

Combating Systemic Racism in Medicine Requires Systemic Change: Addressing Implicit Bias in Medical Schools

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Abstract

Over this past year, systemic racism has proven to be a pertinent problem in our society, revealing itself in forms of police brutality and healthcare inequality in the COVID-19 pandemic. One important step in addressing these issues is confronting implicit racial biases, our unconscious attitudes and stereotypes that may further perpetuate systemic racism. This article underscores the need for strategic and impactful implicit bias training in medical education. Medical students must become aware of their own implicit racial biases, and learn about racial injustice in the medical system in pre-clinical training so that they are prepared to combat systemic racism throughout their careers.

Over the last year, the COVID-19 pandemic, police brutality, and nationwide protests have served as stark reminders that racism against Black Americans not only still exists, but permeates throughout the United States. It extends through generations, across state lines, and within industries, and medicine is not immune. Black women are two to three times more likely to die from pregnancy related causes than white women (Ojo, 2020). Black patients are 15% less likely than white patients to receive pain medication despite higher pain scores (Hoffman, 2016). Black men have the lowest life expectancy of any demographic group (Torres, 2018). Most recently with the pandemic, we have seen that Black Americans are infected with COVID-19 at

nearly three times the rate of white Americans, and twice as likely to die from COVID-19 (Soucheray, 2020). While these study results are complex and may be somewhat attributed to inequities in social determinants of health, the role of racial discrimination in medical practice cannot be ignored.

Racial discrimination in medicine is not something new, and its influence on the current state of affairs implores us to take a brief look at our profession's history. As a reminder, much of our medical knowledge base is predicated on experiments on Black patients without consent, such as in the Tuskegee Syphilis Study and Dr. J Marion Sims' surgical studies on female slaves. Historically, the medical profession promoted segregation of Black patients and physicians

from traditional practice. For example, in the late 1800s, physicians were required to be American Medical Association members in order to practice in hospitals. Local AMA chapters would reject Black physicians' applications, essentially barring them from practicing medicine (Jordan, 2016). Medical education in the South was segregated until 1948. Even today, Black patients still face the stigma of suffering from certain diseases. Some physicians provide inferior quality of care for their Black patients (van Ryn, 2000). Black physicians and medical students are constantly underestimated and scrutinized. Many have reported being mistaken for housekeeping staff in hospitals. Their accounts of interactions with their patients and other healthcare providers can be horrifying (Ojo, 2020). One student recounted from his Psychiatry rotation that it was an unspoken rule on the unit that "the darker someone's skin, the lower the threshold to restrain the patient" regardless of the level of threat they carried (Ojo, 2020). These findings are not limited to practice, but stem from discrimination in medical school training.

A logical and perhaps most immediately impactful step in combating systemic racial injustice in medicine is to diversify medical schools. African Americans comprise approximately 13% of the US population, but less than 4% of physicians and 7% of medical students are African American (Alsan, 2019). Minorities account for only 4% of US medical school faculty members (University of Alabama, 2020). This lack of representation is a critical detriment

to the medical community, including its patients. A recent study at the University of California Berkeley demonstrated the importance of having a diverse workforce in medicine. They showed that Black patients were more likely to follow preventative care advice and schedule follow up visits with their physician if he or she were also Black. The study results showed that Black doctors could reduce the black-white male gap in cardiovascular mortality by 19% (Alsan, 2020). By investing in the diversity of our profession, we can directly improve medical outcomes for all racial groups.

Improving the diversity of the medical student class must be faced with maximal effort and resources. However, much of the work will still remain after admittance. Medical students arrive to campus with their own implicit biases and perspectives. It is paramount that these must be addressed with the same, if not more, rigor as anatomy and the basic science curriculums. Unfortunately, the status quo sits far from this. Most medical schools in the United States do not have a formal implicit bias training requirement, which has further perpetuated a *laissez-faire* attitude towards addressing underlying systemic racism. A 2015 study at the University of Virginia recruited medical students and residents to complete a survey to detect false beliefs about biological differences between blacks and whites (Hoffman, 2016). Half of the medical students subscribed to at least one false belief. Perhaps more disturbing, 25% of residents, who have completed a four year medical school curriculum, believed black

people had physically thicker skin (Hoffman, 2016), a notion with absolutely no scientific backing. Regardless of a student's own implicit biases, what further ingrains these false beliefs may be the training, or lack thereof. Pathology textbooks include images of various rashes, diseases, and infections on light skin, but hardly any on dark skin. Disparities in prevalence of disease may be mentioned, but there is no context to that discrepancy, no follow up on how it may connect to practice, and no discussion of how that may impact a patient-physician interaction. This is not to say that a mandatory implicit bias training is the key solution. As Dr. Kevin J. Gutierrez explains in his recent publication, there is a danger in an "institution declaring a commitment to learning about racism, but not unlearning the pathological structural forces that perpetuate it." (Gutierrez, 2020) There is no benefit to implementing bias trainings without simultaneously taking measures to change the infrastructure that preserves bias. Otherwise, the well-intentioned educational changes may come off as performative, and in turn, do little but make light of the deeper issues at hand.

