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Elizabeth Dwyer

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Racism pandemic

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Racism in Healthcare

By Elizabeth Dwyer © August 14, 2020

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Adopted by the General Assembly of the World Medical Association (WMA) at Geneva in 1948, the Declaration of Geneva is one example of the oath taken by medical students upon entering their new profession. In the aftermath of World War II, international communities learned of the horrific human experiments conducted by doctors within the Nazi regime and the Japanese Imperial Army's Unit 731 (where biological and chemical weapons were routinely tested on imprisoned human beings and on populations in Chinese cities and towns).

The WMA saw an urgent need to set standards regarding the value of human life, and the role of physicians in honoring and caring for their fellow human beings. In its current form, one key component of the Declaration of Geneva states:

As a member of the medical profession...

...I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.

While it is not the only oath sworn by medical students, most aspiring physicians swear a similar vow regarding the sanctity of human life – all human life. In theory, a person's race and/or ethnicity does not factor into their standard of care. Unfortunately, the reality experienced by patients of color in the United States today is far too often one riddled with bias, judgment, and as a result, subpar treatment.

According to Dr. Tracie Collins, physician, researcher, and administrator currently serving as Dean for UNM's College of Population Health, the structure of our health care system doesn't help physicians work outside of their own biases. In fact, it often does the opposite.

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"To get all the information you need, you begin to run things quickly through your brain and create these sort of little boxes or areas where you put information," Dr. Collins says. "What's happening, unfortunately, as you do that, is you're also processing the phenotypic expressions that your patient has."

What this means is that even if a patient is being seen for the first time, the clinician will mentally, likely subconsciously, place them into categories that fall in line with other patients whose outward appearance looks "the same" in terms of race, gender, and ethnicity. The result, as Dr. Collins illuminates, is often treatment based on prejudices instead of facts.

"So the person sitting in front of you might be a Latino man who's really in pain and needs medication, but you're putting him through extra scrutiny because you're worried about substance use disorder when you wouldn't apply that to a White male (patient)."

As individuals, none of us are exempt from adopting biases and prejudices throughout our lives, largely due to the messages of White supremacy we've received from nearly every facet of American society. The medical profession is no different, and doctors, clinicians, and researchers continue to struggle with questions of race, ethnicity, and identity.



Dr. Tracie Collins, dean,
UNM College of Population
Health

“For decades a lot of our medical research has been done on White men, so we don’t have the same amount of data on other populations,” says Dr. Felisha Rohan-Minjares, a professor in UNM’s Department of Family and Community Medicine and Assistant Dean of Clinical Education & Learning Environments at the UNM School of Medicine. “And once we started doing that research, we started focusing on race – like how does a Black man compare to a White man? And how does a Native American man compare to those other two groups? There’s pushback because what people are finding now is that it’s not actually *race* we should be looking at, but the *experience of racism*, as well as structural forces that are creating those differences in health.”

With a background in health inequities with a focus on vascular disease, as a med student Dr. Collins noticed there were quite a few minority patients at the VA hospital in Oklahoma City who had undergone lower extremity non-traumatic amputations (i.e., amputations resulting not from trauma or accidents, but from advanced disease or pathology).

It planted a seed that stayed with her, and in considering how her skills and work could have a broader impact on patients and communities, she furthered her studies by earning a Masters in Public Health and as a general medicine fellow at Harvard.

“I was able to access my mentor’s database, the National Surgical Quality Improvement Program (NSQIP), and began to look at these questions: Was there a difference by race, ethnicity, and rates of amputations?” Dr. Collins recalls.

“So the person sitting in front of you might be a Latino man who’s really in pain and needs medication, but you’re putting him through extra scrutiny because you’re worried about substance use disorder when you wouldn’t apply that to a White male (patient).” – Dr. Tracie Collins

What she discovered was a higher rate of non-traumatic amputations among African American and Latino patients, as compared to non-Hispanic White patients. Exploring the why, Dr. Collins examined the diseases and underlying pathologies leading to the amputations.

“Peripheral artery disease (PAD) was something we didn’t spend much time on when I was a medical student or as a resident,” Dr. Collins says, “and it really was driving a lot of these amputations.”

The prevalence of PAD among Black and Latino patients is one of the contributing factors that, if left untreated, can ultimately necessitate an amputation. But Dr. Collins wondered, why do these patients have diabetes in the first place? Why are they smoking?

As a society we are inundated with oversimplified messages about health and wellness-focused on “eat well and exercise,” and the buck often stops there. Despite their critical importance, social determinants of health are rarely discussed or even acknowledged outside hospitals, clinics, or medical classrooms.

Social determinants of health are also referred to as “upstream” factors that contribute to a person’s overall wellbeing. Considerations such as food security (access to healthy, nutrient-dense food that’s affordable and close to home), the safety of one’s environment (can a person walk, run, or get physical activity where they live?), and access to everything from education to job opportunities to ever-evolving media and technology can have a profound impact on the state of a person’s health.

