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Clinicians' Racial Biases as Pathways to Iatrogenic Harms for Black People

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Abstract

Access to care is a health determinant because health care resources, interventions, and personnel help maintain health and well-being. In addition to social determinants' roles in health inequity, clinicians' racial bias undermines the quality of Black persons' health care experiences and is a pathway to iatrogenic harm. This article considers pain management and limb amputation outcomes as examples of how clinicians' racial biases exacerbate inequitable access to health care for Black people in the United States.

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Clinician Bias and Access to Health Care

Access to health care helps us maintain our health and well-being. Because of institutional barriers and systemic inequities, (self-identified) Black people and other marginalized populations generally have lesser access to health care than White people.¹ Like lesser access to health care, lesser access to quality education and public transportation and lower income harm Black people by making it more difficult for them to maintain their health.² Although inequities in social determinants of health are examples of harmful structural inequities that contribute to racial disparities in health outcomes, they are harms that occur outside of clinical settings. There are, however, inequities in social determinants of health that harm Black people's health that originate within the clinical setting. These harms, also referred to as iatrogenic harms (eg, harms to patients in the course of health care), can include clinician behaviors that express racial bias toward Black people.

Although access to health care is a social determinant of health, clinicians' racial biases act as a barrier to Black people's access to health care. More specifically, clinicians' racial biases act as pathways for health care to impose iatrogenic harms and inequitable health outcomes on Black people.³ Physicians, nurses, clerical staff, and other stewards and gatekeepers of health care have racial biases just like other people.⁴ When left unchecked, clinicians' biases—and the behaviors toward Black people they encourage—threaten health equity for Black people. Racial disparities in adequate pain

management and limb amputations due to diabetes complications are examples of the kinds of harms and inequities that clinicians' biases create for Black people. Although some of the brazen abuses that were once a mainstay in health care are no longer serious problems, clinicians' racial biases still jeopardize Black people's health and must be overcome if we are to extend equitable health care benefits to all people.

Racial Biases in Decision Making

Health care workers harm Black people when they rely on their racial biases to develop care recommendations. For example, one study found that White medical students and residents who endorsed false beliefs about Black people's tolerance to pain rated the Black patient's pain as lower than the White patient's and showed **bias in their pain treatment recommendations** for Black people.⁵ Similarly, a large study of a single health system found that Black patients were less likely to be referred to a pain specialist and more likely to be screened for substances and referred for substance use evaluation than White patients,⁶ suggesting that clinicians subscribed to the racially biased belief that Black people exaggerate their pain and use deceitful practices to illicitly acquire opioids.

When health care practitioners' racial biases influence the quality of care they dispense to Black people, they deny Black people proper and equitable care. When Black people don't receive proper care, they are denied access to health and well-being. For instance, when racial bias influences pain management, clinicians stand in the way of Black people living pain-free lives. Pain incapacitates and destroys people's ability to participate in activities that give their life meaning; chronic pain makes it difficult for people to enjoy their hobbies, care for themselves or their families, or have careers. When people's pain is not treated or is undertreated because of the color of their skin, the injustice is even greater because their misery is justified by an amoral, uncontrollable feature of their being. Their skin color and Black race become central to what kind of life they deserve. In this instance, health care sends the message that Black people's lives and the joy Black people could have from a pain-free life are not as important as White people's lives and their joy.

Health care practitioner bias, which makes it difficult for Black people to receive proper care, contributes to 2 interconnected and ongoing problems in US health care systems: (1) **damage to the relationship** between Black people and health care and (2) the impossibility of viewing US health care institutions as sources of equitable care for all people. Through their own experiences, anecdotal evidence from their peers, or scholarship and research, Black people are aware that encountering racial bias is part of the experience of being a Black person seeking health care. Clinicians' racial biases can act as pathways to iatrogenic harms by indirectly discouraging Black people from getting care for their illnesses, as health care's image and reputation are damaged in the eyes of Black people. Furthermore, clinicians' racial biases damage health care institutions' reputation as places of health equity. In these ways, clinicians' racial biases harm Black people as individuals and contribute to their marginalization.

