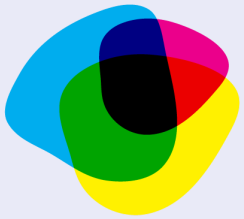
Combating *Anti-Blackness* in Medicine

A Resource for Providers

Community Health
Access Initiative
www.chai-mi.org

Combating Anti-Blackness in Medicine was created in November 2020 by the Community Health Access Initiative, which is funded by Community Health Services at Michigan Medicine.

Community Health Access Initiative
www.chai-mi.org

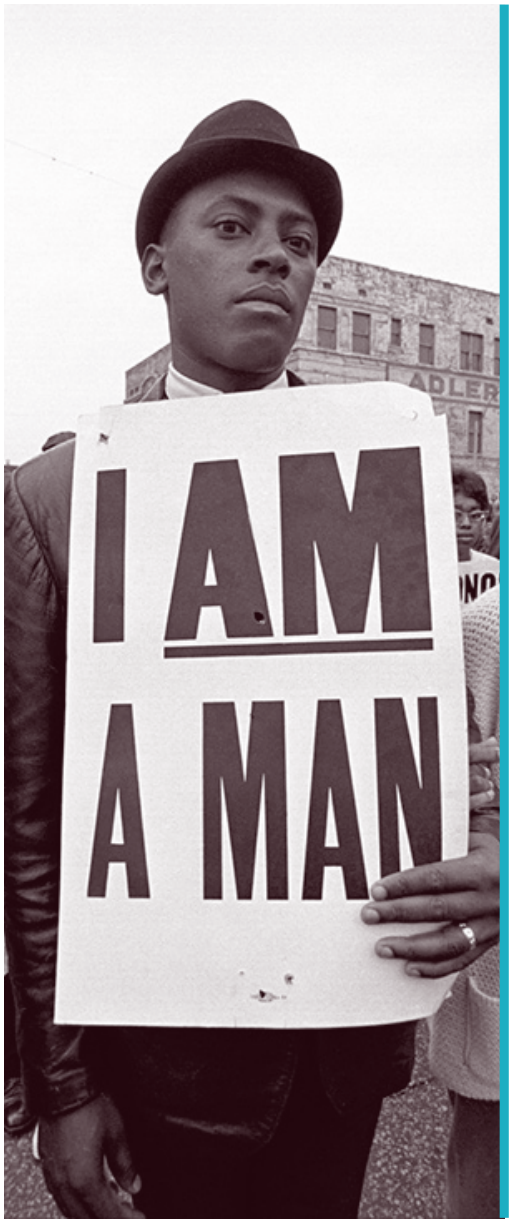


RESILIENCE + RESISTANCE COLLECTIVE

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

What is Anti-blackness?

Anti-blackness describes the unique formations of racism which specifically impact descendants of Africa and people perceived to be Black. Anti-black racism is rooted in myths about the inferiority of Black or African people. These myths were used to justify enslavement and manifest, to this day, as **overt racist acts** (slurs, direct discrimination, violence) and **covert policies and practices** that systematically pre-determine the socioeconomic status and health of Black people.



The cumulative effects of structural violence, deprivation, and exclusion, combined with medical abuse and neglect, have resulted in sustained, generational wear and tear, described as "weathering." Weathering is a term used to refer to the allostatic load of chronic stress induced by systemic racism on Black people's bodies and minds, particularly among Black people surviving at the intersections of multiple and intersecting systems of oppression, including Black disabled people, Black low/no income people, Black women, Black LGB+ and Black trans, intersex, and gender nonconforming people. These effects are compounded for Black criminalized and incarcerated people and for Black migrants, who experience additional stresses of being hunted, violated, and caged by the state, and for whom medical care is largely inaccessible to the point of being virtually non-existent.

—The Movement For Black Lives, *Anti-Blackness as a Determinant of Health*

Anti-blackness in Medicine

In *A Treatise on Tropical Diseases* (1787) Dr. Benjamin Moseley claimed that Black people could "disregard" pain that was intolerable to white men. Like other racist conclusions drawn during his time, Moseley's unfounded medical claim informed physicians for generations—Dr. J. Marion Sims' notoriously founded gynecology by experimenting on enslaved women. These myths were used to justify Black enslavement, but they persist today. Up to the mid-20th Century Black patients were legally denied rides in ambulances and refused life-saving care by white physicians. In 2013, the AMA Journal of Ethics found that Black patients are still less likely to receive pain medication than white patients, despite higher pain scores.

