Anna Klein

Professor Little and Dr. Stannard

HN-300-C

22 March 2021

The Role of Structural Racism in Defining the Treatment of Minorities, Especially Black Americans, as Physicians and Patients in Healthcare

The summer of 2020 brought up a flurry of issues that our shook our society and forced many civilians to begin calling for reform and justice. Not only was the entire world in the midst of a pandemic that revealed major cracks in the healthcare system, but racial inequities were brought to light in a way that they had not since the Civil Rights Movement. Two major figures in igniting this movement were Black Americans George Floyd and Breonna Taylor who were both murdered by law enforcement officers (Baptiste et al 2020). Their deaths, along with the growing tension of race relations in the United States created an uproar of conversations regarding racism and white privilege that could no longer be avoided. Racism is defined as "prejudice, discrimination, or antagonism directed against a person or people on the basis of their membership of a particular racial or ethnic group" ("Key Definitions" 2019). This discrimination is extremely prevalent in the United States and has left any non-white members of society at an immediate disadvantage solely due to the color of their skin. One of the most prominent disadvantages non-white civilians face is health status. The five recognized categories of determinants of health are social environment, biology and genetics, physical environment, individual behavior, and health service (Yearby 2020). Of these five factors, black Americans are disadvantaged in every single

one (Louis et al 2015). The unequal access to healthcare is extremely concerning because almost every citizen must rely on the medical field at least once in their life. In the current climate that society is in dealing with a pandemic, the imbalance in access is entirely unjust. It has been repeatedly found that Black Americans are treated differently to white Americans in regard to healthcare. This pertains to both minority patients as well as minority physicians (Nunez-Smith et al 2007, Synder and Schwartz 2019, Tajeu 2018, Yearby 2018, Baptiste et al 2020). In addition to unequal access, this differential treatment causes much room for concern because of the multitude of issues that it causes down the road. The black population in the United States has higher mortality rates, earlier onset of many diseases (often with more severity and progression), as well as an immense increase in stress and decrease in mental health status in comparison to the white population (Cockerham 2017). These outcomes cannot be pinpointed to one particular cause of racism, as it is clear that it is present in many aspects of society, however racial discrimination in the medical field plays a large role in these consequences. Although there are policies in place to combat racial discrimination in healthcare, these measures are not enough as structural racism has deep roots in the medical field leading to disparities in access, large gaps in infant and maternal mortality rate, treatment of physicians, and implicit biases still present that allow for this unacceptable mistreatment.

It is difficult to find the exact cause that led to the disparities in healthcare that we see today, however the most likely root of this problem is the structural racism that is present in the United States. This is due in part to the failure of the U.S. Government in implementing Civil Rights Laws. This failure has given Caucasians advantages in society in regard to wealth, employment, income, and healthcare, all of which shape the everyday lives of citizens and impact their outcomes in life. These advantages for those that are positively impacted by this structural

racism also have severe repercussions for those that are on the other end of the spectrum. This is extremely significant when proven that the largest overall factor in health outcomes for blacks and other minorities is not their biological buildup, but rather their socioeconomic status (Cockerham 2017). There is not some magical biological advantage that has given white citizens a longer lasting lives and a lesser chance of chronic disease, but it is truly their white privilege and advantages in society that has granted it to them. Aspects such as poverty, marginal employment, low incomes, segregated living conditions, and unequal education are consistently found to be socioeconomic factors that are more prevalent in the lives of black citizens when compared to whites. Not only that, but these factors are known to cause poor health. Black Americans living in poverty are often living in neighborhoods that are overwhelmed with crime, danger, public drinking as well as drug use, and incivility. These components become daily stressors in the lives of both adults and children that are facing it every day which promote risk behaviors in order to cope. These risk behaviors include smoking, alcohol intake, and excess weight and obesity which leads to high blood pressure, high cholesterol levels, and diabetes (Cockerham 2017). These socioeconomic disadvantages had the ability to be decreased and for conditions to improve for black citizens in part with the Civil Rights Movement, however the effort from the government was not nearly adequate enough. Title VI of the Civil Rights Act of 1964 was created in order to conclude the "separate but equal" access of Black Americans to healthcare, but federal funding was extremely limited at the time and so not much change could be brought about immediately. This changed in 1965 with the authorization of Medicare and Medicaid which was able to greatly increase federal funding to healthcare entities. This desegregation of hospitals helped decrease infant mortality rates among African American women for a short period of time, however in the long run not much else was improved. Title VI is essential in order to prevent the discrimination of patients

based on race, color, and national origin for programs that are receiving federal funding, however it was not enforced nearly enough. Because the federal government failed to apply Title VI to healthcare providers many physicians were still able to discriminate patients based on their race (Yearby 2018).

