MEDICAL DISCRIMINATION

POLICY IMPLICATIONS OF MUTING PATIENTS' VOICES

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INTRODUCTION

WHAT IS MEDICAL DISCRIMINATION?

The influence of implicit bias within the health care system is seen through significant health care disparities between different groups in society. Physicians are making significantly different treatment decisions according to a patient's characteristics; gender, race, ethnicity, sexual orientation, gender identity, and more. This can lead to significant increases in morbidity and mortality for certain groups in society (Chapman & Carnes, 2013). Perceived discrimination across racial and ethnic, gender, sexual orientation, and gender identity lines impacts perceptions of health care providers and health outcomes (Benjamins & Middleton, 2019). Mistrust between patients and providers discourages marginalized people from seeking out healthcare and disclosng information to medical professionals (Cahill et al., 2016).

HISTORY

Sex Discrimination and Gender Bias in Medicine

Sex differences are often overlooked in clinical trials and medical research. Within the medical research community there has been frequent debate over whether or not there are biological differences between males and females and whether or not these differences should be studied. Women have historically been underrepresented in clinical research trials because of the traditional view that men and women are equal when it comes to research. Most clinical trials aim to recruit an equal number of male and female participants regardless of the trial. Despite this, many women end up not being included in clinical trials for a number of reasons, most commonly risk of hormone interference from the menstrual cycle and potential risks to pregnancy (Flanagan, 2014). Because of these barriers most participants in clinical trials are male and therefore most data concerning drugs and vaccines come from men. Further, many trials do not analyze data by sex at all due to their high costs and need for even larger sample sizes. The lack of female participants severely limits the amount of research and knowledge regarding how certain drugs and vaccines could affect women differently than men (Mager, 2016).

Since the early 1990s the National Institutes of Health (NIH) has been working to combat the issue of under representation and other disparities in clinical trials. While several pieces of legislation have been enacted to address these issues, little has actually been done. The NIH's Revitalization Act of 1993 required that women and people of color be included in clinical trials. This act only applies to government funded research trials, while the majority of trials are conducted through private pharmaceutical companies (Mazure & Jones, 2015). The Food and Drug Administration (FDA) has also attempted to increase the participation of women by requiring that they be included in research trials. Despite this provision, there is no requirement that the proportion of women be equal to that of men or the burden of the disease to women. The gender gap that exists in clinical research can have serious negative effects on all women.

Pregnant women are often not willing or not able to participate in research trials because of unknown risks to the pregnancy (Frew et al.). While this may seem like a good practice on the surface, it has left 91% of drugs with having an "undetermined" safety status for pregnant women (Frew et al.). Women are also often placed at disadvantage due to the lack of sex specific research. Upcoming research has revealed that sex hormones and differences can influence the development of certain diseases including lung cancer and Alzheimer's. Women can also present different symptoms for certain conditions than men. One study found that women are largely underrepresented in cardiovascular disease research and are less likely to survive a heart attack than men (Westervelt, 2015). Some credit this disparity with the fact that a heart attack can feel vastly different for women than men.

In addition to women being given inequitable treatment, this issue is further shown amongst Black women, specifically. The issue involving medical discrimination among Black women is not a new topic, and derives from systemic racism. Systemic racism is discrimination that is engrained within institutions, and reflected though disparities in wealth and income (Feagin and Bennefield, 1982). Systemic racism is important to examine because it furthers an understanding of practices that are deliberately embedded into society. This idea stems from the fact that America has fundamental racism that negatively affects people of color. Systemic racism can be linked to stressors that pregnant Black women face. These stressors include, but are not limited to: societal pressures placed on black women, and stereotypes about black women as a whole (Rosenthal, 2011).

Scientific Racism and Racial Bias in Medicine

In order to understand some of the discrimination that people of color, particularly black patients, face in modern medicine, we must trace its roots to scientific racism, which is defined as "a pseudoscientific belief that empirical evidence exists to support or justify racism (racial discrimination), racial inferiority, or racial superiority" (Wikipedia, 2020). Scientific racism began to appear in the United States in the early-mid 19th century when physicians began "experimenting" in order to find biological differences between blacks and whites. More specifically, physicians intended to prove that blacks were inferior to whites, and they did this not using real science but a rather biased observation.