Originally from Gallup, N.M., Dr. Rohan-Minjares has witnessed how “social determinants of health are incredibly important in determining someone’s access to good health care,” she says. “I’ve been able to experience the contrast between the

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health care system in a place like Albuquerque, where there is more ready access to specialists and lots of primary care facilities, compared to being in Gallup, where if something happens and you need a specialist to provide care, you need to travel to Albuquerque. Something as simple as whether or not you have enough gas in your tank will determine if you can go to Albuquerque to get the care you need.”

Dr. Collins emphasizes the inherent systems in place that disproportionately affect people of color and negatively impact their health, wellbeing, and quality of life.

“Why do some of the most impoverished neighborhoods exist?” Dr. Collins asks. “There’s a systemic cycle that starts with redlining – not providing loans (to African Americans) for better housing.”

The interactive project Mapping Inequality reported on by Camila Domonoske at NPR (<https://www.npr.org/sections/thetwo-way/2016/10/19/498536077/interactive-redlining-map-zooms-in-on-americas-history-of-discrimination>) paints a stark and vivid picture of redlining as a key component of the racial and wealth inequalities that persist in today’s America.

Resulting from restricted access to loans and housing, in many families of color “kids attend lower-quality schools and their employment opportunities are limited,” Dr. Collins says. “And then, if a child does get through college and has improved employment opportunities, who is the person hiring them? How much is unconscious bias playing a factor in who they hire? There’s limited access, even if you’re qualified, to those high-paying, high-quality jobs.”

How does all of this relate to health care? As recently pointed out by Ed Young, reporting on Covid-19 for The Atlantic (<https://www.theatlantic.com/magazine/archive/2020/09/coronavirus-american-failure/614191/>), the United States is “a country that—uniquely and absurdly—ties health care to employment.” What kind of job you have determines what kind of health insurance you have (or don’t have), which can greatly influence the quality of care you’re able to access.

“When you think about access,” Dr. Collins says, “think about who can afford the private insurance, and that is going to influence which providers you have access to, and how often you can get in to be seen.”

Dr. Rohan-Minjares agrees. “Economics and ability to access the clinic or get the medications you need to make a huge difference in whether or not someone can achieve their healthiest outcomes.”

She goes on to illustrate the particular truth of these inequalities in New Mexico, and especially during the Covid-19 pandemic. “The issues around health disparities during COVID have brought all of this to the forefront in a really dramatic way. Like issues around whether or not there’s access to clean water on the Navajo reservation – having clean water to wash hands and stay healthy as a fundamental principle. The economic disparities and educational disparities in New Mexico clearly have a huge impact on our population.”

Living with the daily experience of racism can also have direct, adverse effects on the health and wellbeing of Black, Indigenous, and People of Color (BIPOC) communities.

“If you think about static load or the amount of stress that one person has to endure,” says Dr. Collins, “and the intersection of race and gender and poverty – which are so intertwined – those situations and the constant day-in-and-day-out of microaggressions and/or overt racism... that leads to an increased production of cortisol. And cortisol is your body’s fight-or-flight hormone, so if you’re in this constant state of being stressed out, tense... that hormone is going to then put fat around your midsection, which then increases your risk for being insulin-resistant, for



*Dr. Felisha Rohan-Minjares,
professor, UNM’s Department of
Family and Community Medicine*

progressing to diabetes, for having mild to severe hypertension... So that static load, because you're in a system that's racist because day-in and day-out you're trying to fight against the racism and keep going, that's a lot of stress on your body."

“As a woman of color who’s a physician. There’s this perception like, ‘Are you really the doctor? Or is there someone you’re working for, to help you?’ During residency, I really had to put my foot down, because I’d be rotating with students – I’m the resident, and the student is learning from me – and the patient would turn to the (white) student and ask for their opinion, or say, ‘Is what she’s saying correct?’” – Dr. Tracie Collins

One very serious example of how racism plays out and affects health very directly was recently brought to the forefront of public discourse: the increased morbidity and mortality rates for Black women and their babies.

“Many public health experts postulate and can connect these rates to the experience of racism,” says Dr. Rohan-Minjares. “African American women in America have much worse outcomes when it comes to pregnancy, and more babies with low birth rate, and higher instances of infant mortality. There are many studies to back it up that a lot of this is related... to the daily experience of racism. Higher levels of cortisol circulating in the body... is stressful on a pregnancy. A lifetime – two or three decades – of experiencing daily racism and increased levels of cortisol puts that woman in a vulnerable place when she begins a pregnancy.”

Both Dr. Rohan-Minjares and Dr. Collins commented on other forms of racism in health care, and the potentially fraught dynamics between patients and their providers.

“As a woman of color who’s a physician,” Dr. Collins says, “there’s this perception like, ‘Are you really the doctor? Or is there someone you’re working for, to help you?’ During residency, I really had to put my foot down, because I’d be rotating with students – I’m the resident, and the student is learning from me – and the patient would turn to the (white) student and ask for their opinion, or say, ‘Is what she’s saying correct?’”

