blacks were driven by sexual desires and had underdeveloped brains
- Even after penicillin was determined first line therapy for syphilis in 1945, it was withheld from Black men to see how the disease affected them and the trial continued until 1972
    - By that time, 128 of the men had died, 40 spouses were diagnosed with syphilis, and 19 children had acquired it through birth
- Fostered significant distrust in black communities of healthcare system that still persists today

- **1939**: Margaret Sanger (founder of Planned Parenthood) helps start the “Negro Project” which used birth control eugenics as a way of reducing the black population
  - High levels of hormones put Black women at increased risk of stroke and HTN
  - Early IUDs killed many Black women through infection
- **1951: Henriette Lacks** goes to Johns Hopkins for treatment of cervical cancer where the doctor cultured cells from the tumor without her consent
  - Became the first immortalized cell line (HeLa) that was used to develop the polio vaccine and is still used today, including for COVID19 vaccines
- **1961: Fannie Lou Hamer** goes to have a uterine tumor removed and instead her white doctor performs a hysterectomy
  - Black women were often victims of forced sterilization as a way to reduce the Black population
  - “Mississippi appendectomy”

2000s:

Racial bias in medical training

- **2014:** Pearson publishes a nursing textbook with the following advice on how to treat pain



Focus on Diversity and Culture **Cultural Differences in Response to Pain**

A clients' culture influences their response to and beliefs about pain. Some common cultural differences related to pain are listed here.

Arabs/Muslims

- May not request pain medicine but instead thank Allah for pain if it is the result of a healing medical procedure.
- Pain is considered a test of faith. Therefore Muslim clients must endure pain as a sign of faith in return for forgiveness and mercy. However, Muslims must seek pain relief when necessary because needless pain and suffering are frowned upon.
- Arabs and Muslims prefer to be with family when in pain and may express pain more freely around family.

Asians

- Chinese clients may not ask for medication because they do not want to take the nurse away from a more important task.
- Clients from Asian cultures often value stoicism as a response to pain. A client who complains openly about pain is thought to have poor social skills.
- Filipino clients may not take pain medication because they view pain as being the will of God.
- Indians who follow Hindu practices believe that pain must be endured in preparation for a better life in the next cycle.

Blacks

- Blacks often report higher pain intensity than other cultures.
- They believe suffering and pain are inevitable.
- They believe in prayer and laying on of hands to heal pain and believe that relief is proportional to faith.

Jews

- Jews may be vocal and demanding of assistance.
- They believe that pain must be shared and validated by others.

Hispanics

- Hispanics may believe that pain is a form of punishment and that suffering must be endured if they are to enter heaven.
- They vary widely in their expression of pain: Some are stoic and some are expressive.
- Catholic Hispanics may turn to religious practices to help them endure the pain.

Native Americans

- Native Americans may prefer to receive medications that have been blessed by a tribal shaman. They believe such a blessing allows the client to be more at peace with the creator and makes the medicine stronger.
- They tend to be less expressive both verbally and nonverbally.
- They usually tolerate a high level of pain without requesting pain medication.
- They may pick a sacred number when asked to rate pain on a numerical pain scale.

- **2016**: study finds that 40% of first and second year medical students believe that “black people’s skin is thicker than white people’s”

- **2020:** University of Minnesota medical student defaces George Floyd mural and poses for a picture after

Immigration and Customs Enforcement (ICE)

Sep 15, 2020: Dawn Wooten, nurse at Irwin County Detention Center in Ocilla, GA housing immigrants detained by ICE, reveals that the center refused COVID testing for detainees and allowed symptomatic workers to continue working. She also raised concern for the rate at which hysterectomies were being performed and inability for detainees to comprehend and consent

Whistleblower Alleges 'Medical Neglect,' Questionable Hysterectomies Of ICE Detainees