Some of the "experiments" conducted were extremely gruesome, as shown in the story of John Brown, who was an enslaved black man in the 1820s. In one account, Brown recalled Dr. Hamilton, who would apply blisters to Brown's skin repeatedly in order to prove that black skin was thicker than white skin. The experimentation got so brutal that Brown could not return to his labor in the fields. Other recorded instances of how scientific racism was adopted and practiced by many respected physicians include the amputation of black extremities (to prove blacks had a higher pain tolerance) and the genital mutilation of enslaved black women (in order to understand the female reproductive system).

As a result, physicians of this time published ideas that became widely believed including that black people had...

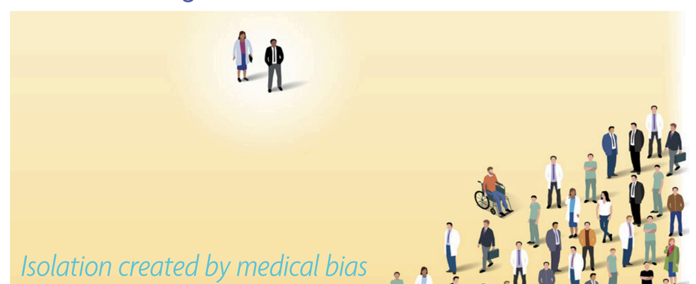
"large sex organs and small skulls — which translated to promiscuity and a lack of intelligence — and higher tolerance for heat, as well as immunity to some illnesses and susceptibility to others" (Villarosa, 2019). From these findings and the overall nature of the history itself, it is clear that racism is in fact embedded in American Medicine.

Due to this embeddedness, racism is still taught and believed by many practicing medical professionals today. For example, a 2016 survey found that "half of 222 white medical students and residents endorsed at least one myth about physiological differences between black people and white people, including that black people's nerve endings are less sensitive than white people's.

When asked to imagine how much pain white or black patients experienced in hypothetical situations, the medical students and residents insisted that black people felt less pain. This made the providers less likely to recommend the appropriate treatment. A third of these doctors also still believed the lie that Thomas Hamilton tortured John Brown to prove nearly two centuries ago: that black skin is thicker than white skin" (Villarosa, 2019). These misconceptions are stemmed in scientific racism and are now fueled and maintained through implicit biases in the health care field.

As mentioned, implicit bias, specifically biases about race, continues to negatively affect community health outcomes and patient-provider relations.

In a study, it was found that "Twenty-three out of 113 patients (20.4%) reported experiencing unfair treatment in a medical setting." (Hagiwara, N., et. al., 2016). This statistic specifically suggests that medical discrimination is occurring pretty frequently, giving the issue more salience to be on a policymaker's agenda. In addition, studies also show that these implicit biases and negative health outcomes are more common in communities of color. For example, Another study was conducted to assess implicit biases in health care workers, and it found that "levels of implicit bias against Black, Hispanic/Latino/Latina, and dark-skinned people were relatively similar across groups" (Hall, W. J., et. al., 2015). The study also revealed that "implicit attitudes were more often significantly related to patient-provider interactions and health outcomes than treatment processes" (Hall, W. J., et. al., 2015). These findings clearly show that multiple groups of people of color are subject to the discriminatory implicit biases of their medical providers. The dark reality of these statistics, as concluded by the above-mentioned study is that "most health care providers appear to have implicit biases in terms of positive attitudes toward Whites and negative attitudes toward people of color"(Hall, W. J., et. al., 2015). It is evident that implicit biases influenced by centuries of false beliefs in scientific racism are pretty ubiquitous among health care workers, and, in providing that these biases encourage negative health outcomes. Policymakers, health care workers, and educators should be taking a more active role in de-structuring these false beliefs.


Isolation created by medical bias

Heterosexism and Bias Against LGBT Communities

Existing health disparities based on sexual orientation and gender identities are rooted in historical stigma and discrimination against the LGBT community. The stigma that LGBT people face in all aspects of society shapes their perceptions and interactions with the healthcare system. Similarly, the socialization of heterosexual people, including healthcare providers, shapes their interactions with LGBT patients. Existing social norms establish cisgender identities and heterosexuality as the norm, while marginalizing individuals who exist outside of those identities.

During the 1940s, the conceptualization of homosexuals as a deviant sexual minority contributed to psychoanalysis of homosexuality as an illness. In 1952, the first edition of the DSM listed homosexuality as a sociopathic personality disturbance akin to substance abuse. This classification legitimized discrimination against LGBT people both in the mental health care system and in general society. Many gay men and women during the World War II era were pressured into seeking psychiatric treatment to "cure" their sexual orientation. As a result, this led to an acceptance of a marginalized status by the LGBT commnuity, building an environment of mistrust against the healthcare providers. During the 1970s, after a history of successful activism, the American Psychiatric Association removed homosexuality as a diagnosis.