The demographic profiles of physicians are often out of sync with the populations they’re serving. According to data released by the U.S. Census Bureau on June 25, 2020, for the first time, “non-whites and Hispanics were a majority of people under age 16 in 2019,” an expected shift that will only grow over time. In other words, White people will soon be the minority in America. And yet, the American Association of Medical Colleges (<https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018>) reported that in 2018, 56.2 percent of active physicians identified as White. (*“Note that the race for 13.7% of active physicians is Unknown, making that the largest subgroup after White and Asian.”*)

“We have much lower numbers of African American, Native American, and Latino physicians in the country,” says Dr. Rohan-Minjares, “and there are some studies that demonstrate that patients who have a physician that looks like him or her might lead to increased patient satisfaction and increased compliance with treatment, which may then lead to better health outcomes for the patient.”

Dr. Collins agrees with the need to diversify the health care provider workforce. “I think the more we change what a doctor looks like, and bring more diverse groups into medicine, that we’ll continue to see people more comfortable recognizing that physicians are not just white males.”

Issues of race and ethnicity in health care – and everywhere else – are complex, and Dr. Rohan-Minjares goes on to clarify that the need to improve medical profession access for people of color does not mean White providers should be dissuaded from supplying care to communities who need it most.

“Our underserved communities, particularly Native American communities across the state (of New Mexico), really, really need dedicated physicians who are ready to learn about them and provide care,” she says. “We want to support all physicians and health care workers who want to provide care to underserved communities.”

With the SARS-CoV-2 coronavirus disproportionately harming BIPOC communities compounded by persistent police violence against those same individuals, new uprisings swept across the country and into the streets. White people, many for the first time, are not only bearing witness to the true consequences of our country’s systemic racism, but are also feeling the weight of the effort to fight against it every single day. A weight previously borne almost exclusively by people of color.

“The current momentum created by the White Coats for Black and Indigenous Lives group on campus has generated many, many conversations going on in different parts of the HSC – with lots of enthusiasm – to include issues of racism and structural inequities as part of the discussion and education of all our health care professionals from day one.” – Dr. Felisha Rohan-Minjares

It’s a sea change that many people are looking to as a sign of hope, an indication that we truly are emerging from the centuries of white supremacy that have permeated our culture. That hope, tempered with cautious optimism, has reached the University of New Mexico Health Sciences Center (HSC).

“The current momentum created by the White Coats for Black and Indigenous Lives group on campus has generated many, many conversations going on in different parts of the HSC – with lots of enthusiasm – to include issues of racism and structural inequities as part of the discussion and education of all our health care professionals from day one,” says Dr. Rohan-Minjares.

For the first time in the School of Medicine’s history, new student orientation included a discussion about Race, Racism, and Health, led by several faculty members, staff, and residents. The energy and eagerness to have these essential conversations is spreading throughout campus.

“The same group has been invited to lead discussions in the School of Pharmacy orientation,” Dr. Rohan-Minjares says, “and there’s discussion about this (subject matter) being incorporated into the Biomedical Sciences Graduate Program as well as the Physical Therapy program. So that momentum is something I think all of us should be excited about, and all of us should be working to sustain. It’s going to require work, and the sustainability piece of it is going to be the most important to seeing true change at our institution.”

These conversations are instrumental in identifying areas for improvement and opportunity and developing plans, programs, and sustainable processes for implementing them.

One area identified by Dr. Collins is that “We really need to have a mechanism of recruiting and retaining faculty of color across the board. UNM has done a good job of pulling in faculty of color, but they don’t hang onto them. And we’ve got to begin to chip away at what’s going on behind the scenes and what’s systemically happening in the institution that’s lending itself to that outcome.”

Such examination and resulting solutions won’t be possible without opening up seats at the table to include feedback from learners, especially BIPOC learners whose voices and stories have been unheard and overlooked for far too long.

“We need to listen to the voices that haven’t previously been part of the conversation, and actually solicit input from those voices,” says Dr. Rohan-Minjares. “If we really listen to them, and hear their story, hear about their experience, I think we can make broader change that will create a more open environment for our learners, and I think in that way

we'll be able to grow as an institution."

Special thank you to Dr. Tracie Collins, physician, researcher and dean for UNM's College of Population Health (<https://hsc.unm.edu/population-health/>) and Dr. Felisha Rohan-Minjares, professor in UNM's Department of Family and Community Medicine (<https://hsc.unm.edu/school-of-medicine/education/learning-environment-office.html>) and assistant dean of Clinical Education & Learning Environments (<https://hsc.unm.edu/school-of-medicine/education/learning-environment-office.html>) at the UNM School of Medicine (<https://hsc.unm.edu/school-of-medicine/>) for their time and insights regarding racism in healthcare and how it affects patients' outcomes.

Racism: An Educational Series (previous stories)

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- The complicated history of environmental racism (<http://news.unm.edu/news/the-complicated-history-of-environmental-racism>) - Aug. 4
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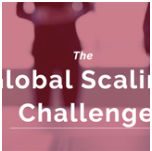
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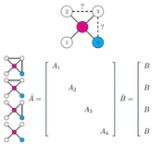


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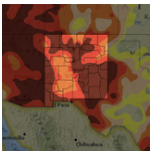
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