Inequitable Outcomes

Clinicians' racial bias also contributes to Black people's relatively worse health outcomes. For example, there are racial disparities in limb amputations necessitated by diabetes.⁷ Black people are more likely than White people to have their limbs amputated due to complications from diabetes, while White people with diabetes and related issues are more likely than Black people to have surgical interventions to save their limbs. Even

Black people with the lowest risk of amputation have higher rates of amputation than non-Black people.⁷

Part of Black people's higher rates of limb amputations can be explained by inequities in social determinants of health that result in their having lesser access to health care than White people. Low income, poor neighborhoods, low rates of food security, low access to well-resourced hospitals and clinics, and low access to preventive care, which contribute to diabetes outcomes,⁸ can all contribute to Black people's greater likelihood of limb amputation.^{7,9} However, Black people's lesser access to health care than White people's does not explain the problem of disparities in limb amputation in its entirety.

Durazzo and colleagues found that differences in hospital and local resources and in the severity of disease when people with lower limb ischemia seek care can explain Black people's greater odds of limb amputation than White people's.⁹ They found that Black people had increasingly greater odds of limb amputation than White people as the presenting hospital's capacity for revascularization and the median income of the patient's zip code increased. Even when the authors adjusted for confounding factors, such as access, Black people still had higher odds of limb amputation than White people. The researchers suggest that race may influence the kind of treatment people with lower limb ischemia receive and conclude that "The role of unintentional or unconscious bias ... cannot be ruled out as contributing to the disparity." Similarly, Stapleton and colleagues suggest that clinician bias plays a role in the higher amputation rate for Black people than White people.¹⁰ They found that the disparity between Black and White patients' amputation rates was greater among surgeons who treat fewer Black patients, further supporting the idea that clinicians' racial bias at least partially influences limb amputation rates among Black people.

These examples of racial disparities in pain management and limb amputations suggest that clinicians' racial biases are an unfortunate, yet undeniable, harm imposed on Black people by the very nature of health care. These examples thus show that the nature of health care itself stands in the way of Black people's equitable treatment and access to health care. Indeed, even if preclinical inequities in the social determinants of health that create and sustain racial disparities in health outcomes were eliminated, health care practitioners' racial bias would still serve as a barrier to Black people's and other marginalized groups' equitable treatment and access to health care.

Conclusion

To secure health and well-being, Black people must overcome harms to their health imposed by almost every aspect of the modern world—from environmental racism to housing inequities—simply because they are the target of racism. When they need health care to secure their health, they are faced with additional harms from health care practitioners who view and treat their Black patients through the lens of racial bias. Because racial bias is embedded in the way medicine is practiced, the harms of racial bias are a part of the very nature of health care.

To eliminate the harm to Black people's health that comes from health care itself, health care systems must make concerted efforts to protect Black people. They can start by making it clear that Black people's health care needs are as important as White people's health care needs. Doing so includes identifying the kinds of harm clinicians' racial bias causes and how these harms affect Black people. Health care institutions must also identify **methods to remedy these iatrogenic harms**, such as educating

clinicians and creating an environment where clinicians asking their fellow clinicians for help with checking their racial biases is an accepted and encouraged clinical norm. The need for these changes is greater for White clinicians and requires their commitment to identifying and eliminating racial bias and its effects. These actions are all a part of a larger goal of health care systems reckoning with their historical and contemporary abuses of Black people and their tendency to center whiteness and the White experience. When the harms of clinicians' racial bias are left unchecked and health care does not address its "whiteness problem," the gatekeepers of health care become obstacles in the very institutions that charge them with caring for all people, regardless of race. Black people already carry the burden of inequitable access to the social determinants of health; health care should not be another source of inequity for an already overburdened population.

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