The AIDS epidemic dramatically changed the health of the LGBT community, leading to the deaths of thousands of gay and bisexual men in the United States. This collective loss also contributed to community trauma and emotional distress. The AIDS epidemic triggered further hostility, stigma, and discrimination towards the LGBT community. Healthcare workers were often responsible for inadvertently "outing" gay patients and continuing to ostracize them. Physicians often refused to treat AIDS patients and become educated about AIDS.

"The medical society says the only ethical obligation is to refer the patient. In the hospitals, they don't require doctors to take AIDS patients. In the medical school, only a few people were assigned to AIDS, and interns weren't required to go into the clinic." - New York Times, 1990

Recent visiblity of the LGBT community has paved the way for groundbreaking research of health disparities for both LGB and transgender populations. Many of the barriers to healthcare that LGBT people face today stem from historically-rooted personal and structural stigma. Lack of health insurance, limited knowledge of LGBT health, and discrimination within the healthcare system contribute to existing health inequities .

More recently, there has been a recognition of the need to differentiatie helth risks specific to transgender populations. Historically, gender and sexuality were linked in early understandings of sexual orientation. However, transgender people face unique challenges with healthcare professionals providing gender-affirming services such as hormone therapy and genital reconstructive surgery. Transgender people also face increased harm from harassment and violence (Institute of Medicine, 2011).

DISCRIMINATION AMONG POPULATIONS

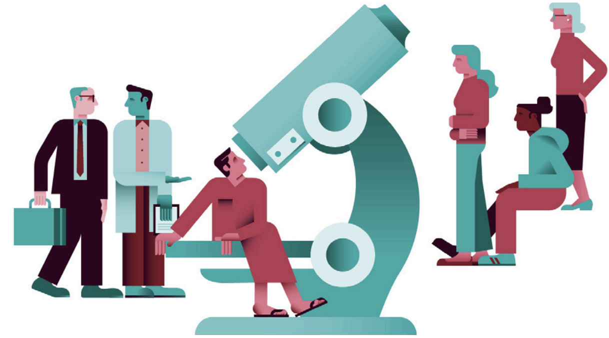
Discriminatory Attitudes by Medical Professionals

Against Women

Gender blindness and the passive affirmation of gender stereotypical differences and a subsequent overestimation of these differences by medical professionals can lead to unequal interpretations of medically identical cases for male and female patients (Hamberg, 2008). While there are many medical cases where there is a need for differing diagnosis and treatment according to a patient's gender, there is also alarming evidence of unequal treatment of men and women for no medical reason. Additionally, biological differences by gender are often used to justify gender-biased practices (Samulowitz et al., 2018).

These gender-biased practices often reinforce gender stereotypes which generalize men as more stoic and women as more emotional. Thus, women are seen as overreporting their pain and seeking care for their pain too readily, as compared to men (Dusenberry, 2018). Additionally, because of the dire lack of information and research specific to the female body and how illnesses impact it, women are more likely to experience symptoms which cannot be fully explained. Unfortunately, this does not often result in efforts to expand medical knowledge, but rather a dismissal of symptoms of this nature as psychogenic, hysterical, and ultimately imagined in their heads (Dusenberry, 2018).

Within maternity care, when women try to take a role in their own treatment by "declining procedures", they are seen as uncooperative and non-compliant patients.



However, in reality there is often an overuse of medical procedures within maternity care resulting in negative health outcomes for women (Attanasio & Hardeman, 2019). This situation reflects how the female voice is subject to greater questioning and higher standards while the male voice often has default legitimacy and authority (Dusenberry, 2018). Thus, women are often ignored, undermined, and overruled, even in regards to their own health care and body.

Overall, there is a disconnect in the validation of physical symptoms that doctors observe and document over self-perceived symptoms that women observe and report.

Against the LGBT Community

Although medical and nursing students might have knowledge about sexual orientations and gender identities, that does not indicate acceptance of LGBT identities. These attitudes disable health care professionals to deliver equitable and non-prejudiced care to LGBT patients and their families. (Chapman, Watkins, Zappia, Nicol & Shields, 2011). One survey found that 39.4% of physicians reported feeling discomfort providing care to gay patients (Bonvicini & Perlin, 2003).

