Medical Racism

Racist ideologies are the foundation for the belief that human biological/genetic diversity among racially defined groups is the reason for social and cultural differences between these groups. Racism emerges when racist ideologies are used to claim that biological differences are a legitimate reason for differential treatment of human populations. Racism is based on the belief that *Homo sapiens* are composed of distinct biological groups (races) with biologically based cultural characteristics and that races can be ranked.

Medical racism is prejudice and discrimination in medicine and the medical/healthcare system based upon perceived race. Racism in medicine can occur in at least four ways. First, on a conceptual level, it can occur as members of a society learn about races and racism as well as the validity of white privilege. Healthcare providers are a product of their social environment. They learn negative attitudes and beliefs about human biological diversity from society that may be brought to the work/health setting. They may be unaware of this racism, and it can be subtle or overt. Second, collective racial discrimination, based on shared cultural beliefs, can result in differential medical treatment and health care. Third, experiences with racism in society and the medical setting can result in stress that negatively impacts health. Lastly, institutional racism in the medical/healthcare system can affect the quality and quantity of health care for minorities.

RACE AND HEALTH

Genes linked to skin color have not been shown to be determinants of disease. Genes "are almost always a minor, unstable, and insufficient cause" of disease (Goodman 2000, p. 1700). Rather skin color (race) is a centrally determining characteristic of obligations and social identity and a determinant of access to desirable resources.

Medical studies include race in the demographic triad of age, sex, and race, where race is considered a biological trait and a predictor of health in the same way as age and sex. It is assumed that any association with the race category is the result of genes, although there is no evidence that genetic markers for race or geographic region of origin are linked to those that determine health. Rather than race being used as a risk factor, it should be viewed as a risk marker. Race is a risk marker for exposure to health risks such as occupational health hazards, environmental toxins, and poor quality of medical care.

From a biological perspective, races do not exist in nature. Human biological diversity does not conform to groups described as races. For example, physical criteria for assignment to racial groups such as skin color, facial features, and hair texture are inconsistent and discordant. That is, a person with blond hair may or may not have blue eyes. Also, there are no qualitative

differences between groups. Rather, one finds a clinal distribution, or overlapping gradients, for traits in nature without boundaries between populations. In any population, individual variability overwhelms group differences. It may seem easy to identify characteristics perceived to represent races, but the differences dissolve when one scans the genome for deoxyribonucleic acid (DNA) hallmarks of race. Data from the Human Genome Project indicate that the percentage of genes contributing to physical differences between populations account for only 0.1 percent of the human genome (Angier 2000). Since there is greater variation within populations than between them, group differences are very small.

Race is a social rather than a biological construct. Characteristics chosen to identify races are subjective and can vary over time and among countries. For instance, race can change between birth and death. In addition, individuals may change their racial classification over time. For example, using NHANES I data, it was reported that 42 percent specified different ancestries at different interviews (Hahn, Truman, and Barker 1996).

The contemporary idea of race is not based in nature or biology but is the product of U.S. colonization and slavery. With increased desire for profits from agriculture, settlers wanted more slaves. And with ideas of freedom and equality written into the Declaration of Independence, a justification and legalization of the institution of slavery and simultaneously a way to legitimize racism, especially institutional racism, was needed. To increase and maintain a large, cheap labor force, the rights of blacks and other people of color were eliminated. A legacy of this chapter in U.S. history is continued beliefs about minorities as diseased populations with lowered mental abilities.

While race is not real from a biological perspective, racism still exists and is harmful. In epidemiological surveillance, medicine, and public health, race as a variable suggests a genetic basis for the differences in prevalence, severity, or outcome of health conditions. This leads readers to assume that specific races have a certain predisposition, risk, or susceptibility to the illness or behavior under study. Since such assumptions are not substantiated, this type of comparison may represent a subtle form of racism because “racial differences in mortality are in all likelihood not due to fundamental biological differences, but are in large part due to racism and discrimination” (Herman 1996, p. 13).

RACISM AND MEDICAL/HEALTHCARE PROVIDERS

Since at least the colonial period, health providers conformed to a model of health that viewed race as a function of biological homogeneity and black-white differences in health as mainly biologically determined. This model is based on the belief that race is a valid biological category and that genes that determine race are linked to those that determine health. Although no scientific evidence supports these assumptions, in the medical community and in public health, a genetic etiology for disease is equated with racial-genetic susceptibility to that disease.