The sociological theory of structural functionalism is found to heavily conflict with the factors mentioned above. This theory states that the glue of society can be considered harmonious patterns of shared norms and values, and it is believed that proper civilians will act based on these values, therefore maintain a society that is in equilibrium. The poverty and risk factors faced by black Americans can be considered "dysfunctional" because they disrupt the social order of society. This theory is a major issue because it is essentially saying that those who are placed in poverty, and as a result engage in risk behaviors, deserve to be punished and potentially placed in jail in order to maintain societal stability. However, when it is observed that structural racism is the key factor to these risk behaviors, it is found that these deviant behaviors are not a choice but rather a lifestyle many black Americans were never able to escape (Cockerham 2017). Increased risk behaviors in addition to the failure of the government to enact Title VI conflicts against this theory. In no way should physicians be able to discriminate against patients without retribution by this "equilibrium," however it is still occurring due to the improper enactment by the government. This has led to less African Americans seeking out healthcare out of fear of discrimination as well as factoring into the disparities in access to healthcare.

Income and employment play large roles in the access of black Americans to quality healthcare because of the structural racism in place. White Americans have many advantages in the workforce as far as getting hired and being considered for jobs that are not classified as "low-wage." These higher quality jobs permit for employer-sponsored health insurance. Insurance plays

a massive role in health status because uninsured adults are more likely to be under-treated as well as rely on home health in order to avoid medical bills (Williams and Rucker 2000). These factors may cause even more stress and tension within their lives. This difference in insurance is concerning because among adults it was found that 52% of African Americans have avoided seeking healthcare due to lack of insurance and fear of costly treatment (Yearby 2018). For the uninsured patients that decide to seek medical attention, they have a 25% higher mortality rate from trauma injuries in comparison to insured adults receiving any kind of treatment (Yearby 2018). These patients are not treated with equal care and attentiveness as it has been found that uninsured patients experience delays in treatment as well as fewer diagnostic tests. While some uninsured civilians avoid hospitals entirely, those that seek professional help are mistreated as well and, in both instances, uninsured patients suffer unnecessary deaths.

Insurance does play a large role in the treatment of patients; in addition, it must also be noted that the access of the treatments is extremely disproportional as well. This is due in part to the location of hospitals as well as the funding of these hospitals. It was found that as the percentage of African Americans residents increased in a neighborhood, so did the amount of hospital closures or relocations. Of hospitals that were opened in 1970, 45% of those hospitals closed by 2010, and of those that closed 60% were located in neighborhoods with a majority African American population (Yearby 2018). The closure of hospitals puts more pressure on the remaining locations to provide for the community, however both the lack of funding and resources in comparison to demand for quality treatments leads to these hospitals gradually deteriorating their care. When this begins to happen, “physician flight” in turn takes place and the quality of healthcare is lowered even more. Physicians begin to leave these hospitals to avoid the inevitable closure or relocation, and many patients are left to rely on either emergency rooms or public

hospitals, both of which are usually understaffed and provide sub-par treatments (Yearby 2018). The combination of minimal to no insurance paired with continual closure of hospitals, that in and of themselves are low-quality, leads to massive differences in the overall health of minority patients (Cockerham 2017). This is not a minor coincidence, but rather blatant structural racism baring its ugly teeth in the American society. Time and time again, black Americans are treated as if they are less worthy of a quality life, without ever being given a reason why besides the color of their skin. Experiencing this type of explicit racism causes extensive damage on the mental and physical health of minority civilians that are continually exposed to it, as does the implicit racism that also takes place within the healthcare field (Baptiste et al 2020, Yearby 2018).