Additionally, 65% of LGBT physicians reported hearing derogatory comments from other healthcare professionals about LGBT patients, and 34% witnessed discriminatory care of a LGBT patient (Bonvicini, 2017). In 2019, the Trump administration and the Department of Health and Human Services announced a new regulation allowing health care providers to refuse care on the basis of personal/religious objections. This will be particularly discriminatory against LGBT individuals as more people will likely be denied care (Clymer, 2019). In a 2011 US survey, 19% of transgender patients reported being refused medical care (Bonvicini, 2017). The Lambda Legal survey, a landmark LGBT health survey conducted in 2010, showed that 29% of transgender and gender non-conforming patients reported denial of care (Lambda Legal, 2010).

The survey also unveiled that 56% of LGB respondents and 70% of transgender/gender non-conforming respondents experienced "being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive."

In 2015, 55% of transgender patients were denied transition-related care by a physician (Clymer, 2019). Discriminatory attitudes are further amplified if the patient is low-income and/or a person of color (Lambda Legal, 2010).

Discrimination in Medical Education and Training

Against Women

There is a significant gender imbalance in research populations because clinical trials have for the most part been performed on primarily young to middle-aged white males (Hamberg, 2008). This disparity legitimizes andronormativity and hegemonic masculinity within health care, as any variation from the norms of the male body are seen as irregularities and often dismissed by health care providers (Samulowitz et al., 2018). Ultimately, this process introduces subjectivity into the diagnosis and treatment of patients through gender bias, and stereotypes are prioritized over individual needs.

Against the LGBT Community

Many physicians are simply not knowledgeable about LGBT people. This is due to lack of formal education and training in medical and nursing education. There was no LGBT-specific content in the clinical curriculum provided in 33% of medical schools (Bonvicini, 2017). Additionally, 29% of physicians reported they would talk about sexual orientation when discussing sexual health with adolescents, they believed that sexual orientation "was not significant," showing a lack of concern about LGBT health issues (Bonvicini, 2017). The LGBT-specific content that is presented in medical and nursing training is framed through the lens of human sexuality, which trivializes real LGBT health concerns (Bonvicini & Perlin, 2003).

IMPLICATIONS OF DISCRIMINATION

...on overall Female Health

Women of all groups face much worse health treatment, examination, and outcomes as compared to men. Women experiencing coronary artery disease, Parkinson's disease, irritable bowel syndrome, neck pain, knee joint arthrosis, tuberculosis, HIV treatment, dementia, and many other diseases and medical issues are examined and treated less extensively, have a harder time accessing examination and treatment, take more potentially harmful medication, and receive overall worse medical treatment compared to men (Hamberg, 2008; Hammarström et al., 2016; Schopen, 2017).

Additionally, women are three times less likely than men to receive knee arthroplasty when clinically appropriate. Despite the fact that men and women smoke at similar rates and women are becoming increasingly more likely to contract chronic obstructive pulmonary disease (COPD), men are more likely than women to be diagnosed with COPD while women more frequently receive less serious and incorrect diagnoses of asthma or even non-respiratory problems (Chapman & Carnes, 2013). Issues regarding gendered health disparities even occur at all ages, as older women are less likely than older men to be admitted to the ICU or receive life-saving interventions.

A specific context within medicine where women are especially penalized is treatment of pain. Women are more likely to have chronic pain than men, biologically more sensitive to pain than men, and respond differently to pain-killers (Samulowitz et al., 2018). Despite this, during the health care process, women are more likely to be given sedatives while men are more likely to be given pain medication (Hoffmann & Tarzian, 2001).

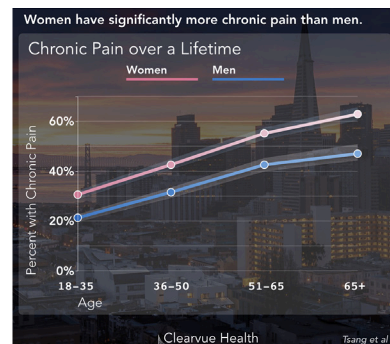


Figure 1: Women experience more pain than men in a lifetime[9]

However, when women report pain more frequently than men, they are often told that this pain is emotional, psychogenic, and ultimately not real, which results in their pain being taken less seriously and treated less adequately (Dusenberry, 2018; Samulowitz et al., 2018).

In addition to disparate health outcomes as compared to men, women also experience lower-quality treatment and dismissal of their self-reported health regarding health assistance only women need. In the process of childbirth hospitalization, women of all racial and ethnic groups are more likely to report perceived discrimination when they are seen as uncooperative by declining care in some form, and these negative consequences are amplified for women of color (Attanasio & Hardeman, 2019). It takes, on average, seven to eight years for women to be diagnosed with endometriosis, a very painful disorder (Schopen, 2017).

