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Recommended Citation
Wang E. Healthcare for All Colors: Anti-Racism in Medical Professions. BU Well. 2021; 6(1).

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Healthcare for All Colors: Anti-Racism in Medical Professions

Elise Wang

Abstract: Racism in the United States’ healthcare system has a longstanding history and exists at both the macro and microlevel. Medical professionals have a responsibility to be anti-racist in their practices. Healthcare providers and organizations can create a more equitable and beneficial medical experience for Black, Indigenous, and People of Color (BIPOC) patients through anti-racism praxis, increasing the health literacy of patients, and shifting power to patients to equalize the provider-patient dynamic. While these initiatives cannot bring the systemic change needed to fully eradicate racism from medicine, it will join providers and patients together in the fight against interpersonal, and eventually institutional, racism in healthcare.

The death of George Floyd has sparked greater mainstream attention toward systemic racism in policing as well as other areas of social life, including healthcare. Medical institutions and healthcare providers alike are acknowledging the pervasive impacts of racism and making strides toward being actively anti-racist. While systemic racism is central to the continuation of racial and ethnic health disparities, hospitals and other healthcare settings can be seen as a microcosm of the macro-level consequences of racism in medicine. Previous initiatives, such as broad diversity training programs for employees, have proven to be ineffective. In order to prevent medical racism, healthcare providers must implement a concentrated initiative which involves anti-racism praxis, increasing the health literacy of patients, and shifting power to patients to equalize the provider-patient dynamic.

Racism in healthcare is not a new occurrence. Medical wrongdoings against Black, Indigenous, and people of color (BIPOC) in the United States have an extended and withstanding foundation. Women of color have a history of being sterilized by medical professionals without consent, deemed “unfit” for reproduction in the 1950s and receiving negligent procedures at US Immigration and Customs Enforcement (ICE) detention centers. Furthermore, Black Americans have been treated as experimental objects rather than humans, as seen through J. Marion Sims’s unanesthetized gynecological procedures on enslaved women and the Tuskegee Syphilis Study denying treatment beyond placbos to marginalized Black men. As a result of systemic racism, Black, Indigenous, and Hispanic Americans are more likely to have significantly worse health outcomes and experience more health disparities than White individuals. Black patients report lower quality of care and amount of trust in providers who demonstrate racial bias. As seen from these examples, racism plays a significant role in harming the health and healthcare experience of BIPOC individuals in the US. Therefore, steps must be taken to improve the wellbeing and medical care of racial minorities.

Creating an anti-racist praxis for healthcare employees is a step towards eliminating racial bias in provider-patient interactions. Eliminating provider bias is quite valuable, as the absence of prejudice increases patients’ trust and improves their quality of care. Anti-racist praxis is an educational tool regarding the intentional combatting of racism through individual and systemic actions. Unlike diversity training, which involves a broad recognition of the impact of race, anti-racist praxis focuses on the intersecting, structural oppressions that impact BIPOC individuals. Instead of teaching cultural competence alone, anti-racist praxis aims to build a skill set of knowledge on systemic, racial oppression and how to combat it in a clinical setting. It places those who experience racism at the center of the narrative and encourages listening and implementation of strategies. Furthermore, anti-racist praxis provides an alternative to other initiatives such as diversity training, which lack the skills and organizational techniques needed to effectively work against the consequences of racism. In giving providers the knowledge and skills to eliminate racial biases and organize against systemic racism, providers can more effectively be anti-racist and improve the experience of BIPOC patients.

Ensuring that patients are thoroughly educated about their health can aid in the elimination of medical racism. One form of racism BIPOC patients experience in the US healthcare system is the packaging of information by providers. The packaging of information occurs when a provider does not provide a complete picture of the health issue or therapeutic options, possibly due to racial bias. As a result, BIPOC patients feel disrespected by the provider and sense a loss of authority in their medical care. Healthcare professionals can avoid race-based packaging of information by taking the time to educate their patients. Improving patients’ health literacy helps patients feel more respected and in control of their well-being. Increased patient education provides a step toward removing racial bias in healthcare interactions by ridicing the interactions of the immense power barrier of information packaging. Furthermore, health literacy can improve health outcomes. Being knowledgeable in the subjects of health risks and safety measures allows individuals the opportunity to reduce morbidity and/or mortality from preventable illnesses. Avoidable diseases, such as breast cancer, high blood pressure, and type II diabetes, cause more detrimental outcomes in BIPOC communities than white communities. Providing BIPOC individuals with better health education improves their chances at avoiding and battling such diseases.

To better serve racially marginalized groups, the provider-patient relationship must adapt and become more of an equal partnership. The original relationship was seen as having an unequal power distribution, with the physician having more authority. The role of the healthcare provider was to use their medical knowledge to determine the necessary treatment, and the patient’s role was to accept and implement the doctor’s orders. Remnants of the original relationship conceptualization can still be seen today; physicians and other medical professionals see themselves as experts on the individual needs of all patients, even without consulting or fully informing the patient on their illness or treatment options. However, the exemplary provider-patient relationship of today is more of an equal partnership than a hierarchical correspondence. While providers have the medical expertise, that is not all that is needed to determine an appropriate course of action for a patient’s health. The patient is the expert of their own body, which is a vital contribution to the complete picture of a patient’s health. This is often overlooked during medical interactions with BIPOC patients, as seen through the prevalence of rushed appointments, lack of dialogue, and withheld information when caring for a racial minority. A shift to create an equitable and balanced interaction with the patient is essential for BIPOC individuals. Providers should understand and work...
to correct the power dynamics that exist in the provider-patient and non-BIPOC-BIPOC relationships. In doing so, racially marginalized patients will feel more empowered in their interactions with providers and be better served in healthcare settings.

One case that exemplifies the importance of the objectives outlined above is Dr. Susan Moore’s Covid-19 experience. Dr. Moore was a medical doctor from Indianapolis who was diagnosed with Covid-19 in late November of 2020. Her Facebook posts, especially a video she recorded from her hospital bed, illustrated the healthcare experience of Black women in America. Dr. Moore recognized that without her medical training, she would not have known how severe her symptoms were nor have known to ask for the appropriate treatment, such as a neck and lung scan which showed the drastic impact Covid-19 had on her lungs. Providers are responsible for both listening to the concerns of their patients and educating them on their health so that patients can best advocate for themselves. As Dr. Moore’s experience exemplifies, racial bias in healthcare is a common experience for BIPOC, but especially Black individuals. Patients should not have to be White nor have high health literacy to be treated properly by their providers.

Despite the deeply rooted history of racism in American medicine, the intense focus on the issue in the United States is an early sign of progress. By implementing anti-racist praxis, increasing patient health education, and balancing the power dynamic in the provider-patient relationship, healthcare professionals will be better equipped to foster an equitable and comfortable interaction with BIPOC patients. Providers will be able to utilize their knowledge of systemic racism and understand how it impacts the medical institution and patients alike. Furthermore, providers will have the tools to empower their patients by giving them a complete picture of their health, thereby granting their patients authority over their own health as the provider and patient collaborate to find the best solution for the patient. While these initiatives cannot bring forth the macro-level, systemic change needed to fully eradicate racism from medicine, it will join providers and patients together in the fight against interpersonal, and eventually institutional, racism in healthcare.

References