Physicians’ perceptions of patients are influenced by gender, socioeconomic status, and race/ethnicity. These perceptions affect physicians’ behavior in medical encounters. For

example, Wilson et al. (2004) reported that perceptions of unfair treatment in health care varied among medical students and physicians. They found that first-year medical students were more likely to perceive unfair treatment in health care compared to fourth-year medical students, who were more likely to perceive unfairness relative to physicians. The process of acculturation into the medical profession may account for perceptions of unfair treatment. In other words, during the educational process, medical students become less likely to view health disparities as the result of unequal treatment by their peers and the health-care system. Medical students and physicians are less likely to accept the possibility that their peers harbor prejudice and practice discrimination in health care, although physicians are aware that inequalities in treatment exist.

Barbee (1993) argued that racism is unacknowledged in nursing education to avoid conflict and to emphasize empathy, where all patients are treated the same. Also, a nursing population similar to the faculty is perceived as efficient, and nurses are geared toward an individual paradigm that does not focus on societal structures that impact health. She argues that these factors result in racism being ignored in nursing education.

Examination of third-year medical students' perceptions of social and cultural issues in medicine showed a lack of awareness. Canadian medical students either failed to recognize or denied the importance of race, class, gender, culture, and sexual orientation in their medical encounters with patients and colleagues. Those who acknowledged social differences denied social inequality and their own privilege in society (Beagan 2003).

In another study, medical students viewed ethnic groups as discrete and "well defined" groups, and they had difficulty with issues of cultural diversity in medical practice. White medical students did not consider themselves advantaged, were less likely to believe that doctors harbor prejudices, and had problems believing that racism exists in the United States (Dogra and Karnik 2003). Training as a physician, nurse, or other health-care provider does not prepare one to interact with people of other races/ethnicities. Physicians, nurses, and other health-care workers are part of society and subject to the same biases and prejudices that are found in society.

RACISM IN MEDICINE

The previous discussion described the conceptual underpinnings of medical racism. In this section racism in medicine is examined from a structural and institutional perspective. In order for racism to operate in medicine and the medical care system, institutions must collaborate in a systematic way. Carmichael and Hamilton (1967) stated that institutional racism occurs when one or more of the institutions of a society function to impose more burdens on and give less benefit to members of one racial or ethnic group than another on an ongoing basis. Bowser and Hunt (1996) stated that racism is an expression of "institutionalized patterns of white power and social control that were rooted in the very structures of society" (p. xiii). The medical care system is an institution and like other institutions reflects the racial culture of the wider society.

Experimentation. Historically, since blacks were viewed as a separate species that were biologically, mentally, and morally inferior, they were considered appropriate subjects for experimentation. Although the Tuskegee Syphilis Experiment illuminated the enormity of problems in the recruitment of disenfranchised people in medical research, this type of racism has a long history. For example, James Marion Sims, the father of gynecology and president of the American Medical Association (1875–1876), experimented on slave women between 1845 and 1849 in an attempt to find a cure for vaginal fistula. Experimentation on these women was considered acceptable because of their "inhuman" status.

Experiments on disenfranchised people continue into contemporary times. For instance, Jones (1993) and Brandt (1978) examined the Tuskegee Syphilis Experiment (1932–1972) and its sponsorship by the United States Public Health Service (USPHS). From the beginning it was assumed that blacks in Macon County, Alabama, constituted a "natural" syphilitic population. The USPHS believed the study might show that treatment for syphilis was unnecessary for blacks and that existing knowledge concerning treatment for latent syphilis did not apply to them. To the USPHS, syphilis was a different disease in blacks as opposed to whites (Jones 1993). Even in the early 2000s one finds evidence of this logic in medical journals; for example, in 2001 the *American Journal of Surgery* included an article titled "Is Breast Cancer in Young Latinas a Different Disease?"

By the mid-1970s the Department of Health, Education and Welfare (HEW) report suggested that failure to provide penicillin (by 1947 the treatment of choice for syphilis) was the major ethical problem with the study, but Brandt (1978) suggested that lying to the men about treatment was the major problem. The fact that a comparative sample of whites was not included in the research design shows the racial orientation of the USPHS. Nothing scientifically useful resulted from this experiment.