The study of implicit bias corresponds with social psychology and is defined as the "assumption that our unconscious negative and positive associations with people of different races are formed through various processes of socialization and can correspond with and impact our conscious race-based interactions" (Kempf 2020, 115). Implicit biases are extremely dangerous and harmful to society in part because many people are entirely unaware of their existence at all, and consequently are not putting in an effort to mitigate their effects. These implicit biases start from a young age in media that coined the "Bad is Black" effect which forces a negative connotation with dark skin. As a result, it has been found that African American boys under the age of 11 are more likely to have their age overestimated, to be believed to be guilty of a crime, as well as being more likely to be victims of police violence when being accused of criminal behavior in comparison to white boys under the age of 11 (Kempf 2020). These implicit biases and immediate associations connect to the fundamental attribution error of sociology in which treatment of minorities is based on stereotypes rather than actual evidence of improper behaviors (Cockerham 2017). Associations like those listed previously cause implicit biases to alter the way

humans treat people of other races and cause considerable effects on the way minorities are treated in healthcare.

An overwhelming 22 percent of African Americans avoid seeking healthcare in fear of racism, while an even greater 32 percent describe an experience in which they have personally been discriminated against while at a physician or health clinic (Yearby 2018). The assumption of racist treatment taking place during a healthcare visit stems from the implicit biases that many physicians today are still carrying with them which cause differences in treatment plans between white and black patients. A survey was conducted regarding physicians' and their perceptions of patients which found that physicians had natural and automatic negative judgements of African American patients, without any specific reason for these criticisms. These physicians' classified African Americans as less intelligent, less educated, as well as less likely to comply with medical advice received from physicians in comparison to white patients (Yearby 2018). While this is a massive issue in society, it directly alters the treatments received by African Americans. A repeated study found that physicians that displayed prejudices towards African American patients were then less likely to recommend medically necessary coronary bypass surgery for black males in comparison to white males (Yearby 2018). As it has been shown that heart disease is the number one cause of death for Black Americans, these findings are not shocking (Cockerham 2017). Both of these findings led to even further research that physicians did in fact subconsciously favor white patients over black patients. While physicians stated that they were not explicitly biases, most of them, regardless of race or ethnicity, displayed implicit negative biases towards African Americans. Once again, this is a large finding because it has been found that the stronger the implicit bias from a physician, the less likely they are to recommend pertinent medical treatment in regard to African American patients for heart attacks (Yearby 2018). The hearts of African

Americans are quite literally being ripped apart by both society and the healthcare industry from these implicit biases that lead to racial discrimination in their treatments. It was found that by 2002, if African American death rates were equivalent to those of Caucasians, an estimated 83,570 African American lives would have been saved (Yearby 2018). This differential in death rates has not ceased since then. Although there is effort being put forth to try and create equal access to healthcare for non-white Americans, but these measures on their own are simply not enough. In addition, physicians hold staff privileges in which they can require large deposits before admitting civilians for inpatient care. This automatically puts many Medicaid and Medicare patients at a massive disadvantage and prevents them from receiving proper treatment (Williams and Rucker 2000). Black Americans will still experience these high death rates because of the structural racism in society that puts them at a higher risk for these diseases which ultimately lead to their deaths. While the overall death rate of black Americans compared to white Americans is considerable, it is even more shocking when viewing the maternal and infant mortality rates.

The disparities in maternal mortality rate are a firsthand example of the structural and systemic racism that is present within the healthcare. According to the CDC, in 2018, black women were found to have died at 3.3 times the rate of white women in pregnancy-related deaths (Martinovich 2020). This stems from a twofold issue, firstly, black women are more likely to be mistreated by physicians as explored previously, and secondly, black women have much higher exposure rates to preconception risk factors. The treatment received by black mothers is sub-par at best. It has been reported that black women are given less involvement in decision-making, experience lower quality communication from healthcare workers, and commonly experience more racial discrimination during healthcare visits (Bapstiste et al 2020). Black women are repeatedly dismissed and neglected by healthcare professionals from due to implicit biases from

healthcare professionals. These professionals are consistently failing black women and causing unnecessary deaths of young mothers, in turn causing even more stress in the lives of many. The chronic stress that black women experience is intense due to repeated exposure to discrimination regarding their race as well as gender. Because of structural racism, many black women are exposed to stress early in life later causing many possible risks in their pregnancies. The most common preconception risk factors include obesity, diabetes, hypertension, alcohol intake, and smoking which all have the ability to alter maternal results. In comparison to any other ethnic group, it has been found that black women have the highest rates of obesity (Baptiste et al 2020). Not only are black women facing obstructions in their biological health, but they also face challenges from society as well.