...on Black Women's Health

Research finds a three percent higher likelihood for preterm births among black women who were near to an incarceration increase among black individuals as a whole. This research shines a new light on how mass incarceration can play a role in health inequity in the black community (Dyer et al. 2019). Black women make up 44 maternal deaths per 1000, while white women see 12.4.

One of the ways that black women feel more comfortable during their healthcare treatment is by having a black doctor or nurse meet their needs more effectively. However, 5.7% of U.S physicians are African American, while 13% of the population identifies as black. Because of a gap between the number of black patients and the number of black doctors, this cannot be properly implemented (Etowa, 2012).

...on LGBT Health

Members of the LGBT community face heightened burden for disease compared to the general population. Gay and bisexual men are at increased risk for certain STIs such as HIV/AIDS.

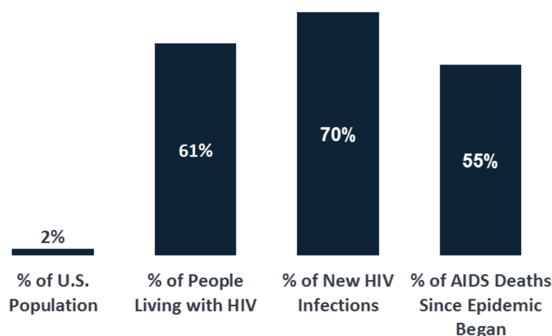


Figure 2: Impact of HIV/AIDS on Gay and Bisexual Men[1]

Lesbian women also face significant burdens related to reproductive health. They are less likely to have mammograms or pap test screenings for cancer (Daniel & Butkus, 2015). Additionally, they have higher risk for both illness and death from breast, ovarian, lung, and endometrial cancers than heterosexual women (Bonvicini & Perlin, 2003). Lesbian and bisexual women are more likely to be overweight or obese; and LGBT people are more likely to be disabled at a younger age than heterosexual people (Daniel & Butkus, 2015). LGBT people are at higher risk for mental health issues with 30-40% of gay adolescents attempting suicide, this is 6 times the national average (Bonvicini & Perlin, 2003). The risk for suicide is heightened for transgender adolescents and adolescents of color.

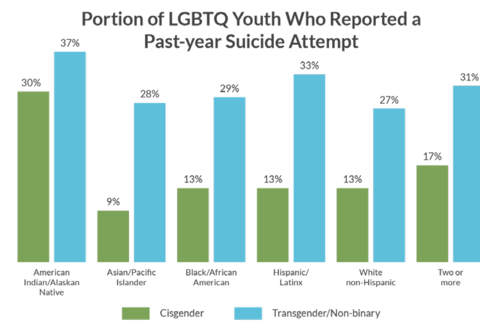


Figure 3: LGBT Youth Suicide Rates by Race[36]

The most significant medical risk that LGBT people face is avoiding regular health care. This is due to perceived insensitivity among health care providers and fear of being "outed" by medical professionals (Bonvicini & Perlin, 2003). According to the 2015 US Transgender Survey, 23% of transgender people reported not seeing a doctor when they needed to because they feared mistreatment over their gender identity (Clymer, 2019). LGBT people have long histories of negative interactions with healthcare professionals (such as homophobia and receiving inadequate care), as a result they can be reluctant to disclose their sexual orientation or gender identity and may be reluctant to seek out care (Chapman, Watkins, Zappia, Nicol & Shields, 2011). The Lambda Legal survey reported that 9% of LGB patients and over 50% of transgender patients anticipated discriminatory care from health care professionals, and that such concerns were barriers to seeking care (Lambda Legal, 2010). Stigma, including discrimination by medical professionals, is associated with higher suicide rates (Raifman & Galea, 2018). The Trump Administration's religious exemptions would further increase barriers to healthcare by allowing medical providers to turn away LGBT patients by assertying a religious or moral objection to treatment. In a 2017 study, 8% of LGB respondents and 29% of transgender respondents reported that a healthcare provider had refused to see them because of their sexual orientation or gender identity in the past year (Human Rights Watch, 2018).

POLICY RECOMMENDATIONS

1. Decrease the Negative Impact of Implicit Bias

The role of physicians is very important in attempting to promote more equal health outcomes for women and for all groups in general that experience discrimination in the doctor's office. Physicians should thus actively work to acknowledge that biases have negative impacts on health care and that they themselves may be susceptible to treating a patient differently based on their own biases. In order to combat this while working, physicians should try to understand the perspective of the patient and focus on each individual patient's medical information as separate from their social identifications (Chapman & Carnes, 2013).

