“Racial Disparities in the Medical Field”

An Honors Thesis

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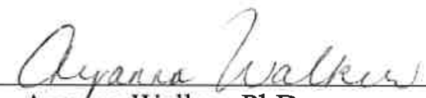
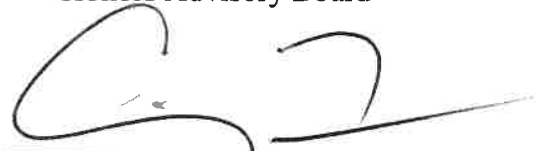
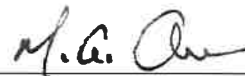
11-16-20	 Ayanna Walker, PhD Honors Advisory Board
11-16-20	 Craig Fox, PhD Associate Director, Honors Program
16 November 2020	 M. G. Aune, PhD Director, Honors Program

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Abstract

In an evolving social climate, racial disparities highlight flaws within systems that citizens once believed to be beneficial. Recently, attention shifted to health care and the unfair disadvantages targeting minorities. This paper focuses on the issues, effects, and possible solutions to medical discrepancies. Prevalent gaps between ethnic groups with respect to treatment, mortality rate, and treatment cost; results in minorities harboring a negative perspective of medical professionals. In addition to the lack of proper care minorities receive, adverse attitudes toward health care further bolster health complications that result in unfavorable statistics (HealthyPeople.gov, 2020a). The unsavory experiences reported by minorities perpetuate distrust for medical professionals, cultivating tension and fear between the provider and the patient. By analyzing sources, the paper will discuss how unrecognized bias affects treatment and how it further preserves racism. Cases in which improper care resulted in dire consequences will also be used within the paper to support the intentions of the main idea. The paper will conclude with programs and activism groups that have taken steps to reduce racial disparities in health care.

Introduction

A disparity is defined as a great difference (Merriam-Webster, n.d.). Within the medical field, disparities exist in the form of disproportionate diagnoses and mortality rates between races and ethnicities. This paper discusses the reasons that these disparities exist, the effects of the disparities, cases of medical discrepancies between races, and solutions and advocacy groups for medical reform.

The 1985 Report of the Secretary's Task Force on Black and Minority Health, organized by the Center for Disease Control and Prevention (CDC), emphasized the importance of making race-centered health disparities a priority, recommending solutions. The necessity for a movement dates back to 1950 when the mortality rate for Black infants was estimated to be twice as high when compared to White infants. Additionally, during the mid-1980s it is reported that when compared to non-Hispanic Whites, Mexican Americans were 2.8 times more likely to be uninsured. Furthermore, analyzing rates of death from unintentional injuries reveal that Native Americans rates reached significantly higher numbers than other U.S. populations during the mid-1980s (CDC, 1993).

Causes

Identifying and understanding social determinants of health is necessary to acknowledge the relationship between population experience and the impact of place on social and physical health. HealthyPeople.gov is a task force within the Office of Disease Prevention and Health Promotion (ODPHP) and the U.S. Department of Health and Human Services. They utilize social determinants and other criteria to provide

public health objectives over a ten year period. Social determinants of health include: availability of resources to meet daily needs, access to health care services, quality of education, transportation options, social norms and attitudes, socioeconomic conditions, access to mass media, and culture. Physical health determinants include: natural environment, built environment, housing and community design, exposure to toxic substances, physical barriers, and aesthetic elements. Varying combinations of these elements affect health within communities (HealthyPeople.gov, 2020b). Healthy People 2020 coordinated a structure demonstrating five crucial areas of social determinants of health: economic stability, education, social and community context, health and health care, neighborhood and built environment. Each area mirrors leading concerns that constitute underlying components of social determinants of health.

It is important to analyze the social aspect of interracial interactions. The causes of these differences range from explicit to implicit, ingrained, institutionalized, and intentional or unintentional. Dovidio and Fiske (2012) analyzes the psychological perception between patient and provider as one facet for imbalanced medical treatment. The article states that a primary meeting between patient and provider triggers two adaptive questions. The first question focuses on the cooperative intentions of the other person. Cooperation solicits a feeling of warmth, whereas defiance comes across as cold. The second question leads the perceiver to determine whether the other can execute their positive or negative intentions. Perceived status influences inference of competence. High status equates to competence and vice versa. The combination of these two dimensions centrally govern individual reaction to others. This philosophy is further perpetuated when medical mistrust presents itself between patient and provider.

