CHAPTER 13

Race, Racial Bias, and Health Care

In the twenty-first century, we want to believe that racial bias could not and does not infect modern science-based health care. But it can and it does. Research shows that the health of minority persons is generally worse than that of whites (often *much* worse)—and that the differences are not due primarily to racial or genetic inferiority or to personal or social preferences. To a very large extent, the differences derive from racial bias and inequities built into the very structures and institutions of society. We want to believe that people of color have the same access to health care as everyone else and that the care provided is as good as that provided to whites. But extensive evidence shows that this is not the case. We would like to think that racial profiling—which is so objectionable in law enforcement and schooling—does not exist in the clinic or hospital or doctor's office. But despite the competence and compassion of well-meaning health care workers, it does.

To make moral sense of all this, we must first understand what race and racism are, and we must examine what recent scientific studies of racial bias in health and medicine have revealed.

RACE AND RACISM

The basic presupposition of racism is that there are in fact such things as races—the notion that there are discrete groups of people who share certain essential, inherent characteristics. The traditional idea is that race is a matter of heritable *biological* features common to all members of a racial group and that these features explain the psychological and cultural traits of those members. Race scholar Lawrence Blum points out that the popular idea of race generally omits the biological element but keeps the idea of *inherency*—the notion that "certain traits of mind, character, and temperament are inescapably part of a racial group's 'nature' and hence define its racial fate."[1] A group's nature is supposed to be permanent and unchanging. On this conception of race, Whites are just naturally that way; Blacks are naturally this way; Jews have these inherent traits; Asians have these inherent characteristics; Native Americans have this inherent disposition. Racism, then, presupposes the idea that distinct races exist and that important, inherent differences among them can be distinguished. This presupposition alone, however, does not constitute racism. **Racism** is the additional belief that some races are inferior in these important ways or are otherwise deserving of dislike or hostility.

The two essential elements in this definition are what Blum calls *inferiorization* and *antipathy*. All forms of racism, he says, can be identified by reference to one or both of these concepts:

> Inferiorization is linked to historical racist doctrine and racist social systems. Slavery, segregation, imperialism, apartheid, and Nazism all treated certain groups as inferior to other groups . . .
>
> Though race-based antipathy is less related to the original concept of "racism," today the term unequivocally encompasses racial bigotry, hostility, and hatred. Indeed, the racial bigot is many people's paradigm image of a "racist.". . .
>
> Historical systems of racism did of course inevitably involve racial antipathy as well as

> inferiorization. Hatred of Jews was central to Nazi philosophy; and it is impossible to understand American racism without seeing hostility to blacks and Native Americans as integral to the nexus of attitudes and emotions that shored up slavery and segregation.[2]

Racism is morally wrong, and shortly we'll examine exactly why that is. But racism is also *empirically* wrong—it is based on assumptions about the world that science has shown to be unfounded. The consensus among scientists and scholars is that the traditional view of races—that there are distinct groups of people sharing significant biological characteristics—is false. Race, in other words, has no physical scientific basis. Sociologist Tanya Maria Golash-Boza explains:

> Race is a social construction, an idea we endow with meaning through daily interactions. It has no biological basis. This might seem odd to read, as the physical differences between a Kenyan, a Swede, and a Han Chinese, for example, are obvious. However, these physical differences do not necessarily mean that the world can be divided into discrete racial groups. If you were to walk from Kenya to Sweden to China, you would note incremental gradations in physical differences between people across space, and it would be difficult to decide where to draw the line between Africa and Europe and between Europe and Asia. There may be genetic differences between Kenyans and Swedes, but the genetic variations within the Kenyan population are actually greater than those between Swedes and Kenyans. Although race is a social, as opposed to a biological, construction, it has a wide range of consequences in our society, especially when used as a sorting and stratifying mechanism.[3]

Philosopher Naomi Zack, editor of *The Oxford Handbook of Philosophy and Race*, sums up the science like this:

> There are no general genes for race, such that, once identified, their presence could be used to predict more specific, or secondary, racial characteristics. None of the physical differences associated with racial difference in society is correlated with any important difference in human talent, function, or skill. . . .
>
> To conclude, there is no foundation in science for racial difference, either on the basis of physical traits that in American society are believed to indicate biological racial membership, or on the basis of any traits that may be presumed to determine mental and psychological capabilities.[4]

If races don't exist in any biological sense—if there is no physical basis for sorting people into recognizable racial categories—then the central assumption underlying the traditional form of racism collapses.

Many people assume that the idea of race has been around since the dawn of history, but this assumption is incorrect. Historically, the idea that people can be divided into discrete groups based on their common biological and cultural traits is relatively new. In the ancient world, people did not think to categorize humanity into exclusive racial groups. They recognized that cultures might differ in various ways—in skin color, for example—but they did not lump all persons of a particular skin tone into a single social classification. The idea of race arose in different forms over time beginning only around the sixteenth century. Historians and sociologists maintain that as Europeans subjugated and enslaved Africans and native peoples in the Americas, the idea of inferior and superior races developed and was used to rationalize the unequal status and ill treatment of whole cultures.