Racial underpinnings of this experiment are shown by the fact that the study was widely reported for almost forty years without evoking widespread protest within the medical community and at the USPHS (Brandt 1978). Examples of these publications include: *Environmental Factors in the Tuskegee Study of Untreated Syphilis* (Public Health Reports 1954); *Untreated Syphilis in the Male Negro; Background and Current Status of Patients in the Tuskegee Study (Journal of Chronic Disease* 1955); and *The Tuskegee Study of Untreated Syphilis: The 30th Year of Observation* (Archives of Internal Medicine 1964).

Access to Health Care. A number of epidemiologic studies reported differences in access to health care and differential treatment based on race. Giachello (1996) examined the sociodemographic disadvantages of Latinos in the United States, especially women. Latina access to health care is restricted by lack of health insurance, white male orientation of health services, institutionalized sexism and racism, and the inability of the medical system to recognize and adapt to the needs of the poor and those of diverse cultures and languages.

Numerous studies report differences in recommendations for specific medical treatments by race and sex of patient. After adjustment for clinical status and health insurance, whites were more likely than blacks to receive coronary angiography, bypass surgery, angioplasty, chemodialysis, kidney transplants, and intensive care for pneumonia. Blacks and women were

less likely than whites and males to receive cardiac catheterization or coronary-artery bypass graft surgery when they were admitted to the hospital for myocardial infarction or chest pain. Although blacks and whites had similar hospitalization rates for circulatory disease or chest pain, whites were one-third more likely to undergo coronary angiography and were twice as likely to receive bypass surgery or angioplasty. This disparity persisted after controlling for income and severity of disease (Wenneker and Epstein 1989).

In a study of physicians, Schulman et al. (1999) found that women and blacks were less likely to be referred for cardiac catheterization than men and whites, respectively. The authors suggested that the race and sex of a patient independently influenced the decision-making process for physicians' management of chest pain. In other words, after adjustment for symptoms, the physicians' estimates of the probability of coronary disease and perceptions of the personalities of the patient, along with clinical characteristics, race, and sex, still affected the physicians' decisions about whether to refer patients with chest pain for cardiac catheterization. This suggests a bias on the part of the physician that may represent overt prejudice or subtle racism.

Individual racism can operate as aversive or subtle racism when individuals of the dominant group unknowingly or without intent express prejudice and discrimination against subordinate groups. Prejudice, negative stereotypes, ethnocentrism, and discrimination can be incorporated into individual racism, the negative attitudes and behaviors expressed by members of the dominant group toward the minority group. With this type of racism individuals believe that biological traits are determinants of morality, intellectual qualities, social behavior, and health. Ultimately, it is assumed that biological differences are a legitimate basis for differential treatment.

BIOLOGICAL CONSEQUENCES OF RACISM

Stress. The state of stress alerts physiological mechanisms to meet the challenge imposed by stressors (stimuli that produce stress). One of the first responses to stress is an increase in sympathetic activity. Sympathetic fibers innervate blood vessels and stimulate the secretion of epinephrine, which increases blood sugar, blood pressure, and heart rate. Denial of racism, experiences with racism, and acceptance of racist ideology may serve as stressors that adversely impact mental and physical health.

Numerous studies show a positive association between racial discrimination and mental distress. Racism can lead to self-hatred and impact how individuals view themselves relative to the dominant group. For instance, experiences with discrimination, as measured by being Mexican American, have been associated with depression.

Racial discrimination is related to decreased measures of personal life satisfaction and more psychological distress. Using data from the National Survey of Black Americans, Jackson et al. (1996) found that unfair treatment because of race was inversely related to subjective measures of well-being. Perceived racism (whites want to keep blacks down) was associated with increased psychological stress and lower levels of subjective well-being. Perceived racism and

discrimination resulted in poorer mental health but over time better physical health. They posit that life satisfaction and psychological distress are transitory and situational, whereas physical health problems are chronic with intervening and mediating factors that modify the relationship between racism and health. For instance, those who perceive whites as "holding blacks down" may be more vigilant about their own physical health. Alternatively, recognizing racism and discrimination may be a protective mechanism for combating stress related to racism (Jackson et al. 1996).

