

How microaggressions in health care hurt minorities

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Far too often, when Sarah Perren went to a Philadelphia hospital for her regular diabetes care, her doctor gave her dietary recommendations that she never could have afforded. Just stepping into the office made the

59-year-old Black woman feel tense and self-conscious; she sensed that the doctor thought she was just lazy for not following his diet.

One time, another doctor at the clinic literally jumped back when she took off Perren's socks and saw her dry skin—a frequent consequence of diabetes. The doctor announced that she didn't want any skin flakes to get onto her clothes.

"I felt it was racial," the West Philadelphia resident recalled. "You just have a feeling the way they talk to you. That's when I told myself my health is more important somewhere else."

She has since established care with another hospital, but still feels the toll of what experts increasingly recognize as microaggressions—interactions that may not be obviously racist, but still feel dismissive or even hostile to patients of color.

A growing body of research indicates that microaggressions can seriously harm [patient care](#) by making important communication impossible and turning people off entirely from getting [medical care](#). Patients report feeling marginalized in a variety of ways.

Perren recounts a time when she brought her son to the emergency room with severe stomach pain. They waited hours to get attention for what turned out to be appendicitis, while watching a white doctor and his wife jump to the front of the line in 15 minutes for no clear reason.

And while Perren's physician never bothered to learn whether she could manage the recommended complicated and costly dietary rules, other patients report that doctors assume they can't afford the best therapy. One study found, for instance, that children of color with type 1 diabetes were much less likely than white children to get the most effective blood glucose monitors, regardless of their parents' income.

Microaggressions, despite the name, can have outsized impacts.

"What they do is make patients feel marginalized," said Georges Benjamin, executive director of the American Public Health Association. "Some (microaggressions) are more overt—people assume you're having less pain than you actually are or you're going to abuse pain medications so they give you just enough for the weekend."

A study from just a few years ago out of the University of Virginia's psychology department found that racist myths persist among some white doctors and medical students, such as that Black people don't feel pain as acutely as whites, or that their skin is literally thicker. Multiple studies have shown that Black patients are significantly less likely to receive pain medications for fractures in the emergency room, for example.

Microaggressions erode the most important relationship in health care.

Patients of color "don't connect with doctors a lot of the time," said Cheryl Garfield, of the Penn Center for Community Health Workers. Professionals such as Garfield know their clients' needs and circumstances because they often come from similar backgrounds.

"They (doctors) want you to eat healthy, but the budget doesn't fit what you want us to do," Garfield said. "If I bring home \$192 a month, the canned goods are cheaper than the fresh ones. I can't control my blood pressure or diabetes because I don't have the healthier foods."

Or it might never occur to a doctor that a patient with sleep apnea is refusing his prescription for a CPAP machine not out of stubbornness but because she has no electricity—as one client confided to Garfield.

"There is a deep-rooted and legitimate concern (for people of color)

whether your doctor has your best interest," said Regina Davis Moss, associate executive director of public health policy and practice for the American Public Health Association. "There tends to be more comfort when you have a provider that can tell you (the) options, instead of whether I'm compliant or worthy" of a specific treatment given without knowing much about the patient.

Benjamin notes that health-care providers are busy people, and so it's understandable to reach for the remedies they know best. But the fast answer can be worse than useless to a patient who can't use it and feels powerless to explain why.

"It can affect you in a way where you don't want to go to the hospital," Perren said. "And it's bad for you because you need to be healthy as much as anyone else."

Institutions throughout society are starting to better recognize the harms of systemic racism, and the need to invest in addressing the root causes. These can be as large as unemployment and food insecurity, and as subtle as the unconscious biases that persist in the majority culture among people who still don't understand how they might be perpetuating harmful attitudes. Last month, for example, Penn Medicine announced that every department will appoint a vice chair for inclusion, diversity, and equity, that Martin Luther King Day will become a paid holiday for employees, and that everyone must participate in unconscious-bias training.

"We are tired of describing disparities," said Nwamaka Eneanya, a medical professor at Penn who now directs health equity and anti-racism in her department. "It's now time to move past that and look at the root causes why we have disparities and issues in diversity and inclusion in health care."

Often groups believe that the first and last step is to raise awareness and educate people how to recognize and modify their biases, she said. But that's just a beginning.

One of Eneanya's larger goals is to recruit and retain minority trainees and students. Only 7.7% of [medical students](#) identify as African American or Black—which is a critical issue as so many patients of all races say they feel most comfortable with a provider who looks like them.

"Shared (life) experience is priceless and so organic," Eneanya said, and can make the difference between having a doctor whose understanding of a patient allows the professional to find the best treatment plan.

"On an individual level, health-care providers, even the most well-intentioned, they haven't been in the same situations" as patients of color, said Shreya Kangovi, associate professor of medicine at the Perelman School of Medicine.

Yet diversifying the workforce will take time, and patients need help now from caring, enlightened professionals of all backgrounds. "We're going to need support and it can't just be people of color," Eneanya said.

Perren agrees that what she needs most is a doctor who is interested enough to get to know her life situation, not just her health condition.

"You're not helping me heal," Perren once wanted to tell her doctor. "You can say something, but are you helping me with the resources or the people I can contact to get some help? Or are you just telling me what you want me to hear?"

Her advice to providers: Follow up regularly with your patients and ask "How are you doing today?" Listen to your patients, not just what you

want to hear. Treat your patients the same, whatever insurance they might or might not have. Spend the same amount of time with your patients, regardless of their skin color. And whatever you do, don't put them down or make them feel bad over health problems such as dry skin for which they are seeking your help.

"They need to listen and be aware of what is going on in your surroundings," Perren said. "If the doctor doesn't understand you, then they need to bring a translator."

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