In the nineteenth and early twentieth centuries, scientifically minded thinkers sought to prove that there were indeed separate races, that race could explain the basic differences among people, that some races were superior to others, and that the White European race was superior to all. These endeavors came to be known as *scientific racism*, and they have been largely discredited by modern science. Starting from dubious assumptions and drawing from data such as skull and brain measurements and

"intelligence" tests, these early investigators argued that European men were biologically more advanced and more intelligent than any other racial group and that these advantages explained their dominance in the world. Scientific research in later decades, however, debunked these conclusions by showing that they were based on obvious biases, faulty assumptions, methodological errors, and motivated reasoning.

So if race is a social construction, should we discard the concept of race altogether? Many who have studied this question are reluctant to do that. The political scientist Michael James, for example, says,

> Race constructivists accept the skeptics' dismissal of biological race but argue that the term still meaningfully refers to the widespread grouping of individuals into certain categories by society, indeed often by the very members of such racial ascriptions. Normatively, race constructivists argue that since society labels people according to racial categories, and since such labeling often leads to race-based differences in resources, opportunities, and well-being, the concept of race must be conserved, in order to facilitate race-based social movements or policies, such as affirmative action, that compensate for socially constructed but socially relevant racial differences.[5]

Even though races in the biological sense don't exist, "racialized groups"—groups that people *believe* are discrete races and treat as such—do. Scholars contend that despite the nonexistence of biological race, giving up entirely our ability to talk and think about racialized groups and racial realities would have disastrous effects—which is why so many observers condemn the notion of racial color blindness. As Blum says,

> Jettisoning race in the two ways I've mentioned (racial language and racial thinking) would have important moral costs as well. Many would be misled into thinking that if there are no races, there can be no racism, no groups to be its target. But to be a target of racism requires only that a group is racialized, not that it is actually a race.
>
> More fundamentally, race is part of our history and our current social arrangements. Groups defined by race are continuing targets of discrimination, inferiorizing, and stigmatizing. These groups, especially blacks, Native Americans, and some Latino/Hispanic groups, also live with accumulated deficits from even more horrendous injustices in the past. Whites possess a range of unearned advantages in virtually every major domain of social existence—education, jobs, health care, and political power; and often they harbor subtle assumptions that they are "all right" while other groups are defective in some way. If we give up race entirely, we abandon the ability to name these racial wrongs. . . . Color blindness has assumed the status of an almost absolute principle that further motivates whites to be blind to continuing racial discrimination and injustice.[6]

So racism involves either the idea that some racial groups are inferior to others or that some deserve dislike or hostility. It can be manifested in personal beliefs, attitudes, and actions, or in the activities, rules, or policies of governments and organizations. It can harm people through institutions and procedures—even when the persons behind those systems do not themselves harbor any racial prejudice.

Racism is widely regarded as a kind of moral failing, something of which most people would want never to be guilty; nor would they ever want to be called a racist, whether or not they are guilty of the charge.

Racism is morally wrong. But why?

Inferiorizing racism is morally wrong mainly because it is a violation of fundamental moral principles (discussed in Chapter 1). It violates the principle of *respect for persons*, the precept that persons are possessors of ultimate inherent worth and should be treated as such. Persons have rights—the rights of free expression, choice, and privacy, the right not to be coerced, enslaved, cheated, or discriminated against.

This form of racism also violates the *principle of justice*, the idea that people should get what is fair or what is their due or, more generally, that equals should be treated equally. People should be treated the same unless there is a morally relevant reason for treating them differently—and racial difference is *not* morally relevant.

Antipathy racism is morally blameworthy because hatred, hostility, and bigotry are vices, especially when they are directed against people who have been made to suffer solely because of their membership in a racial group. Antipathy racism, like the inferiorizing kind, has led to, and still leads to, racial conflict, suffering, injustice, and violence.

For many ethicists, racism is morally wrong simply because it hurts people. This is an appeal to another moral principle, the principle of *utility*, which says we should produce the most favorable balance of benefit over harm for all concerned. It is obvious that racist beliefs, words, and actions can do harm or lead to harm, and the harm is magnified when racism operates through institutions, corporations, governments, and the law.