Black women are more likely to be uninsured when compared to white women (Baptiste et al 2020). As mentioned previously, this stems from society and opportunity for income, however it is especially important when looking at these mortality rates because black women are not able to get the proper prenatal care that is needed to have a healthy birth. Prenatal care plays a key role in pregnancies and often leads to a much more high-risk pregnancy. This is especially relevant because black women are 9.9 times more likely to die from these high-risk pregnancy complications compared to white women (Louis et al 2015). In addition to this, maternal mortality rates in the deep South mimic the same rates as sub-Saharan Africa. This fact is found to be even more disturbing because in those same areas, the mortality rates for white women are near zero ("How racism" 2016). The previously mentioned staff privileges of physicians also gives them the ability to deny delivering the babies of some mothers based on their prenatal care. Because many of these black mothers cannot receive proper prenatal care under Medicaid, they are rejected from hospitals and left to find another location to deliver their child (Williams and Rucker 2000). This

has the potential to put both the mother and child at even further risk. By black women experiencing such cruelty and discrimination throughout their lives, their health is put at risk which in the terms of a pregnancy puts their infants at risk as well. Black infants have around twice as high infant mortality rate in comparison to white infants (Cockerham 2017). Both infant and maternal mortality rates are higher among the black population because of the structural racism that prevents them from receiving or accessing proper care and treatment from medical professionals during both pregnancy and postpartum. While many of these healthcare workers discrimination against black patients, it must also be noted that many patients discriminate against black healthcare workers (Nunez-Smith et al. 2007).

Having a diverse workforce in hospitals that reflects the makeup of the United States is essential in ensuring equal treatment for patients of any race and depleting the disparities found above. While this is ideal, it is also extremely difficult because of the discrimination that non-white healthcare workers face. Many black physicians are constantly reminded of their race and while some of these experiences can be positive, there are many negative interactions as a result of their skin color. This pertains to the group identity of ethnocentrism which contains both in-group and out-group. On one hand, many of the in-group interactions of minority physicians with other minority patients are extremely beneficial due to the deep connection and sense of belonging many feel based on race. However, negative experiences stem from many out-group interactions for both minority patients and physicians when in contact with white Americans due to the structural racism in place that gives Caucasians the constant upper hand and feeling of superiority (Cockerham 2017). Positive experiences are extremely difficult for most physicians to come by, however at times they can play a helping hand in patient care. Race allowed for the creation of trust, rapport, and communication among minority physicians with minority patients (Nunez-Smith et al 2007).

These interactions are key in building a healthcare system that values patients to the utmost degree and in which no civilian is treated unfairly because of the color of their skin. By having these in-group connections between patients and physicians, it strengthens society because black Americans will be less likely to avoid treatments out of fear for discrimination. In addition, black physicians are given a surge of energy in continuing their work towards diminishing racial discrimination in their workplace. The feeling of appreciation and acceptance in the workforce has numerous beneficial effects on the lives of minority workers (Snyder and Schwartz 2019).

On the other hand, negative experiences cause extreme distress in the lives of minority physicians. This includes feeling devalued and isolated, being casted into race-defined roles, and being held to much different performance standards than white colleagues. A national survey found that just over 70 percent of black physicians state that they have experienced racial discrimination in their workplace (Yearby 2018). The most direct form of racism that many physicians face is the complete rejection and refusal by patients to be treated by them. In a study, many black physicians reported that they were called racial slurs or rejected by patients because they assumed the doctor would not do a proper job because of their race. This type of repetitive mistreatment of non-white physicians is entirely unacceptable. The same study also found that the feeling of isolation resulted from consistently being mistaken for maintenance, housekeeping, or food service employees. While that is a massive issue in and of itself, these mistakes were made by both patients and coworkers alike. Many physicians of African descent also felt that they were held to higher standards than their white counterparts and that their hard work was hardly acknowledged or ignored entirely (Nunez-Smith et al 2007). In all of these cases, the blatant racism taking place is heartbreaking and demeaning. Out-group situations like these are what shy many black and minority Americans from pursuing careers in white dominated field professions in which