The solution to tackling racism in the medical profession is complex, and it must start at the medical school level. Furthermore, it must include not only improving representation at medical school, but also addressing implicit biases, and educating students on broader health inequities and social determinants of health. Firstly, schools must increase rates of Black faculty members and medical students.

Representation is important at all levels and will help dissolve stereotypes and racial biases. Appropriate and strategic implicit bias training should include real patient perspectives of how bias from physicians has shaped medical care. Dr. Jennifer Tsai explains, "While implicit bias curricula encourage increased recognition of personal prejudices, their pedagogical approaches fail to consider structural inequities that generate pervasive bias. Absent broader context, implicit bias training can normalize bias and neglect examination of differences in power that enable individuals and institutions to systematically enact prejudice." This training must coincide with education on the systemic forces that create environments that permit racial injustice (Tsai, 2017). One way to do this is by using the critical race theory (CRT). CRT is a framework that describes social, economic, and societal structures as causes of race inequality. It combines education on the historical marginalization of Black people with experiential perspectives to teach future physicians, firstly, how these injustices came to exist and, secondly, to be better equipped to articulate and address unjust practices against people of color in medicine (Tsai, 2017). These are just a few of the ways medical schools can enhance their curricula to foster competent, fair-minded, and ethical future physicians.

Systemic change is not additive. It is disruptive. Medical schools must confront their past, but more importantly, they must confront their now. Changing a system that has been in place for hundreds of years is not an easy task, but it is vital to the progress of

medicine. The understanding of the role of racism in medicine and medical education is not a novel concept; yet, little has been done to address this. Evidently, existing efforts to combat this racism in medicine have left a lot to be desired, given recent data. A comprehensive restoration to address racial inequality and implicit bias in medical school would go a long way in ensuring that medical schools do not simply teach statistics about healthcare disparities and inequities, but more importantly, do the tough work of confronting implicit biases and from where they stem. It may be difficult to reckon with the parts of our field that run contrary to our commitment to justice and non-maleficence, but it is crucial that we make this systemic change.

References

- Alsan, et. Al. (2019) Does Diversity Matter for Health? Experimental Evidence from Oakland. National Bureau of Economic Research: NBER Working Paper Series. Retrieved from: <https://www.nber.org/papers/w24787.pdf>
- Gutierrez, Kevin J. (2020) The Performance of “Antiracism” Curricula. The New England Journal of Medicine. <https://doi.org/10.1056/NEJMp2025046>
- Halperin, E. (2020) Portraits of Diversity. Inside Higher Ed. Retrieved from: <https://www.insidehighered.com/views/2020/07/06/colleges-should->
[hang-portraits-diverse-people-their-campus-walls-opinion](https://www.insidehighered.com/views/2020/07/06/colleges-should-hang-portraits-diverse-people-their-campus-walls-opinion)
- History of Minorities in Medicine. University of Alabama at Birmingham: Office for Diversity and Inclusion. Retrieved from: <https://www.uab.edu/medicine/diversity/initiatives/minorities/history>
- Hoffman, Kelly M. et. Al. (2016) Racial Bias in pain assessment and treatment recommendations, and false beliefs about biological differences between black and whites. Proceedings of the National Academy of Sciences of the USA. <https://doi.org/10.1073/pnas.1516047113>
- Jordan, Karen. (2016) The Struggle and Triumph of America’s First Black Doctors. The Atlantic. Retrieved from: <https://www.theatlantic.com/health/archive/2016/12/black-doctors/510017/>
- Ojo, Ayotomiwa. (2020) Racism In Medicine Isn’t An Abstract Notion. It’s Happening All Around Us, Every Day. WBUR. Retrieved from: <https://www.wbur.org/cognoscenti/2020/06/12/anti-racism-in-medicine-hospitals-ayotomiwa-ojo>
- Soucheray, Stephanie. (2020) US black 3 times more likely than whites to get COVID-19. University of Minnesota Center for Infectious Disease Research and Policy. Retrieved from: <https://www.cidrap.umn.edu/news-perspective/2020/08/us-blacks-3-times-more-likely-whites-get-covid-19>

Torres, Nicole. (2018) Research: Having a Black Doctor Led Black Men to Receive More Effective Care. Harvard Business Review. Retrieved from: <https://hbr.org/2018/08/research-having-a-black-doctor-led-black-men-to-receive-more-effective-care>

The history of African Americans and organized medicine. American Medical Association. Retrieved from: <https://www.ama-assn.org/about/ama-history/history-african-americans-and-organized-medicine>

Tsai, Jennifer & Crawford-Roberts, Ann. (2017) A Call for Critical Race Theory in Medical Education. Journal of the Association of American Medical Colleges. <https://doi.org/10.1097/ACM.0000000000001810>

Van Ryn, Michelle & Burke, Jane. (2000) The effect of patient race and socioeconomic status on physicians' perceptions of patients. Social Science and Medicine. [https://doi.org/10.1016/S0277-9536\(99\)00338-X](https://doi.org/10.1016/S0277-9536(99)00338-X)