Many today believe that racism and racial discrimination, despite a few racist incidents here and there, are a thing of the past. But most experts who have studied racism and race relations would strongly disagree. They say racism is indeed a significant problem in America, as evidenced by widespread racial inequalities at nearly every level of society. Naomi Zack asks,

> How is it that in a post-civil rights age of racial equality, people of color are disproportionately undereducated, poor, incarcerated, and more likely to be treated violently by police? The contradiction between equality as stated in law and humanitarian and scientific consensus versus the reality of social inequality and injustice cannot be adequately addressed as a psychological or ethical issue, on the level of individuals. Deeper cultural, political, and economic analyses are required to explain why and how people behave in ways that appear to violate their highest and most general legal and moral principles.[7]

Here's a sketch of some of the more striking examples of racial inequality today, from the social scientist and race scholar Eduardo Bonilla-Silva:

> Blacks and dark-skinned racial minorities lag well behind whites in virtually every area of social life; they are about three times more likely to be poor than whites, earn about 40 percent less than whites, and have about an eighth of the net worth that whites have. They also receive an inferior education compared to whites, even when they attend integrated institutions. In terms of housing, black-owned units comparable to white-owned ones are valued at 35 percent less. Blacks and Latinos also have less access to the entire housing market because whites, through a variety of exclusionary practices by white realtors and homeowners, have been successful in effectively limiting their entrance into many neighborhoods. Blacks receive impolite treatment in stores, in restaurants, and in a host of other commercial transactions. Researchers have also documented that blacks pay more for goods such as cars and houses than do whites. Finally, blacks and dark-skinned Latinos are the targets of racial profiling by the police, which, combined with the highly racialized criminal court system, guarantees their overrepresentation among those arrested, prosecuted, incarcerated, and if charged for a capital crime, executed. Racial profiling on the highways has become such a prevalent phenomenon that a term has emerged to describe it: driving while black. In short, blacks and most minorities are "at the bottom of the well."[8]

How do we explain these inequalities? And how is it that many Whites claim not to see racism? According to Bonilla-Silva,

> Nowadays, except for members of white supremacist organizations, few whites in the United States claim to be "racist." Most whites assert they "don't see any color, just people"; that although the ugly face of discrimination is still with us, it is no longer the central factor determining minorities' life chances; and, finally, that, like Dr. Martin

> Luther King Jr., they aspire to live in a society where "people are judged by the content of their character, not by the color of their skin." More poignantly, most whites insist that minorities (especially blacks) are the ones responsible for what "race problem" we have in this country. . . . Most whites believe that if blacks and other minorities would just stop thinking about the past, work hard, and complain less (particularly about racial discrimination), then Americans of all hues could "all get along."[9]

If Whites do see contemporary racial inequality, says Bonilla-Silva, they are likely to blame it on nonracial factors:

> Whites rationalize minorities' contemporary status as the product of market dynamics, naturally occurring phenomena, and blacks' imputed cultural limitations. For instance, whites can attribute Latinos' high poverty rate to a relaxed work ethic ("the Hispanics are mañana, mañana, mañana—tomorrow, tomorrow, tomorrow") or residential segregation as the result of natural tendencies among groups ("Does a cat and dog mix? I can't see it. You can't drink milk and scotch. Certain mixes don't mix.").[10]

For many people, racism is basically **individual racism**, person-to-person acts of intolerance or discrimination. But as we've seen, a prevalent, seldom acknowledged kind of racism is **institutional** or **structural racism**, unequal treatment that arises from the way organizations, institutions, and social systems operate. This is inferiorizing or antipathy racism that functions almost unseen in corporations, government agencies, schools, the labor market, and systems of health care, housing, and criminal justice. The people who work within such systems may or may not be racially prejudiced, but the systems themselves cause racial discrimination and inequality through their policies and procedures.

Both individuals and systems can perpetuate racial prejudice or racial discrimination. **Racial prejudice** is antipathy toward a racial group based on a faulty view of that group. **Racial discrimination** is unfavorable treatment of people because of their race. Of course, prejudice and discrimination can be directed at traits other than race, including sexual orientation, age, gender, ethnicity, religion, and national origin.

Overt, individual racism (the kind voiced publicly in racial slurs, for example) may be less common these days, but scholars insist that institutional or structural racism is common and nearly invisible. According to Bonilla-Silva:

> Contemporary racial inequality is reproduced through "new racism" practices that are subtle, institutional, and apparently nonracial. In contrast to the Jim Crow era, where racial inequality was enforced through overt means (e.g., signs saying "No Niggers Welcomed Here" or shotgun diplomacy at the voting booth), today racial practices operate in a "now you see it, now you don't" fashion. For example, residential segregation, which is almost as high today as it was in the past, is no longer accomplished through overtly discriminatory practices. Instead, covert behaviors such as not showing all the available units, steering minorities and whites into certain neighborhoods, quoting higher rents or prices to minority applicants, or not advertising units at all are the weapons of choice to maintain separate communities. In the economic field, "smiling face" discrimination ("We don't have jobs now, but please check later"), advertising job openings in mostly white networks and ethnic newspapers, and steering highly educated people of color into poorly remunerated jobs or jobs with limited opportunities for mobility are the new ways of keeping minorities in a secondary position. Politically, although the civil rights struggles have helped remove many of the obstacles for the electoral participation of people of color, racial gerrymandering, multimember legislative districts, election runoffs, annexation of predominately white areas, at-large district elections, and anti-single-shot devices (disallowing concentrating votes [on] one or two candidates in cities using at-large elections) have become standard practices to disenfranchise people of color.[11]

Today Blacks fare much worse than Whites in income, wealth, education, employment, home ownership, and health (discussed in the next section). These inequalities are caused by racist policies and conditions of the past, and they have in most cases been allowed to continue or been made worse by inequalities in the present.