their race is a constant factor in how they are perceived by others. While many physicians of color believe in themselves and uphold the belief that they belong in their career, the constant effort of reminding themselves of their worth is draining. Racial fatigue commonly takes place among minority physicians which leads many physicians to have feelings of professional dissatisfaction as well as a complete change in their career trajectory. These changes in careers were done in order to find healthier and more supportive work environments (Nunez-Smith 2007). Not only are physicians experiencing racism directed towards themselves, but around 62% of physicians were found to witness a patient receive poor healthcare treatment due to their race or ethnicity (Yearby 2018). Overall, these factors diminish the mental health of the physicians on the receiving end and take a serious toll on their mental health.

The treatment of minority civilians in the healthcare industry is entirely unacceptable as racial discrimination is still running rampant. This discrimination embeds itself in structural racism and appears in many aspects of healthcare like disparities in access, large gaps in infant and maternal mortality rate, treatment of physicians, and implicit biases that cause differences in treatment. While some policies are in place to defeat the endemic of racism in the United States, they are not nearly enough. More conscious effort and work needs to be put forth by society in order to improve the lives of those on the receiving end of this racism and discrimination, specifically in the healthcare field. To address disparities in access to healthcare, the federal government needs to enact Title VI to halt the racially based closure of hospitals in black dominated communities. This can be done by state and federal regulators further reviewing plans that intend to close or relocate high-quality healthcare facilities to majority white neighborhoods. This extra review will force hospitals to observe the destructive results these closures and relocations have on the black community and ensure they realize the racism behind their desires

(Yearby 2018). To address the disparities in treatment of patients because of implicit biases, the government needs to cease funding and supporting racial discrimination that is found in the healthcare system. This can be done by ensuring everyone that is accepting federal funds under the Medicare and Medicare Acts is consistently adhering to Title VI. If they are not willing to comply, the government needs to enact penalties and fines upon the opposing parties, specifically medical professionals. They can be held accountable by defining physicians and all healthcare professionals as healthcare entities and therefore ensuring that if they do not provide equal care to patients based on race, they will be held legally responsible (Yearby 2018). In order to diminish the unfair racial treatment experienced by both minority physicians, hospitals should be required to review the policies and practices of the institution for both racial prejudice and discrimination. It would be beneficial to physicians to directly confront their implicit biases, towards colleagues and patients, by going through reeducation methods which has proven to help unlearn automatic and implicit prejudices (Kempf 2020). In addition, hospitals should be more willing to openly discuss and address racial tensions in the workforce to prevent the belittlement of minority healthcare workers. This will strengthen the field as a whole by promoting equality and making everyone feel part of a united team, rather than a sense of divide (Nunez-Smith et al. 2007, Snyder and Schwartz 2019). To address the disparities in maternal and infant mortality rate, there should be greater access to insurance through the Affordable Care Act (ACA) as well as an extension in Medicaid coverage. By expanding access to insurance, more women will be able to receive prenatal care and postpartum visits and therefore the chances of pregnancy-related complications will reduce as will maternal mortality. By extending the length of Medicaid coverage from 6 weeks to 12 months postpartum, maternal mortality and infant mortality will decline, as it has been found to do so in states that have already enacted this order. In addition to these movements, the initial

risk factors faced by black women must also be confronted as those health issues cause immense obstacles in their pregnancies in general (Louis et al 2015). Racial discrimination in the healthcare field, due to structural racism, is the cause of an immense number of unnecessary deaths. The disparities in treatment for minority physicians and patients is despicable, however it is not a lost cause. By implementing new policies, holding racist physicians accountable for their actions, and giving black women the proper access to pregnancy care, there can be a change and it is most definitely worth fighting for.

I would like to thank Professor Lilley for his guidance in helping me write my paper.