The expectation from doctors that their Black patients are more likely to be less knowledgeable and less active results in a lower likelihood for doctors to prescribe effective medical treatment than what is given for White patients, such as in cases of coronary bypass surgery (Dovidio & Fiske, 2012).

During a vignette study by Green, et al. (2007), prospective physicians were tested for their implicit and explicit bias. Actions and behaviors performed at a conscious level are categorized as explicit bias, whereas implicit bias is demonstrated in an unconscious mind. Using an Implicit Association (IAT) test, internal and emergency medicine resident participants from four academic medical centers in Atlanta and Boston were tested for implicit bias. 287 participants received randomized clinical vignettes of Black or White patients. The IAT used in this study was structured using a photo of a Black or White patient with neutral facial expressions. The participants were then asked to rate the likelihood of coronary artery disease (CAD) when the hypothetical patient arrives with complaints of chest pain. They were also asked whether they would prescribe thrombolysis treatment, and the firmness of their suggestion.

Additional questions regarding negative and positive associations with each respective race were presented in a rapid manner. Rapid testing reduces the chance of the participant second-guessing their choice. This way, the results reflect their implicit bias that occurs without conscious thought. To test explicit bias, the survey asks the participants to rate on a scale whether they prefer Black or White Americans, their feelings of warmth toward each group independently, and the belief of Black and White cooperative nature with respect to medical procedures. The end of the survey

asks participants about the demographics of their region, thrombolysis effectiveness, and pre- and posttest opinions regarding unconscious bias and IATs. When analyzing the explicit bias, respondents indicated impartial preference on a five-point scale and equal measures of warmth on a ten-point scale for Black and White Americans. The participants also recorded equal cooperative behaviors for Black and White patients with respect to medical procedures. Queries on general cooperativeness resulted in the same equal measurements. With respect to implicit bias, the IATs reported that participants demonstrated substantial association of negative attributes to Black people than to White people. Further analysis of responses revealed that implicit bias influenced treatment decisions with respect to the thrombolysis treatment for the hypothetical patient. When graphing for correlation, the increase in antiblack bias resulted in decreased thrombolysis treatment for Black patients (Green, et al., 2007).

In addition to bias and stereotype, inaccessible health care contributes to racial health differences. Communication often breaks down and access to appropriate health information is limited in areas where citizens are impoverished and lack education equal to other areas. Differences in sociocultural translation of necessities and principles become lost because of racial bias within the health system. Often, these mistranslations occur at the hands of White framing. White framing is language that is purposefully vague and described as “euphemistic or white concealing” (Vardeman-Winter, 2017, p. 631). The term “racial disparities” is used as an example. Racial stereotypes, expected images, and ideologies of differing racial groups is connected to prejudiced practice. These subconscious behaviors endure because of the subtle, hidden nature within language. Identifying and controlling White framing presents

difficulty due to the evolving face of racism. Health communication study focuses on racism on account of the suggestion that a privileged group decides meaning and messages of health for those with less privilege (Vardeman-Winter, 2017).

Most often, The National Institutes of Health (NIH) is more likely to invest funds into White researchers than to Black researchers. White researchers initiating studies limits the perspective to a White standpoint. Social and physical distance from target populations cultivates systemic racism and a lack of participation from people of color. Communicators stemming from White communities with college education means that communities experiencing health disparities are not reached. These areas are often populated by people of color with less education and income compared to the researchers (Vardeman-Winter, 2017, p. 631).

With respect to medical research, medical mistrust contributes to differential statistics. Not only do researchers remain within populations from which they are familiar, populations of color refrain from participating in studies that could level the data. Because of past exploitation of people of color in the past, such as the Tuskegee Trials, the Black community considers these offenses unforgivable. Black communities maintain a suspicion toward any future research for fear of manipulation (Ridley-Merriweather & Head, 2017).

Effects

Experiences with racism outside of the clinical environment correlates with reports of poorer health. Negative encounters influenced by race relates to perceived bias in clinical interactions. Racial and ethnic minorities believe that their race

contributes to unfavorable experiences with medical professionals. Medical mistrust results from a perception of bias and predicts less favorable behaviors from Black patients, from which negative provider and care quality reviews emerge. Whether or not the reviews stem from truth or perception, a breakdown in trust, lower medical adherence, and utilization of health care services occurs (Dovidio & Fiske, 2012). Overall, less healthy populations ensue.