A good example is racial inequalities in wealth. Income is the money an individual earns from work, but wealth consists of a person's total assets—cash and property (land, houses, cars, savings, investments), minus debt. In the United States, in 2016, the typical Black household could claim just $13,024 in wealth, while a typical White household had $149,703.[12] The vast difference can be explained by a history of official and unofficial anti-Black discrimination. According to Golash-Boza:

> One of the main reasons for the inability of blacks to build wealth has been the creation of housing segregation within U.S. cities. . . .
>
> A combination of three forces led to residential segregation: collective racial violence carried out by whites, federal housing programs and policies that exclusively benefited whites, and practices created and reinforced by the nascent real estate industry. . . .
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> The Federal Housing Administration (FHA) was established in 1934 with the purpose of bolstering the economy and, in particular, the construction industry. . . . The FHA created the conditions under which banks could loan people money to purchase homes with small down payments and at reasonable interest rates. . . .
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> Banks used FHA guidelines to decide who should be permitted to borrow money. The 1938 *Underwriting Manual* of the FHA stated that "if a neighborhood is to retain stability, it is necessary that properties shall continue to be occupied by the same social and racial classes." . . . The *Manual* also endorsed a practice known as *redlining*, in which communities where loans were not recommended were outlined in red on a map. Those communities where loans were denied were primarily black.
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> Between 1933 and 1978, U.S. government policies enabled over 35 million families to increase their wealth through housing equity. As homeowners, millions of Americans were able to begin to accumulate tax savings, home equity, economic stability, and other benefits associated with homeownership. White Americans benefited disproportionately from this shift for two primary reasons: (1) it was easier for white people to purchase homes, and (2) the homes that whites bought increased in value more rapidly than those purchased by blacks because of the perceived desirability of all-white neighborhoods. . . .
>
> The final factor that contributed to residential segregation was *racially restrictive covenants*—contractual agreements that prevent the sale or lease of property within an area to non-whites—created and enforced by the real estate industry. By the 1920s, deeds in nearly every new housing development in the northern United States prevented the ownership or rental of houses in the development by anyone who was not white. . . .
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> In 1948, the Supreme Court declared racially restrictive covenants unenforceable. And in 1968, the passage of the Fair Housing Act made these covenants illegal. Once the covenants became illegal, real estate agents developed new tactics to preserve residential segregation. One of the most common activities was *steering*, in which real estate agents would show homes in white neighborhoods only to whites and homes in black neighborhoods only to blacks. For these and other reasons, over sixty years after the passage of the Fair Housing Act, we still have high levels of residential segregation, exacerbating wealth inequality.[13]

Racial disparities in education have also been linked to racial segregation, prejudice, and discrimination—while many Whites incorrectly assume the inequalities are due to minority children's mental deficiencies. Most scholars reject this psychological explanation, as Lawrence Blum explains:

> The idea that conventionally defined racial groups differ in intelligence has been largely

> discredited by contemporary science, and popular adherence to it has declined sharply. But it has by no means entirely disappeared in popular thought, and a more statistically based form has arisen in genetic science as well. In the United States, both forms are encouraged by a basic fact on the ground in education—often referred to as the "achievement gap"—that by almost every plausible measure, black, Native American, and Latino students do not do as well in school as white and Asian students. This gap encourages the view that there is something educationally deficient about black, Latino, and Native American students. Racial achievement gaps can be explained by a range of factors, most of which concern black and Latino students' circumstances rather than their innate capacities—poorer health among disadvantaged racial minorities; less parental education, which disadvantages students in various different ways; lower parental socio-economic status (SES), often leading to unstable home and living situations and moving from school to school; stress from not having decent and regular employment; teacher racial prejudice, ignorance and insensitivity; living in neighborhoods of concentrated disadvantage; and cultural factors relating to school engagement among minority youth.[14]

HEALTH DISPARITIES AND RACE

Health disparities are differences among population groups in mortality and disease. For thirty years, researchers have been finding significant health disparities between Whites and minorities, with the latter often faring worse.[15] The urgent question is why these disparities exist, and more recent investigations have been yielding answers.

Researchers have found the most telling—and most worrisome—disparities in three areas: infant mortality, life expectancy, and age-adjusted death rates.