Works Cited

Baptiste, Diana-Lyn, et al. "Racial discrimination in health care: An 'us' problem." *Journal of Clinical Nursing*, vol. 29, nos. 23-24, 16 Aug. 2020, pp. 4415-17. *Wiley Online Library*, doi:10.1111/jocn.15449. Accessed 21 Feb. 2021.

Cockerham, William C. "Race." Afterword. *Medical Sociology*, 14th ed., New York, Routledge, 2017, pp. 101-13.

"How racism harms pregnant women - and what can help." *TED*, uploaded by Miriam Zoila Pérez, TED Conferences, 2016, www.ted.com/talks/miriam_zoila_perez_how_racism_harms_pregnant_women_and_what_can_help/transcript. Accessed 1 May 2021.

Kempf, Arlo. "If We Are Going to Talk About Implicit Race Bias, We Need to Talk About Structural Racism." *Taboo: The Journal of Culture and Education*, vol. 19, no. 2, Spring 2020, pp. 115-29. *Education Research Complete*, eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=4&sid=d6c26c83-2514-4bf9-a768-7abecfbdb6b2%40sessionmgr102. Accessed 23 Mar. 2021.

"Key Definitions." *Delmarva*, COG Delmarva-DC, 2019, www.cogdelmarvadc.com/definitions. Accessed 1 May 2021.

Louis, Judette M., et al. "Racial and Ethnic Disparities in Maternal Morbidity and Mortality." *Obstetrics and Gynecology*, vol. 125, no. 3, Mar. 2015, pp. 690-94. *The American College of Obstetricians and Gynecologists*, doi:10.1097/AOG.0000000000000704. Accessed 24 Mar. 2021.

Martinovich, Milenko. "Reversing the Tide of Black Maternal Mortality." *Science of Caring*, July 2020, pp. 1-2. *CINAHL Complete*,

eds.b.ebscohost.com/eds/detail/detail?vid=6&sid=d6c26c83-2514-4bf9-a768-7abecfbdb6b2%40sessionmgr102&bdata=JnNpdGU9ZWRzLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=145144379&db=ccm. Accessed 23 Mar. 2021.

Nunez-Smith, Marcella, et al. "Impact of Race on the Professional Lives of Physicians of African Descent." *Annals of Internal Medicine*, vol. 146, no. 1, 2 Jan. 2007, pp. 45-52. *MEDLINE with Full Text*, doi:10.7326/0003-4819-146-1-200701020-00008. Accessed 22 Feb. 2021.

Snyder, Cindy R., and Malaika R. Schwartz. "Experiences of Workplace Discrimination among People of Color in Healthcare Professions." *Journal of Cultural Diversity*, vol. 26, no. 3, Fall 2019, pp. 96-107. *CINAHL Complete*, eds-b-ebscohost-com.sacredheart.idm.oclc.org/eds/detail/detail?vid=5&sid=c8c5050e-d4d2-48f8-8094-1d69dca88a44%40pdc-v-sessmgr04&bdata=JnNpdGU9ZWRzLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#AN=139005697&db=ccm. Accessed 19 Feb. 2021.

Tajeu, Gabriel S., et al. "Exploring the Association of Healthcare Worker Race and Occupation with Implicit and Explicit Racial Bias." *Journal of the National Medical Association*, vol. 110, no. 5, Oct. 2018, pp. 464-72. *ProQuest*, doi:10.1016/j.jnma.2017.12.001. Accessed 19 Feb. 2021.

Williams, David R., and Toni D. Rucker. "Understanding and Addressing Racial Disparities in Health Care." *Health Care Financ Rev*, vol. 21, no. 4, Summer 2000, pp. 75-90, www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/. Accessed 1 May 2021.

Yearby, Ruqaiijah. "Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism." *The American*

Journal of Economics and Sociology, vol. 77, nos. 3-4, May-September 2018, pp. 1113-52. *Gale Academic OneFile*, DOI:10.1111/ajes.12230. Accessed 20 Feb. 2021.

---. "Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause." *Journal of Law, Medicine and Ethics*, vol. 48, no. 3, Sept. 2020, pp. 518-26. *Criminal Justice Abstracts with Full Text*, doi:10.1177/1073110520958876. Accessed 2 Apr. 2021.