Black women are 22% more likely than white women to die of heart disease; 71% more likely to die of cervical cancer; **243%** more likely to die of pregnancy or childbirth related causes. (1)

One study found that **7-22%** of providers reported appropriate requests for pain treatment in sickle cell patients as "drug-seeking behavior." (2)

Black women were less likely to be screened for diabetes, despite having a **63%** higher risk than white women. (3)

Medical Mistrust

Following generations of experimentation, denial, and discrimination, medical mistrust is widespread within Black communities. Fear and mistrust lead especially vulnerable patients to delay or avoid healthcare. Medical mistrust has been a mechanism of survival in Black communities, where the risk of avoiding care was lower than making oneself vulnerable to medical harm. The responsibility for changing this legacy lies with the healthcare system, and begins with taking anti-racist action.

1. Tucker, M. (2007). ***The Black-White disparity in pregnancy-related mortality***. pubmed.ncbi.nlm.nih.gov/17194867/

2. Wyatt, R. (2013). ***Pain and Ethnicity.*** https://journalofethics.ama-assn.org/article/pain-and-ethnicity/2013-05

3. Bower, J.K. (2019). ***Racial/Ethnic Differences in Diabetes Screening.*** cdc.gov/pcd/issues/2019/19_0144.htm

4. Washington, H.A. (2006) ***Medical Apartheid: The Dark History of Medical Experimentation on Black Americans.***

Accountability in Anti-racist Action

All members of the medical community have a responsibility to openly discuss racism and the differential treatment of Black patients, with the intention of identifying how their clinic or hospital can make material changes to spaces, practices, and policies. We know these conversations *are* happening. Many hospital systems and professional health organizations have made statements about the impact of racism on health, following the uprisings against the police murder of George Floyd during the summer of 2020. These statements tend to admonish racism as an external phenomenon, rather than something *produced by* medical practice and other social institutions. These statements fail to identify and account for the specific legacy of racism, racist actions, and racially discriminatory outcomes within their specific professions, and fail to make commitments to traceable changes. We must go beyond *acknowledging* racism, toward taking **accountable anti-racist action,** which includes:

> Openly naming the specific behaviors, practices, and policies that have contributed to differential treatment and outcomes for Black patients.

> Seeking out and listening to impacted Black communities about their needs.

> Contributing actions and resources (time, money, space, labor) to repairing injury or loss, and making material changes to prevent racist practices from continuing.

As leaders in clinical research, and, therefore, in promoting the betterment of healthcare for all, it is crucial that we address the human rights issues plaguing our society. The bitterness and anger which have occurred over the past two weeks suggest a type of societal crisis of an unbelievable magnitude. Just as racism affects socio-economics, education, and countless other aspects of society, so too does it affect medicine... Anti-racism has been included in the research process for many years, and we as an organization don't intend to let that fail now... Let us be reminded that every day is a chance to work toward positive change.

—Academy of Physicians in Clinical Research, ***Statement on Racism in Healthcare and Clinical Research***, June 10 2020

Anti-blackness is a mutually reinforcing system—action is required at all levels.

Intrapersonal

Healthcare workers and providers must examine implicit and covert biases that impact attitudes, actions, and reactions. We should ask ourselves—what experiences inform my understanding of Black people and communities? What do I need to learn and unlearn?

Interpersonal

The relationships we hold with Black patients and their communities must be examined —how have I interacted with Black patients in my practice? What is my relationship with Black communities who rely on my clinic for service? What impressions, experiences, or understandings encourage or discourage Black patients from seeking care from me?

Sociocultural

The policies, practices, and messages of our institutions must also change—what policies prevent Black patients from receiving the best care possible? How can those policies be changed? What environment of care have we created for our patients (who works here, how accessible are our services, who do we welcome and support?)

Structural

Where material resources go is a significant factor in perpetuating anti-Black racism—who receives the highest quality (most expensive) care? How can Black patients and communities access that level of care?

Taking Anti-Racist Action

Individually

Move From Defensiveness & Guilt, Toward Action
I notice and let go of feelings that interfere with my ability to listen to what my Black patients are saying.

Seek More Information
I ask questions to make sure I understand Black patients' reactions, needs, and concerns. I read. I attend workshops. I seek out opportunities to hear from Black community members and their organizations.

Receive Feedback As a Gift
I welcome information about my actions and believe it to be to my benefit to receive it.

Take A New Perspective
I try to understand perspectives that differ from my own.

Problem Solve
I take responsibility for identifying ways that I might change my actions, not assuming that my patients should or will help me.

Integrate New Behavior
I choose different behaviors in the future because I believe it is important for me to do so, not just because I am afraid of being confronted again.

Interventions adapted from the Anti-Oppression Resource & Training Alliance

As a Clinic

Develop a Support Team
Identify people to receive extensive training in supporting patients harmed by racism internally. Pay them to provide that support as needed.