Lack of cultural adaptation to mental health attitudes within differing backgrounds leads to ineffective treatments for groups such as refugees. Because of stigma within minority groups revolving around mental illness, programs within the United States must reform and refine themselves to adequately respond to the needs of refugee groups and others like them (Polonsky, et al., 2018). Programs and treatments must thoroughly inform groups as well as diversify the staff in order to reach target audiences to instill trust that the program is effective, promoting participation.

Systemic racism plays a key role in racial disparities, especially in research regarding myocardial infarctions. Research articulates that states with higher instances of systemic racism record increased racial disparities in myocardial infarction diagnosis and treatment methods when compared to states with weakened structural racism. The authors of the study conclude that "Structural racism may harm the health of groups that are target with discrimination, but at the same time benefit those in a position of dominance" (Vardeman-Winter, 2017, p. 630-631).

Potential racial bias from providers may be subtle and unintentional. Researchers consider sensitivity to bias in Black patients. Trust in medical

professionals following a visit differs between Black and White patients. Prior to the visit, Black and White patients report similar levels of trust. Following the visit, Black patients reported less support and partnership, as well as less information presented. Better comprehension and awareness of interracial interactions can supply researchers with better acumen into possible bias contributed by both the provider and the patient to reinforce health care and status (Dovidio, et al., 2008). Research findings into interracial interactions correlate health disparities with race discordant interactions and health disparities. Medical avoidance behaviors prevent Black patients from pursuing care. Fear of perceived discrimination directly affects psychological distress and poor health status. Patients experiencing negative stereotypes seek treatment less often and report lower care satisfaction. Positive patient/provider relationships result in patient engagement, medical information recall, adherence to treatment, satisfaction with care, and health outcomes.

Cases

A prolific portion of history that is shaping our future is the period of time in which our world has undergone quarantine from Coronavirus. NPR reported that the 2020 pandemic of COVID-19 targeted communities of color. People of color (POC) in the United States (US) are reported as more likely to contract and pass away from COVID-19 when compared to White people and their portion of the population. One of the causes for COVID health disparities, reported by The GW Hatchet, is asymmetric access to health services and adequate information. The city of Washington D.C. reports that three-quarters of COVID-19 deaths have been Black

citizens, in spite of Black people making up less than half of the D.C. population. A diagram of the wards within Washington D.C. illustrates the concentration of cases. The wards where more than half of the population are Black are experiencing the highest number of cases.These disparate health statistics surrounding COVID-19 have demonstrated the truth of living in poverty and of living as a person of color (Govindario, S., 2020; Wood, D., 2020).

The CDC records pregnancy-related deaths as mainly affecting Black and American Indian/Alaska Native (AI/AN) women ("Racial and Ethnic Disparities," n.d.). With a two to three times greater chance of dying from pregnancy, and the preventability of pregnancy-related deaths, racial and ethnic disparities should cease. However, this statistic remains and has remained throughout time. Between 2007-2008 and 2015-2016, pregnancy disparity statistics changed only slightly. Black and AI/AN women over thirty were four to five times more likely to die from pregnancy-related causes. Pregnancy-related deaths are measured per 100,000 live births, or pregnancy-related mortality rates (PRMR). States that reported low PRMR, that also contained women with higher levels of education still record compelling distinctions in race statistics relating to pregnancy.

According to a study by the Immunization Services division of the National Center for Immunization and Respiratory Diseases published in American Journal of Preventive Medicine (2015), Hispanics, non-Hispanic Asians, and non-Hispanic Blacks compared to non-Hispanic Whites possess lower vaccination coverage of the influenza, pneumococcal, Td, shingles, and HPV vaccinations. Each race was split into two age groups (19-64 and 65+) and analyzed for coverage by vaccine. While the

differences between races narrowed for varying vaccines, the divide persisted following consideration of access to health care and socio-demographics for most of the vaccines and groups. While these numbers present themselves in racially and ethnically diverse adults, childhood vaccination disparities in racially and ethnically diverse children report substantially low to unobserved differences. To enter into the school system, vaccinations are required in addition to provisions given by the Vaccines for Children program (VFC). VFC administers vaccinations to children without insurance, children on Medicaid, and other select populations. These requirements and programs may contribute to vaccination coverage in children and the diminished racial and ethnic differences. The perspectives on vaccinations and health care vary, in addition to access to quality care and vaccination safety (Lu, et al. 2015).

Rates of osteoporosis reveal disparities between Black and White women. Research states that physicians who engage in “high discretion procedures” (recommending a test, i.e. osteoporosis) bolster disparity appearances (Dovidio, et al. 2008, p. 4). Furthermore, Black women are less likely to be prescribed proper medication when compared to White women also diagnosed with osteoporosis (Dovidio, et al., 2008).

Racial discrimination does not limit itself to patients. Although the proposal to expand diversity in the healthcare workforce benefits minority patients, minority providers report discrimination in the workplace. Within the physical therapy (PT) profession, studies conducted in the United Kingdom (UK) interviewed minority and White providers. The physiotherapists illustrate their perception of lacking diversity and describe it as a “White profession”. A national UK survey reported 65% of

respondents feel minority groups as underrepresented in PT, 72% of racialized respondents express that minorities encounter barriers while attempting to progress in their careers. Additional studies in the UK and the US discovered racial bias in favor of White students above minority students (Vazir, et al. 2019).

Representation and diversity of medical staff often tilts toward disproportionate levels. As reported in the field of speech-language pathology, universities observe minority students failing to carry out the necessary coursework at the baccalaureate level. Thus the graduating class disproportionately represents the social demographic with 2016 recording only 7.7% of speech-language pathologists and audiologists self-identifying as minorities. In a 2018 study involving eleven speech-language pathologists (SLPs) with varying years of professional experience, interviews and responses were coded to further analyze and identify patterns and themes. The goal of the study was to describe systems and techniques that promote academic accomplishment and provide context to the obstacles facing African American SLPs (AASLPs). Interviewees expressed microaggressions as one of the challenges associated with being a Black student in undergraduate and graduate programs. Microaggressions are subtle or inadvertent actions or assertions that show prejudice against minority and marginalized groups. Five of the participants, who attended historically Black colleges or universities (HBCU), did not record any accounts of obstacles in the way of their education. Participants who did not attend HBCU reported their experiences with microaggressions from guidance counselors and SLPs who questioned their education and capability. Upon the interviewer inquiring into their personal

interpretation of the microaggressions, the participants generally abstained from pegging the aggressors as explicitly racist (Gingsberg, 2018).

Another contributor to academic adversities include social isolation and culture shock. Participants illustrated numerous situations in which they were segregated by their peers and left out of study groups and similar gatherings. The isolation and lack of social inclusion lead the participants to share that the loneliness and deficient visibility of Black students cultivates the characterization of speech-language pathology as a white women's profession. Along the spectrum of social aspects, "culture shock" acts as another microaggression for AASLP students. Participants explain the experience of being treated as a stereotype rather than as an individual. One participant reported her collegiate years as the first time she felt a shift in the manner she was treated, describing the treatment as working off of preconceived notions and stereotypes about African Americans. Microaggressions involving an erasure of individuality on account of stereotypes is often reported by many SLPs. Another participant detailed an experience of being the sole Black student in the program, being asked to exhibit African American dialect. The dangerous rhetoric and actions halting and harming the academic advancement and social involvement of students of color strips the professions of the diversity necessary to identify the institutionalized and systemic racism of the medical fields. Increasing diversity matches the social demographic by proportionately representing minorities and marginalized groups. Proper representation fosters and cultivates an environment where clients, patients, and students feel safe, heard, understood, and inspired (Gingsberg, 2018).