September 16, 2020 · 4:43 AM ET

RACHEL TREISMAN

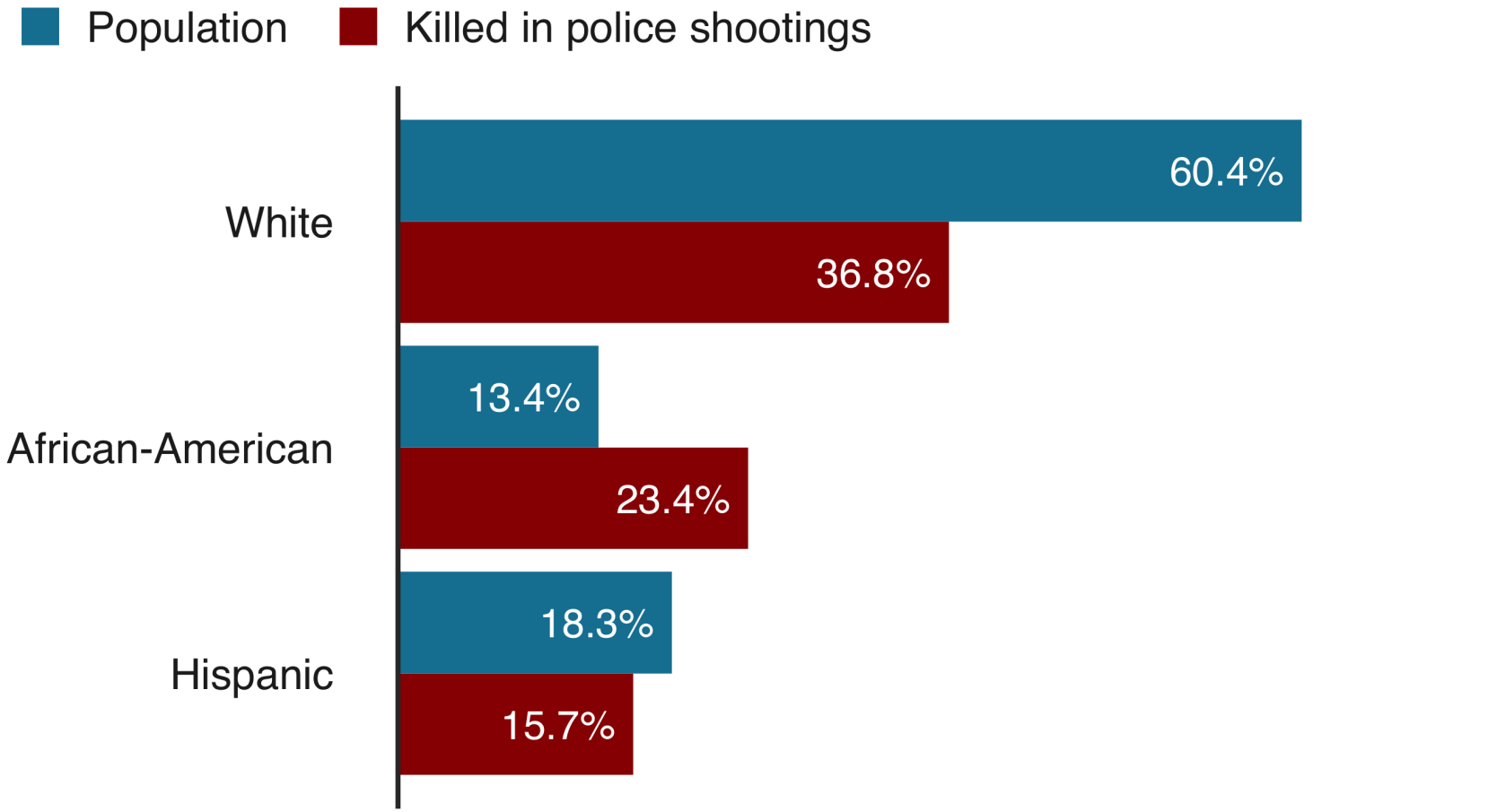
Dawn Wooten (left), who filed the whistleblower complaint about conditions at the Irwin County Detention Center, participates in a news conference Tuesday in Atlanta.

Police Violence

Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study

- 2013-2015 CDC Behavioral Risk Factor Surveillance System Survey combined with national data police killings data
- 38,993 of 103,710 black American (BA) respondents were exposed to ≥1 police killings of unarmed BA in their state in the 3 months prior to the survey
- Each additional police killing of an *unarmed* BA was associated with 0.14 additional poor mental health days during this time period among BA respondents; no impact on white American respondents
- Could contribute to 1.7 additional poor mental health days per person per year, or 55 million excess poor mental health days per year

Percentage of fatal police shootings compared to percentage of population by ethnicity



Note: 1,004 fatal shootings in 2019, 39 in 'other' ethnic groups, 202 'unknown' ethnicity

Source: US census bureau and Statista.com 2019

BBC

COVID-19

COVID-19 CASES, HOSPITALIZATION, AND DEATH BY RACE/ETHNICITY

FACTORS THAT INCREASE COMMUNITY SPREAD AND INDIVIDUAL RISK


CROWDED SITUATIONS


CLOSE / PHYSICAL CONTACT


ENCLOSED SPACE

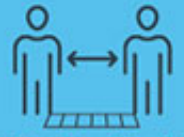

DURATION OF EXPOSURE

Rate ratios compared to White, Non-Hispanic Persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
CASES[1]	2.8x higher	1.1x higher	2.6x higher	2.8x higher
HOSPITALIZATION[2]	5.3x higher	1.3x higher	4.7x higher	4.6x higher
DEATH[3]	1.4x higher	No Increase	2.1x higher	1.1x higher

Race and ethnicity are risk markers for other underlying conditions that impact health — including socioeconomic status, access to health care, and increased exposure to the virus due to occupation (e.g., frontline, essential, and critical infrastructure workers).