Infant mortality is a sign of both infant and maternal health and is regarded as a key indicator of the health of a country. Infant mortality rates are expressed as the number of infants who die before their first birthday per 1,000 live births. According to a landmark report on health disparities from the National Institutes of Health (NIH),

> U.S. infant mortality rates have decreased since 2005 for the overall population and within each racial and ethnic group; however, sharp racial and ethnic disparities persist. In 2013, as in previous years, the infant mortality rate among African Americans (11.1 per 1,000 live births) was double the rate among whites (5.06 per 1,000 live births). American Indians/Alaska Natives and Puerto Ricans also experienced higher infant mortality rates (of 7.61 and 5.93 per 1,000 live births, respectively) than whites. . . . If white America and black America were two separate nations, white America's infant mortality rate would rank 49th in the world, while black America's would be ranked 95th out of 224 nations . . . following Botswana, Sri Lanka, the United Arab Emirates, and Turks and Caicos Islands. . . .
>
> In 2015 the percentage of low-birthweight infants rose for the first time in 7 years. For white infants, the rate of low-birthweight infants was essentially unchanged, but for African American and Hispanic infants, the rate increased.[16]

Premature birth signals an increased risk of infant death. In 2014, non-Hispanic Black mothers had a higher percentage of preterm births than any other racial or ethnic group.

Life expectancy is a measure of the overall health of a population, typically expressed as the average number of years a newborn would be expected to live. It reflects the degree to which fundamental living conditions of a society—socioeconomic, environmental, and health care related—help people live a long and healthy life. From the NIH report:

> Better living conditions and better access to health care-related resources throughout the lifespan extend longevity. From 1980 to 2014, U.S. life expectancy (at birth) increased by

> approximately 6 years for males, reaching 76.4 years, and increased 3 years for females, reaching 81.2 years. Racial and ethnic disparities decreased, but they were not eliminated. In 2014, the life expectancy for African American males was 72.0 years, while that for white males was 76.5 years and that for Latino males was 79.2 years. In the same year, life expectancy was 78.1 years for African American females, 81.1 years for white females, and 84.0 years for Latina females.[17]

Age-adjusted mortality rates sum up deaths in a population from all causes except old age. The age-adjusted death rate per 100,000 (for the years 2012–2014) was 729.1 for Whites and 858.1 for Blacks.[18] The death rate due to heart disease was 165.9 deaths per 100,000 for Whites and 206.3 deaths for Blacks. For cancer the death rate was 161.9 for Whites but 185.6 for Blacks; for diabetes, 19.3 for Whites, 37.3 for Blacks.[19]

Another important benchmark is the potential life lost due to early death, measured in "person-years per 100,000 before the age of 75." On this score, non-Hispanic Whites lost 6,659.4 years; non-Hispanic Blacks lost 9,490.6 years; and American or Alaska Natives lost 6,954.0 years.[20]

What causes all these health disparities? It is tempting to lay most of the blame on what sociologists call socioeconomic status (income, education, etc.), but this explanation is too simplistic. According to the NIH,

> It is well documented that low socioeconomic status (SES) hampers an individual's ability to achieve optimal health by limiting access to health-preserving resources. However, SES does not fully explain health disparities based on race and ethnicity, sexual orientation and gender identity.[21]

Most research on this question points instead to society's structural inequities, the systematic disadvantage of particular social groups in relation to others. When racial groups are affected in this way, the problem is structural racism, a well-documented fact of American life.[22] The NIH report says,

> The evidence linking racism to health disparities is expanding rapidly. A variety of both general and disease-specific mechanisms have been identified; they link racism to outcomes in mental health, cardiovascular disease, birth defects, and other outcomes. Which racism mechanisms matter most depends in part on the disease and, to a lesser degree, the population. The vast majority of studies focus on the role of discrimination; that is racially disparate treatment from another individual or, in some cases, from an institution. Among the studies not focused on discrimination, the majority examine segregation. Generally, findings show that members of all groups, including whites, report experiencing racial discrimination, with levels typically, though not always, higher among African Americans and, to a lesser degree, Hispanics than among whites.[23]

Racial discrimination can lead to health disparities via several paths:

> The mechanisms by which discrimination operates include overt, intentional treatment as well as inadvertent, subconscious treatment of individuals in ways that systematically differ so that minorities are treated worse than nonminorities. Recent meta-analyses suggest that racial discrimination has deleterious effects on the physical and mental health of individuals. Significant percentages of members of racial and ethnic minority populations report experiencing discrimination in health care and non-health care settings. Greater proportions of African Americans than members of other groups report either experiencing discrimination personally or perceiving it as affecting African Americans in general, even if they have not experienced it personally. Hate crimes motivated by race or ethnicity bias disproportionately affect Hispanics and African Americans. . . .
>
> Discrimination is generally associated with worse mental health; greater engagement in risky behaviors; decreased neurological responses; and other biomarkers signaling the dysregulation of allostatic load [cumulative burden of chronic

stress and life events]; hypertension-related outcomes, though some evidence suggests racism does not drive these outcomes; reduced likelihood of some health protecting behaviors; and poorer birth-related outcomes such as preterm delivery. . . .