The 2012 ASHA Annual Convention in Atlanta, Georgia included a

presentation by Wright-Harp, et al. (2012) regarding health disparities in minority populations with communication disorders. The presentation outlined the disproportionate health statistics of racial and ethnic groups with respect to quality of family care among children with autism, children with cerebral palsy (CP), stroke awareness and recognition, among others. Health literacy also reinforces the presence of disparities. Health literacy creates a barrier between provider and patient when the patient struggles to obtain, process, and understand basic health information and services. The presentation offers recommendations of producing health advertisements in more languages to reach a wider audience. Furthermore, formal language assessment segregates culturally and linguistically diverse patients by solely being normed based on the majority language and culture. Literature astutely condemns testing in this manner for diverse language populations, further deterred by legislation and legal decisions. Standardized testing exhibits limitation and bias through underrepresentation of diverse populations in norming, cultural bias, and language/dialect bias. Because of a lack of inclusivity of culturally and linguistic considerations, misdiagnosis and overidentification occur. This leads to disproportionate representation of minority students placed in special education, and under identifies risk populations. The presentation provides recommendations for assessment of diverse populations. By using an ethnographic approach and observing, the provider can interview the family, consider cultural/linguistic differences, avoid stereotypes, use multiple sources of data during comprehensive assessment, and modify scoring while carefully reviewing tests for potential bias (Wright-Harp, et al., 2012).

Solutions

Dovidio (2012) finds that in order for the public to acknowledge racial disparities, provider discrimination must be recognized as a contributing factor. In spite of epidemiological reports, only 55% of White providers concede that "minority patients generally receive lower quality care than White patients."(Dovidio, 2012, pg. 949). Presentation and comprehension of the perplexing essence of bias, stereotypes, and affective responses may better prepare providers to administer equitable care. Dovidio (2012) further proposes mental health habits to self-regulate bias with hopes that recognition of biased behavior can be automatic.

The Anti-Racism Directorate approximates that racialized individuals will account for 48% of Ontario's population by 2036. With this in consideration, the Ontario Ministry of Education began enforcing Equity and Inclusive Education Strategies. The goal of this program is to assist educators in properly analyzing and confronting systemic barriers and discriminatory bias. Vazir's (2019) study participants voiced that informative training may be the most effective practice to counter race-related inequities.

Vazir also proposes that minority knowledge and experience warrants consultation regarding ways to reduce racism within the profession to improve minority health. Federal endeavors in Canada plan to reduce health disparities concern mediation that involves the entire population or aim at particular groups. Policy actors created targeting programs, i.e. Sisters Together, to promote healthy eating, regular physical activity, and preventative efforts to reduce risk of chronic diseases. However, targeted

programs may result in resistance if they are perceived as favoring specific groups rather than the general public (Vazir, et al., 2019).

Grier (2020) studied Minnesota's economic data to analyze the possible financial benefits of eliminating differential health statistics. The study states that the economic benefits of eliminating racial disparities would reduce direct medical care disbursements by $229.4 billion and associated indirect costs by more than $1 trillion. Nanney (2019) furthers this finding by stating a monetary estimate of saving lives as it correlates to finances when racial disparities are reduced. Annually, the approximate number of lives saved ranges from 475 to 812 ($1.2 billion to $2.9 billion). When referring to the entirety of the U.S., Nanney's article utilizes a statistic from LaVeist, Gaskin, and Richard. They state that the yearly expenditures of racial disparities in untimely death range from $236.1 billion to $243.1 billion (Grier & Schaller, 2020; Nanney, et al., 2019).

The CDC (1993) held a workshop to identify the issues of using race and ethnicity in the United States for public health surveillance. The participants were provided with documents and articles on surveillance of public health. They were then encouraged to propose advancements for the use of race and ethnicity to address unbalanced health statistics of the U.S. minority populations. Groups examined the limitations, exclusions, and restrictions affecting specifically Blacks, Hispanics, Native Americans, and immigrant populations. Considerable deviations in data collection of health statistics indicate that categorization of race and ethnicity statistics are inconsistent. The CDC's 1993 workshop focused on six criteria to implement a footing for evaluation and revising the use of race and ethnicity in public health surveillance.

Validity, exclusivity and exhaustiveness, meaningfulness to respondents, measurability, consistency, and reliability. In terms of validity, the CDC states that differing populations should be amassed with caution and with required validation. Exclusivity and exhaustiveness involves statistics representing diverse populations, surveillance categories should encompass all members of a population and only in one category. Meaningfulness to respondents consists of the images of race and ethnicity changing across a varying population. Racial or ethnic classification may be rejected by parts of the population. Measurability requires reasonable sensitivity, and positive predictive value. Sensitivity and positive predictive value ensures proper identification of participant race during habitual public health surveillance. Flexibility of surveillance systems must respond to inconsistent responses to race and ethnicity questions. Reliability of data collection across groups materializes in different methods and measures. Data collection may also vary in terms of vernacular and material (CDC, 1993).