ACTIONS TO REDUCE RISK OF COVID-19


WEARING A MASK


SOCIAL DISTANCING (6 FT GOAL)


HAND HYGIENE


CLEANING AND DISINFECTION

[1] Data source: COVID-19 case-level data reported by state and territorial jurisdictions. Case-level data include about 80% of total reported cases. Numbers are unadjusted rate ratios.

[2] Data source: COVID-NET (https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html, accessed 08/06/20). Numbers are ratios of age-adjusted rates.

[3] Data source: NCHS Provisional Death Counts (https://www.cdc.gov/nchs/nvss/vsrr/COVID19/index.htm, accessed 08/06/20). Numbers are unadjusted rate ratios.

cdc.gov/coronavirus

CS319360-A 08/08/2020

Less Access To educational resources increases likelihood of being a frontline worker

Housing discrimination causes residential segregation and unequal educational opportunities

Frontline workers have more exposure to covid-19 and are therefore more likely to be infected

Higher exposure combined with the stressors of dealing with lifelong racism result in underlying health conditions which cause a disproportionate rate of death

What can we do?

- Advocate
- Build trust, empathy, and self-efficacy into your relationships with patients
- Learn and teach others
- Mitigate unconscious bias
- Create non-threatening strategies to address bias when you recognize it in a clinical encounter

Attendings and Residents:

- Lead by example
- Be an anti-racist advocate within your team
- Make your space welcoming for people of color
- Encourage open discussions on race
- Acknowledge ongoing racism outside of the hospital and how it impacts what happens inside the hospital

We can’t solve a problem we can’t discuss

- Studying and acknowledging issues of race and racism can make a difference in your day-to-day care of patients by:
  - Increasing how much you value health equity
  - Reducing unconscious bias by getting to know patients on an individual level
  - Reducing patient blame by recognizing the larger competing priorities and discriminations in their lives and life histories
  - Mobilizing diverse teams and maximizing teamwork
  - Supporting and empowering yourselves and your colleagues

Where are you?

CASE 1

- A 9 year-old black female presents to the emergency room from home with complications from an intracranial infection (subdural empyema). Prior to admission, her intravenous (PICC) line had fallen out. She has had several recent admissions, and her parents have repeatedly expressed anger and distrust with the healthcare team. A student on the admitting pediatrics team repeatedly witnesses nurses in the emergency department and residents on the neurosurgery and pediatric team refer to the patient and her family as “annoying,” “crazy” and “non-compliant.” At turn-over report the next day on the pediatric ward, one of the residents states, “They must be so stupid to pull the PICC line out. Mom and Dad are so negligent.” Another replies, “Why don’t they just leave. We shouldn’t even admit her anymore.” The student notes that healthcare workers making these comments are from a several different races and backgrounds.

- Why do you think the healthcare professionals are reacting this way? Why are these types of comments accepted and shared by healthcare providers across specialties, responsibilities, and backgrounds?

- Is the patient harmed by these comments and attitudes, even if she and her family do not overhear them? Why or why not?

- What can the student say to the family to try to elicit their perspective? Why is this perspective important and how can it help the student and the healthcare team better understand the effects of the team’s comments?

CASE 2

- You are on your surgery rotation and are doing an overnight trauma call shift. You are called down to the critical care unit for a Level I trauma. Lying in Room 4 is a 26-year-old man with two superficial abdominal stab wounds to the left lower quadrant. His vitals are stable, but he is crying out in pain. You examine the patient with the resident physician, and you take notes as the resident voices the results of his primary and secondary survey. On completion of the exam, the resident determines that the patient does not need surgical intervention. When you ask what the patient will receive for pain control, the resident responds, “Who cares? He is probably on drugs anyway” You feel confused. Last week you were working with this same resident on acute care service when the resident advocated giving a 31-year-old woman Dilaudid for the pain she was experiencing during an episode of acute appendicitis. What do you do?

- What are the factors that you think are impacting the resident’s indifference to this patient’s pain?

- What is the role of bias and stereotyping in this case?

- When we are taught about pain, how are we taught to interpret the patients' reporting of their pain? 'validity'?

- Did you make any assumptions about the race of either patient described in these cases? How might race be relevant in terms of decisions related to treatment of pain?

- How would you approach this topic with your resident and other members of the team?

CASE 3

- On your internal medicine clerkship, you are taking care of a 47-year-old woman with type II diabetes and hypertension who was admitted in a hyperosmolar hyperglycemia state (HHS) and a systolic blood pressure in the 200s. Your patient is black and lives in downtown Allentown. In your presentation you mention that she was admitted for the same thing two months ago. After discussing the medical plan, your resident says with frustration, “I don’t understand why some people just don’t want to take care of themselves, and depend on us to deal with the consequences.”

- What are the racial implications of what the resident said?

- How do policies and discrimination lead to racial segregation and how is racial segregation relevant to why the patient has now presented twice with the same complications.

- What puts this patient at higher risk of hypertension?

- What are the things you can do to avoid comments like these after your presentation?

What are your key takeaways from today?