Studies indicate that racial discrimination is associated with increased cardiovascular responses (CVR). Exposure to and attributions of racial discrimination can increase CVR and maintain a heightened CVR among African Americans. Racist stimuli have been associated with significantly elevated CVR among African Americans. In another study, African Americans who viewed racist scenarios had increased electromyography (EMG) and heart rates (Sutherland and Harrell 1986; Jones et al. 1996).

Numerous studies show a relationship between racism and blood pressure. For instance, denial of racism may lead to higher blood pressures. Black women who did not report discrimination and who were passive when treated unfairly may have higher blood pressures, but those who reported discrimination may have lower pressures (Krieger and Sidney 1996). In another study, African Americans who viewed scenes of racial harassment by white police officers had elevated systolic and diastolic pressures (Morris-Prather et al. 1996). James and colleagues (1984) found higher diastolic pressures among successful black men who worked hard to overcome obstacles, their race (John Henryism), compared to those who saw their race as helpful. These studies indicate that experiences with racism can impair the cardiovascular system.

Aversive racism, a subtle form of racial discrimination, commonly experienced by blacks, was examined in a laboratory stress test. Black men who perceived aversive racism had higher systolic and diastolic blood pressures compared to those who did not acknowledge racism and those who considered it a blatant form of racism. Since blacks show more vascular responses to laboratory stressors, these situations, aversive racism, may be important in black-white disparities in CVR. It is also important because blatant forms of racism are giving way to more subtle forms in U.S. society.

Dressler (1993) suggested a social structural model to explain health inequalities. This model incorporates the concept of incongruence. For example, in a study of African Americans, variation in skin color was used as a proxy for socioeconomic status, where it was hypothesized that darker skin color is equated with lower social class regardless of education or lifestyle. He found that African Americans with darker skin color had higher blood pressures than lighter-skinned blacks. He theorized that this was the result of incongruence, where darker-skinned blacks with a high-status lifestyle have more negative interactions because they are not treated in a way commensurate with their social status (Dressler 1991).

Amputation. A variety of studies indicate an association between race/ethnicity and lower extremity amputation. For instance, the NHANES Epidemiologic Follow-up Study (1971–1992) found that while blacks were 15.2 percent of the cohort, they were 27.8 percent of the subjects with amputations (Resnick et al. 1999). In a national study of veterans, being black and Hispanic

were independent risk factors for lower extremity amputation after controlling for atherosclerosis in veteran patients with peripheral artery disease (Collins et al. 2002).

Organ Transplants. Racism is found in patterns of organ donation. Blacks wait for a first kidney transplant twice as long as whites. In a review of patients who received long-term dialysis in the United States, nonwhite dialysis recipients were two-thirds less likely as white patients to receive a kidney transplant. Also, whites were disproportionately on waiting lists for transplants. Many observers believe that there is a two-tiered health-care system.

HEALTH CONSEQUENCES OF MEDICAL RACISM

Health disparities between minorities and the majority population in the United States are well documented. Such health gaps are demonstrated in, for instance, higher mortality rates among blacks than whites in the United States. In 1900 the life expectancy at birth for whites in the United States was 47.6 years compared to nonwhites (mainly blacks), who had a life expectancy at birth of only 33 years. Life expectancy at birth for black men in 1992 was 65.5 years compared to 73.2 years for white males. For black and white women the figures were 73.9 years and 79.7 years respectively.

Health disparities between whites and other minorities continue to exist. Death rates for heart disease are more than four times higher for African Americans than whites. Hispanics are almost twice as likely to die from diabetes as non-Hispanic whites. While Asians and Pacific Islanders are among the healthiest populations in the United States, there is great diversity within these groups. For example, women of Vietnamese origin suffer from cervical cancer at nearly five times the rate for white women (National Center for Health Statistics 1999).

Medical racism is based on stereotypical folk beliefs about minority groups that have been socially transmitted from one generation to the next. Those who use genetics to explain health disparities between groups ignore alternate explanations. Race/ethnicity should be used to understand individuals' lived experience. It is a risk marker for life experiences and opportunities as well as access to valued resources. Medical racism is the antithesis of the medical motto: First, Do No Harm.

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By Janis Faye Hutchinson

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