In addition, an increased presence of physicians from social groups that are impacted by these health care disparities in the form of descriptive representation can help patients who feel unheard and underrepresented (Chapman & Carnes, 2013). In this way, there is a higher likelihood that patients are matched with doctors who understand their specific health care needs, or at the very least medical professionals will be surrounded by greater diversity and expand their knowledge.

2. Improving Education

There is a need for broader education within medical schools and overall health education, specifically concerning sex- and gender-related processes, reactions, and treatments and further critical reasoning and reflection regarding patient care within this context. With this, it is important to teach gender bias in the context of an intersectional approach rather than a dichotomous view of men versus women.

Hospitals and medical centers also need to create culturally competent training for health care professionals that focus on LGBT-specific content. This includes coursework in medical school, nursing school, and professional training (Lambda Legal, 2010). It is necessary that healthcare providers learn about LGBT health issues outside of human sexuality as well as how to interact with LGBT patients and their families. SImilarly, it is important that the medical curriculum does not uphold heterosexism and the cisgender body as the norm.

People should be aware of what is happening in the healthcare system, even if it does not impact them directly. By increasing education in all groups of people, we can expect change to gradually happen.

3. Implementing a gender equity tool

The implementation of policy solutions aimed at promoting gender equity and gender equality in health care at national and international levels (e.g. Canada's sex- and gender-based research analysis, WHO's "Gender Policy") have certainly met some success (Hammarström et al., 2016). However, there is also great need for micro level approaches which function within specific contexts. With this, monitoring of the efficiency of the policy and the results of implementation are easier. Additionally, macro level approaches can often lack details and end up being too broad and idealistic to be fully successful throughout a large geographic region (Hammarström et al., 2016).

Through this, developing a gender equality tool in the form of a questionnaire to evaluate the degree to which the workplace and the health professionals making clinical assessments and treating patients within it are providing gender equal care is a useful solution at the macro level (Hammarström et al., 2016). With this, both the respective health care facility and its employees can be held accountable for potential biases that may be introduced on a patient-to-patient basis.

4. Promoting Positive Patient-Provider Interactions

LGBT patients must be able to trust that their providers will respect them and protect their confidential information. Healthcare professionals should encourage patients to disclose information about LGBT identities to provide important and relevant information for the delivery of appropriate health care. Strategies such as using gender neutral language facilitates open communication. (Chapman, Watkins, Zappia, Nicol & Shields, 2011) Changing the ways that providers speak with their patients helps to avoid heterosexism and normalize LGBT identities. To build trust, providers must reinforce that personal information (including sexual orientation and gender identity) are confidential, and that all patients are guaranteed equal treatment regardless of status. However, LGBT people should also not be "outed" or forced to disclose information against their will. Providers should let the patient disclose information and set the tone of the discussion at their own pace (Bonvicini & Perlin, 2003).

Lastly, visitation restrictions that only permit spouses and blood relatives or allow providers to protest visitation on personal/ religious grounds can be discriminatory against LGBT people. Hospitals and medical facilities must allow all patients to determine visitors regardless of sexual orientation, gender identity, or marital status (Daniel & Butkus, 2015).

5. Improving Access to Care

Private and public health care plans should cover costs for transgender health care services such as hormone therapy and sex reassignment surgery (Daniel & Butkus, 2015). Lawmakers must also prohibit discrimination in health care on the basis of sexual orientation and gender identity.

"When LGBT people seek medical care, the oath to do no harm too often gives way to judgment and discrimination... Lawmakers need to make clear that patients come first, regardless of their sexual orientation or gender identity."

- Human Rights Watch

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6. Changing Study Protocol

Because health inequities are becoming increasingly prevalent in the medical system, researchers are attempting to find solutions to the problem at hand. Through "EQUIP," an organizational intervention geared towards emergency rooms, medical professions will focus on areas of improvement through workshops. The plan includes: client population, policy and funding context, and surrounds equity-oriented healthcare. By deliberately creating spaces for discussion, leading to a change in action, it allows a focus to be on proper treatment for these groups (Varcoe, 2019).

7. Engaging Elected Officials

Embedding policies prohibiting the proliferation of discrimination in medicine helps start systemtic change. Voting and writing to elected officials is an accessible way to put medical discrimination on the policymaking agenda.

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