While the aforementioned criteria outline the baseline for assessment and improvement of racial and ethnic health surveillance, self classification introduces challenges on its own. The 1990 census only required data collection from four racial groups (black, white, American Indian and Alaskan Native, and Asian/Pacific Islander) and one ethnic group (Hispanic). The report on Improving Minority Health Statistics from Healthy People 2000 and the Public Health Task Force on Minority Health Data affirm that additional race and ethnicity data within the health field is a necessity because of the projection of racial and ethnic population growth in the United States. The Bureau of the Census (BC) verifies that the race and ethnicity questions are

adequate. However, six areas in particular demand consideration. Identification of race, definitions of Hispanic, consistency of responses, misreporting, overlapping concepts of race and ethnicity, and classification of persons of mixed race (CDC, 1993). The CDC's 1993 workshop called for new methodological and statistical research on approaches to race and ethnicity to refine public health data. Given the demographic changes that continue to evolve within the United States, concepts of race and ethnicity should continue to be disaggregated to ensure that minorities can be properly represented in public health surveillance. Negative health effects in racial groups demonstrate the need for an understanding of the detrimental dispersion to better establish resolutions. Unclear racial classification systems and small participant groups cultivate inaccurate numbers and limit data analysis within racial groups. Deficient efforts to correct census undercount and health data alters disease patterns within specific subgroups. Proper representation allows medical professionals and federal agencies to competently treat disparate groups with unfavorable statistics. The Center for American Progress (2015) reports that as the American demographic evolves, as does the content of the census to collect data on minority populations. The Census Bureau began holding focus groups and surveys in the mid-twentieth century to gather information on the Census questionnaire. From these methods of testing, the Bureau learned to remove improper terms and expand question content to reach minority populations. Various advocate groups contribute to the changes made within recording race and ethnicity in data. For example, the advocate groups called for the way target populations record responses (check-mark boxes, write-in boxes, etc.) to be adjusted to reduce indistinct data. The write in boxes to detail national origin results in more

specific and targeted data. Additionally, the National Advisory Committee on Racial, Ethnic and Other Populations suggested to the Bureau that disaggregated data would produce more accurate representation of minority populations. Multiracial advocacy groups pushed for the census to allow multiracial identification, the Bureau implemented this change from 2000 to present day (Ahmad & Hagler, 2015).

In the profession of speech-language pathology, the American Speech-Language-Hearing Association (ASHA) includes advocacy for minority members and clients. ASHA established an outline of goals for the future, with the year 2025 marking the fulfillment of their targets. Included in this statement, ASHA condemns systemic racism and oppression, addressing its impact on communication, health, and education. The Association readily welcomes under-represented groups to practice and learn. Their efforts lie in allowing students and professionals to feel safe, appreciated, and heard. ASHA recognizes individuality within their membership and acknowledges the strengths of background, beliefs, and experience. ASHA views their members as parts of a whole, stating that all of the unique characteristics of speech-language pathologists and audiologists contribute to the progression of disorders and science as well as how to practice in a culturally competent, responsive manner (ASHA's Envisioned, n.d.).

In addition, Black speech-language and hearing professionals gathered together in 1977 to discuss the idea of a Black speech-language and hearing association. They were incorporated as the National Black Association for Speech-Language and Hearing (NBASLH) the following year. Their mission involves creating a community where the needs of Black students, professionals, and individuals with communication disorders

could be sufficiently met. Programs and organizations such as this exist to ensure that proper care is taken for people of color to feel heard, safe, and understood when they seek professional care (“History,” n.d.). NBASLH works to encourage Black individuals to come into the profession to increase diversity. Increased diversity means greater representation to match the changing demographic within society.

With policy actors working to create programs and federal organizations working to collect more accurate data, the hopes for reduction of racial disparities increase with time. Eliminating racial disparities requires the collective efforts of all medical professionals and specialists through education and understanding of the impact of race and ethnicity on individual health. Creating environments focused on comfort and understanding will invite more minorities and marginalized communities into health environments to seek treatment for preventable illnesses. Cultivating inclusion and focus on race-related health disparities ensures a healthier future for generations to come.

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