How coffee shop racism harms black patients

8 May 2018, by Junaid Nabi

A couple of weeks ago, two black men entered the Philadelphia Starbucks store to meet a friend, and have a conversation, just like many of us usually do. Unlike many of us, however, they were arrested for trespassing – after minutes of taking their seats. A phone call – that lasted only 30 seconds – led to an arrest of these young individuals, and a national conversation on race relations in the United States in the ensuing days.

This reprehensible incident is an important reminder of how implicit racial bias – or in this case coffee shop racism – works. While this incident has been condemned widely, the service industry is not the only sector where this is a problem. Implicit racial biases are in fact important indicators of the broader negative perception of black people – which in clinical practice often leads to low-quality care, and harm.

How does this racial bias translate to harm in clinical practice?

In 2016, psychology scientists from University of Virginia demonstrated how racial bias lead to disparities in pain management. The investigators reported that black patients are systematically undertreated for pain compared to white patients.

They found that a significant number of white medical students and residents believed in false biological differences between white and black patients, such as "black people's skin is thicker" and that "black people's blood coagulates more quickly." These findings exemplified how racial bias leads to less accurate treatment recommendations for black patients.

In another milestone report, the *American Journal of Public Health* revealed how implicit racial bias – even if unconscious – leads to reduced trust in the doctor-patient relationship, causes black patients to feel less respected by their doctors, and may contribute to racial disparities in healthcare.

Some of this implicit bias has a historical precedent. In a series of revealing articles last December, the Boston Globe's Spotlight team illustrated how black patients were continuously discriminated against in the 1960s and 1970s. In fact, the report documented that such discrimination continues today – although it has taken new forms: today, it is more systematic and less individualistic.

What can academic medicine learn from such incidents?

As a physician-bioethicist, I am training to develop research protocols that are equitable and apply regardless of race of an individual. But after witnessing incidents where black people are routinely harassed, I believe it is a moral imperative to consider broader societal impositions on black individuals for any bioethical analysis – a feature that academic training programs have not addressed adequately.

It is a mistake to think that black patients' exacting social environments do not affect their agency. Understanding – and addressing – how unfair social forces shape the health of black patients must start early in the medical training. One way to address

this issue is to teach medical students to take a more thorough social history, that includes documenting instances of racial bias.

In 2014, a report from the Robert Wood Johnson Foundation emphasized: "Your health care depends on who you are. Race and ethnicity continue to influence a patient's chance of receiving many specific health care procedures and treatments."

To be sure, most healthcare providers are not actively discriminating against minority patients, but just like the Starbucks manager who called the cops on two innocent black men, the tendency to discriminate is often implicit. Unless one is intentional about their approach to patient care in minorities, it is far too easy to fall in the trap of casual racism.

Black communities already suffer from worse clinical outcomes. Black patients continue to have inadequate access to healthcare; black women are two to three times more likely to die from pregnancy- and childbirth-related complications than white women; and, mortality rate in black infants has not improved in recent years.

Many of these outcomes are driven by implicit bias, which continues to put undue stress on black patients. Implicit racial biases contribute to this perception.

It is important for academic medicine to recognize this issue. A conversation on how culture affects medical care is long overdue. Healthcare providers – and by extension students who are learning from them – are operating on a flawed understanding that societal racism (casual in many instances) does not affect medical care. As noted above, evidence suggests otherwise.

Healthcare providers are in a unique position to address racial bias. By making small intentional changes in routine clinical practice, such as focused empathy and a thorough social history, it is possible to elevate the quality of care for black patients and other minorities that routinely confront racial bias. These small initiatives may help alleviate some of the health disparities.

Equitable medical care can be great equalizer of the health conditions of minority patients.

This story is republished courtesy of PLOS Blogs: blogs.plos.org.

Provided by Public Library of Science