Though people may experience overt forms of racism (e.g., being unfairly fired on the basis of race), the adverse health effects of racism appear to stem primarily from the stress of chronic exposure to seemingly minor forms of "everyday racism" (i.e., racial microaggressions), such as being treated with less respect by others, being stopped by police for no apparent reason, or being monitored by salespeople while shopping. The chronic exposure contributes to stress-related physiological effects. Thus, discrimination appears to exert its greatest effects not because of exposure to a single life traumatic incident but because people must mentally and physically contend with or be prepared to contend with seemingly minor insults and assaults on a near continual basis. The implications appear to be greatest for stress-related conditions such as those tied to hypertension, mental health outcomes, substance abuse behaviors, and birth-related outcomes (e.g., low birth weight and premature birth) than for other outcomes.[24]

Racial segregation is also a powerful force driving health disparities:

> Residential segregation—that is, the degree to which groups live separately from one another—can exacerbate the rates of disease among minorities, and social isolation can reduce the public's sense of urgency about the need to intervene. . . . Racial segregation contributes to disparities in a variety of ways. It limits the socioeconomic resources available to residents of minority neighborhoods as employers and higher SES individuals leave the neighborhoods; it reduces health care provider density in predominately African American communities, which affects access to health care; it constrains opportunities to engage in recommended health behaviors such as walking; it may be associated with greater density of alcohol outlets, tobacco advertisements, and fast food outlets in African American and other minority neighborhoods; it increases the risk for exposure to environmental hazards; and it contributes to the mental and physical consequences of prevalent violence, including gun violence and aggressive policing.[25]

IMPLICIT BIAS IN HEALTH CARE

A substantial body of evidence shows that racial and ethnic bias is a serious problem in health care. In 2003, after reviewing over one hundred studies, the Institute of Medicine (IOM) issued a momentous report concluding that bias and prejudice led to widespread differences in health care by race and ethnicity.[26] In the two decades that followed, mounting evidence confirmed the original findings. Scholars commenting on the report said the IOM

> documented that from the simplest to the most technologically advanced diagnostic and therapeutic interventions, African American (or black) individuals and those in other minority groups receive fewer procedures and poorer-quality medical care than white individuals. These differences existed even after statistical adjustment for variations in health insurance, stage and severity of disease, income or education, comorbid disease, and the type of health care facility. Very limited progress has been made in reducing racial/ethnic disparities in the quality and intensity of care.

This is a shocking finding, especially considering what we know about the benign attitudes and motivations of health care providers. A scholar who has thoroughly investigated this inconsistency is Dayna Bowen Matthew. She notes that

> When compared with other professionals, health providers express overwhelmingly altruistic, fair, and equitable motivations towards their work and the patients they serve. Doctors are well educated and therefore can be expected to be enlightened

about equality matters. They are self-described as members of a "helping" and "healing profession," and throughout their training they adhere to a commitment to "first, do no harm" to patients. Many physicians are actively dedicated to achieving equity and distributive justice in health care, often giving their time freely to serve needy populations at home and abroad. . . .

However, a vast body of social science research describes hundreds of experiments, in scores of medical journals, across virtually every major medical specialty that confirm that a patient's race and ethnicity continue to influence physicians' medical conduct and decision-making, well beyond the limits of what is clinically justifiable.[27]

What is the explanation for this contradiction? The NIH, the IOM, and a host of investigators point to the phenomenon of **implicit bias**, a negative attitude toward a group of people that operates *unintentionally* or *unconsciously*. Four decades of research have demonstrated that virtually everyone has implicit biases, that discriminatory behavior can be predicted based on such biases, and that implicit biases often have a more powerful impact on behavior than explicitly held beliefs. Physicians are not immune to this very human failing. As Matthew says,

> The empirical evidence that race and ethnicity influence physicians to make harmful distinctions in how they treat and interact with white patients versus patients of color is overwhelming. A preponderance of evidence compels the conclusion that the vast majority of provider discrimination causing disparities is a product of implicit, not explicit bias. Physicians' implicit biases lead to unintentional and in some cases, even unconscious discrimination. The resulting biased behavior may directly contradict the physician's sincerely held, explicit beliefs and intentions to provide excellent care to all patients regardless of their race or ethnicity.[28]

The NIH report concurs:

> Much of the public health literature has focused on the implicit biases of health care providers, who with little time to devote to each patient can provide care that is systematically worse for African American patients than for white patients even though the health care provider never intended to do so. The evidence is clear that unconscious racialized perceptions contribute to differences in how various individual actors, including health care providers, perceive others and treat them. Based on psychology lab experiments, functional magnetic resonance imaging (fMRI) pictures of the brain, and other tools, researchers find that white providers hold implicit biases against African Americans and that, to a lesser degree, some minority providers may also hold these biases. Although not limited to health care professionals, the biases lead providers to link negative characteristics (e.g., bad) and emotions (e.g., fear) with people or images they perceive as being African American. As a result of such implicit biases, physicians treat patients differently depending on the patient's race, ethnicity, gender, or other assumed or actual characteristics.[29]

Matthew asks us to imagine this scenario:

> If a white, male family-practice physician with a largely white patient population walks into a new patient's room and encounters an elderly African American woman, immediately and automatically the physician begins to retrieve information from his memory to help him navigate this unfamiliar scene. Even before speaking his first words, the physician will subconsciously recall images stored in memory to help him interact with his new patient. Those images—his "social group knowledge"—may be from television news stories about blacks in poverty, African American incarceration rates, or the war on drugs in black and Hispanic neighborhoods. The physician may be well-read and familiar with studies reported in the *Wall Street Journal* or the *Los Angeles* or *New York Times* about the rate at which African

Americans graduate from college, drop out of high school, or lag in their standardized test performances. . . . Taken together, all of these images "trigger" stereotypes in the subconscious mind. . . .

If asked, the physician would truthfully admit to harboring no ill will toward African Americans generally or toward this African American patient specifically. Yet, without consciously thinking about it, the physician is likely to have made some implicit assumptions about his patient even before meeting her. . . . But the fact that this physician's assumptions and stereotypes—his implicit biases—are neither irrational nor consciously chosen, does not mean that the discrimination that arises from them will not be extremely harmful to his new patient's health. Indeed, her health and health care are quite likely to be adversely affected by these biases from the moment the clinical encounter with her begins. Even in those instances when physicians react with sympathetic compassion in response to the negative stereotypes triggered in their subconscious, the evidence is that the treatment choices they make as a result, such as withholding complex information or deferring expensive treatments, are more likely to harm rather than improve a minority patient's health.[30]

RACIAL PROFILING IN MEDICINE

Using race as a factor in determining appropriate treatment for patients has been called "race-based medicine," and it is controversial. Some physicians see race as a useful data point in customizing treatments for persons perceived to belong to particular racial groups. But a growing number of experts say the practice is built on a groundless supposition—that race is a reliable indicator of genetic differences—and that basing treatments on considerations of race may harm patients. They argue that using race this way is a form of racial profiling that is as morally suspect as racial profiling in law enforcement.

One of these experts is the philosopher Michael Root:

> Many doctors believe that racial profiling in medicine is reasonable and fair even if racial profiling in law enforcement is not; stopping a motorist based on [his] race is wrong, but, in their

IN DEPTH
CAN IMPLICIT BIASES BE CHANGED?

The good news about implicit biases is that they are alterable. Matthew summarizes the relevant research:

> Social scientists have developed a body of empirical evidence that shows implicit biases are malleable over the past quarter century. The empirical record is now well established and offers strong evidence that implicit attitudes are neither inaccessible nor inescapable; they are not impossible to control; they are not out of reach. In fact, implicit associations can be influenced both by the individual who unconsciously holds these stereotypes and prejudices and by external factors. Researchers have reported and reviewed numerous studies that put two important misconceptions about implicit biases to rest. First, the evidence demonstrates that unconscious implicit attitudes are responsive to the deliberate choices and influences of an individual even though that person is not consciously experiencing the bias. Second, implicit biases are not impervious to relatively short-term change even though they arise from social knowledge that was acquired slowly, and over a lifetime.[31]

eyes, prescribing a drug to a patient based on his race is unobjectionable. [32]

Consider this scenario, Root says, where doctors use race in deciding which drug treatment to use:

> According to recent population-level studies of drugs for congestive heart failure, whites respond better to some drugs, such as angiotensin-converting-enzyme (ACE) inhibitors, than blacks do. Based on these studies, doctors use race as a proxy for a response to an ACE inhibitor when they target their white patients for the drug but not their black ones. . . . Doctors do not know how an individual patient will respond to the drug, but they know or think they know a patient's race, and given the correlation between drug response and race, they predict that a white patient will respond well to an ACE inhibitor, whereas a black one will not.[33]

But using a patient's race to make predictions like this is problematic:

> First, to select whites but not blacks for a drug treatment based on a population-level study ignores intraracial differences in response to the drug and adversely affects black patients for whom the "white" drug would be an effective treatment. Though the ACE study showed that whites and blacks as a group respond differently to the drug, it also showed that a significant number of blacks respond as well as whites do to the drug.
>
> Second, targeting blacks assumes that race is the best predictor available, but the rate at which a drug is metabolized varies as a result of many factors, including environment and lifestyle. Most studies that show a racial difference in drug response do not control for differences between black and white patients in socioeconomic status (SES) or other factors that are known to influence drug metabolism. . . .
>
> Third, even if the difference between blacks and whites in drug response is due to a biological (genetic) difference, there is no reason to treat race as an independent variable that causes or explains the difference, since the genes controlling drug response vary independently of race.[34]

Race is biasing many of the standard tools used by physicians to make decisions about patient care. According to a recent report in the *New England Journal of Medicine*:

> Despite mounting evidence that race is not a reliable proxy for genetic difference, the belief that it is has become embedded, sometimes insidiously, within medical practice. One subtle insertion of race into medicine involves diagnostic algorithms and practice guidelines that adjust or "correct" their outputs on the basis of a patient's race or ethnicity. Physicians use these algorithms to individualize risk assessment and guide clinical decisions. By embedding race into the basic data and decisions of health care, these algorithms propagate race-based medicine. Many of these race-adjusted algorithms guide decisions in ways that may direct more attention or resources to white patients than to members of racial and ethnic minorities. . . .
>
> Most race corrections implicitly, if not explicitly, operate on the assumption that genetic difference tracks reliably with race. If the empirical differences seen between racial groups were actually due to genetic differences, then race adjustment might be justified: different coefficients for different bodies.
>
> Such situations, however, are exceedingly unlikely. Studies of the genetic structure of human populations continue to find more variation within racial groups than between them. Moreover, the racial differences found in large data sets most likely often reflect effects of racism—that is, the experience of being black in America rather than being black itself—such as toxic stress and its physiological consequences. In such cases, race adjustment would do nothing to address the cause of the disparity. Instead, if adjustments deter clinicians from offering clinical services to certain patients, they risk baking inequity into the system.[35]

Root thinks stratifying health statistics by race is reasonable—as long as income, education, employment, housing, and other factors are

stratified by race. "But to use race as a proxy for a response to a medical treatment," he says, "is questionable because members of the same race often differ as much in their response to a medical treatment as members of different races do."[36]

KEY TERMS

implicit bias
individual racism
institutional or structural racism
racial discrimination
racial prejudice
racism

SUMMARY

Racism presupposes the idea that distinct races exist and that important, inherent differences among them can be distinguished. This presupposition alone, however, does not constitute racism. Racism is the additional belief that some races are inferior in these important ways or are otherwise deserving of dislike or hostility. The two essential elements in this definition are *inferiorization* and *antipathy*.

Racism is morally wrong, and it is also empirically wrong—it is based on assumptions about the world that science has shown to be unfounded. The consensus among scientists and scholars is that the traditional view of races—that there are distinct groups of people sharing significant biological characteristics—is false. But even though races in the biological sense don't exist, "racialized groups"—groups that people *believe* are discrete races and treat as such—do. Scholars contend that despite the nonexistence of biological race, giving up entirely our ability to talk and think about racialized groups and racial realities would have disastrous effects—which is why so many observers condemn the notion of racial color blindness.

Although many today believe racism and racial discrimination are a thing of the past, most experts who have studied racism and race relations strongly disagree. They say racism is indeed a significant problem in America, as evidenced by widespread racial inequalities at nearly every level of society. For many people, racism is basically individual racism, person-to-person acts of intolerance or discrimination. But a prevalent, seldom-acknowledged kind of racism is institutional or structural racism, unequal treatment that arises from the way organizations, institutions, and social systems operate. An enormous body of sociological and historical evidence shows that huge inequalities between Whites and minorities exist in education, wealth, health, and home ownership—and these disparities have been caused and perpetuated largely through discrimination, segregation, and other forms of structural racism.

Health disparities are differences among population groups in mortality and disease. For thirty years, researchers have been finding significant health disparities between Whites and minorities, with the latter often faring worse. The most worrisome disparities can be found in infant mortality, life expectancy, and age-adjusted death rates. Research suggests that a significant cause of these disparities is various forms of structural racism.

Research reveals that a widespread problem in health care is implicit bias, a negative attitude toward a group of people that operates unintentionally or unconsciously. Decades of studies have demonstrated that virtually everyone has implicit biases, that discriminatory behavior can be predicted based on such biases, that implicit biases often have a more powerful impact on behavior than explicitly held beliefs, and that health care providers are not immune to this very human failing.

Using race as a factor in determining appropriate treatment for patients has been called "race-based medicine." Some physicians see race as a useful data point in customizing treatments for persons perceived to belong to particular racial groups. But a growing number of experts say the practice is built on a groundless supposition—that race is a reliable indicator of genetic differences—and that basing treatments on considerations of race may harm patients. They argue that using race this way is a form of racial profiling that is as morally suspect as racial profiling in law enforcement.