Engage in Ongoing Learning
Provide resources to do *collective* learning with the entire care team; have a passionate leader help the team to develop system change goals that coincide with learning.

Institute Regular Check-Ins
At regular meetings, take specific time to check in about institutional racism and how the organization is meeting goals. Also provide space where staff and providers can share concerns in private.

Institute Exit Interviews (for Patients & Staff) With Space to Reflect on Power
Are there things about the organization (policies, practices, incidents) that prevented you from being your whole self, sharing your concerns, or feeling safe? Are there things you wanted to bring up but found it hard to do so? What are they?

Problem Solve
Proactively address the problems that are raised, with the highest goal of preventing harm rather than protecting the clinic from liability.

Intervening in Racist Incidents

Interpersonal racist incidents are always indicators of a larger, systemic problem. Interpersonal racist incidents might include: a provider undermining what a Black patient is saying about their health or not ordering appropriate tests due to ignorance of social determinants of health or communal risks, or staff making inappropriate racialized comments. We should address the incident immediately but follow-up with a system-wide intervention. Take note, intervening in racist incidents carries significant power dynamics. People in positions of authority should carry the burden of intervening, so that vulnerable workers are not put in a compromising position between caring for patients and confronting their superiors.

4 Methods for Intervention

Direct

If the incident is by a provider toward a patient, immediately direct the provider or staff member in an alternative, anti-racist way to approach the situation. *Actually Carol, our patient mentioned they are having pain so we need to explore that further before moving on.* Follow up with Carol later, when the patient is gone, to explain your concerns.

Delay

If unable to intervene in the moment, follow up with the patient after the fact to hear how they were impacted and offer support. *What I witnessed was wrong and I will be addressing it here. Is there something I can do for you? Can I see you personally to address your concerns?*

Distract

If the person being targeted would be compromised by a direct intervention, distract the person doing harm so that the person being targeted can leave if they want. Follow up with the person responsible so that they understand what happened. Follow up and offer support to the person who may have been harmed.

Delegate

If possible, bring in an alternative provider to continue the exam, procedure, or interaction. Tell the person responsible for the racist act that they're needed elsewhere and then go with them to talk about why you intervened and what they could do differently in the future.

4 Systemic Interventions

Know & Understand Community

Do a deep dive in understanding the demographics, culture, history, and social determinants of health in the region your clinic serves. Seek out information and learning about the most marginalized members of the community, whose faith, culture, and health your colleagues may never have learned about in medical school. Approach this understanding with humility and respect, bringing members of the community forward to share their experiences if they wish. Ensure that all staff and providers are aware of the unique needs of marginalized populations.

Invest in the Future of Medicine

Provide resources and opportunities to Black students who are training for healthcare work and health-related research. In particular, help to improve recruitment and retention of medical students and administrative staff who will have high levels of power and control--and reduce the financial burden of training in these professions. 13% of the U.S. population are Black, but only 4% of U.S. doctors and less than 7% of U.S. medical students are Black.

Evaluate Policies & Procedures

Hire independent consultants who have competency in structural oppression and a proven record of being critically honest about racist systems. Have these consultants examine the policies, procedures, and protocols within the clinic and health system and confidentially interview staff, providers, and patients. Have them review patient outcomes by demographic data. Be wary of consulting firms that exist only to protect health systems from liability.

Transform

However difficult it may be, be proactive in addressing any and all discoveries of racist systems and incidents. Transparently seek ways that will prevent these incidents in the future and track the outcomes of all changes, leaving room for further improvement.

Additional Resources

Association of American Medical Colleges - Anti-racism in Medicine Collection
https://www.mededportal.org/anti-racism

Association of Black Cardiologists: Structural Racism and Anti-Blackness in Medicine
https://abcardio.org/structural_racism_medicine/#

Black Emotional and Mental Health Collective
https://www.beam.community/

Black Health Alliance - Canada
https://blackhealthalliance.ca/

Black Mental Health Alliance
https://blackmentalhealth.com/

Syllabus: A History of Anti-Black Racism in Medicine
https://www.aaihs.org/syllabus-a-history-of-anti-black-racism-in-medicine/

Resource Co-Created By
Gel Henry, Christian Stephenson, Kiandra Powdhar, Isabella Gierlinger, Jack Alferio, and **Sydney Michalowski**

Contact CHAI

chai-mi.org

Project Director, Elliot Popoff
elliopop@umich.edu

Project Coordinator, Luna Hughson
ahughson@umich.edu

CHAI Community Health Access Initiative
www.chai-mi.org

RESILIENCE + RESISTANCE COLLECTIVE

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN