



What do we mean by ‘racism’? Conceptualising the range of what we call racism in health care settings: A commentary on Peek et al.

Hannah Bradby*

Department of Sociology, University of Warwick, Coventry CV4 7AL, UK

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This commentary briefly explores the conceptual issues that underlie studies of race and racism in health care. First, what do we mean by racism in the contemporary medical context? Second, is there a model of racism that can encompass the range of what is referred to as racism? That is, is it possible to conceptualise everything that is meant by racism, from features of interpersonal communication to population-level inequalities, in a single model?

In their article “Race and Shared Decision-Making: Perspectives of African-Americans with Diabetes” [Peek et al. \(2010\)](#) explore how patients’ perceptions of race may influence decision-making in a medical context. A model of shared decision-making (‘Information-sharing, Deliberation or Physician recommendation and Decision-making’) is posited as an intervention capable of reducing disparities in disease outcome. Racialised inequalities in rates of diabetes diagnosis, complication, disease management and quality of outcome are well documented and require urgent remedial attention. Previous research has shown that methods of shared decision-making do not work as well with minority ethnic patients as with majority ethnic patients (e.g. [Cooper et al., 2003](#); [Cooper-Patrick et al., 1999](#)). Peek et al. explore how Black people in the US with diabetes view the role of race in decision-making about medical care with their doctors, using a combination of in-depth interviews and focus groups.

None of the 24 people who were interviewed reported experiencing any ‘discrimination or other race-related encounters’ and most of them said that race did not play an important role in

patient-provider communication ([Peek et al., 2010](#)). By contrast, in the focus groups people were willing to discuss ‘negative communication encounters between White physicians and themselves, family members and/or close friends that they attributed to race’. In particular, ‘cultural discordance’ was discussed, whereby White doctors failed to appreciate Black patients’ ways of being and talking. This failure of communication with White doctors was compared with more satisfactory encounters with African American doctors.

Peek et al. state that in every focus group participants discussed racism at three levels: institutionalized, personally-mediated, and internalized racism. Institutional racism, which the authors see as the least relevant for their study, is defined as ‘differential access to goods and services’ ([Peek et al., 2010](#)). This definition of institutional racism is problematic because it is subject to what [Miles \(1989\)](#) called ‘conceptual inflation’. If inequality in access is assumed to be caused by racism, the effects of other forms of discrimination (sexism or class prejudice) are conflated. If inequality in outcome is an adequate indicator of the operation of racism, we remain ignorant about how it operates. Where racialised inequality can be measured in health care settings institutional racism is increasingly put forward as a cause. Since it is rarely defined in detail, the term institutional racism is increasingly employed as a description of inequality that has no clear cause. One rationale for using the term institutional racism without adequate theoretical justification is to keep the prospect of racism in service provision on the public agenda. However, without credible models of its operation institutional racism will lose analytic purchase and come to be seen as irrelevant.

* Tel.: + 44 2476523072.

E-mail address: h.bradby@warwick.ac.uk

Peek et al. (2010) suggest that ‘personally-mediated’ and ‘internalized racism’ are more relevant to their findings than institutional racism. A ‘cultural discordance’ whereby Black patients feel that their concerns are not taken seriously by White doctors and a reluctance on the part of Black people to speak up in front of White professionals are encompassed under these headings. Neither of these features (or failures) of communication constitutes racism in the sense of being discrimination based on a view of humanity as hierarchically divided into differentially valued races. It is hard to see how the subtle nature of unsatisfactory communication with White doctors, reported by Black people with diabetes, relates to the entrenched racialised inequalities in diabetes outcomes with which the paper by Peek and colleagues opens.

In the study, not only was the dissatisfactory communication reported to be subtle, but discussion of any issues around race was confined to the focus groups, being largely absent from the semi-structured interviews. The researchers employed ‘race-concordant’ interviewers: one-to-one interviewing is often presented as the best way to develop rapport and generate insight (Peek et al., 2010). Nonetheless in this case, it did not generate insights around racism. Even in the focus groups, where, as Peek et al. describe, there are various reasons why people might be more willing to discuss racism, the talk apparently related more to other people’s experiences than to discussants’ first person encounters.

People at risk of suffering the effects of racism may not wish to discuss it as relevant to their own experience of illness for various reasons and may prefer to emphasize their effective resistance to racism (Bradby, 2002). The relative absence of any talk about racism in this study, the subtle nature of the ‘cultural discordance’ described, stands in contrast with the stark racialised health inequalities around the experience of diabetes and health care for the disease. The apparent mismatch between the robustly demonstrable population inequities and the difficulties around interpersonal communication with health care staff where discrimination is difficult to measure, should prompt some serious questions. In particular, how can the conceptual models that link communication around health care to population health outcomes offer causative mechanisms? Peek et al. (2010) suggest that improving the quality of communication between Black patients and White health care staff could be a means of addressing racialised inequity at the population level: how can we envisage or imagine this working?

As detailed in Peek and colleagues’ paper, we know that Black patients feel disrespect in the medical encounter to a greater extent than White patients. The paper expands on how Black patients’ dissatisfaction with medical communication might be a matter of racism. In the stressful conditions of the clinical encounter ‘cognitive shortcuts’ such as stereotypes may be used to facilitate decision-making. We know from research on medical consultations that patients with educational and class backgrounds most similar to their physicians tend to get the best quality service (Waitzkin, 1991). Can poorer quality of medical consultations account for poorer health outcomes? Probably not in and of itself, but in the context of long-term socio-economic racialised disadvantage, it is likely to have an effect. The mechanisms that account for health inequalities that characterize unequal societies (Marmot, 2004) may well be responsible for racialised inequalities too. If a person’s sense of being supported by relationships with others (rather than oppressed by them) is good for health over the life course, then racism would damage health over a life time.

Peek et al. concludes that:

all aspects of shared decision-making information-sharing, deliberation/physician recommendations, and decision-making

have the potential to be negatively influenced by race, through mechanisms of cultural discordance, patient beliefs arising from internalized racism, and unconscious stereotyping/bias (personally-mediated racism). Such influences serve to exacerbate the inherent power imbalance that exists between patients and their physicians. (Peek et al., 2010)

This paragraph describes aspects of communication that can be seen as racism and as a solution, the authors recommend extending ‘cultural competency training and general communication training for physicians to address potential race-related barriers’. The communication problems identified include Black patients’ own internalized racism and unconscious racism from physicians, as well as cultural discordance and yet the solution is seen entirely in terms of physician education around race. This raises some questions: how can physician education address unconscious racism? Should ‘internalized racism’ be tackled through education and if so, whose education?

This is familiar but nonetheless paradoxical territory to anyone interested in racism in health care settings: stark racialised inequalities, a sense among patients and their families that racism is relevant to their experience of health care services together with sparse evidence of the occurrence of overt racism. The great difficulty in identifying specific behaviours, procedures or speech as racist is not surprising given that the public expression of racism is both illegal and largely unacceptable. The existence of subtle racism has been described by researchers of education (e.g. Feagin, Vera, & Imani, 1996) and the law (e.g. Bridges, 2001), but is less well discussed in health research (but see Rocheron, 1988). How can we, in studies of health and illness, understand the subtle communication problems between White doctors and Black patients alongside entrenched racialised inequalities (in evidence even after controlling for socio-economic status) which have persisted across generations? Hypothesizing mechanisms that include the micro-processes of interactions between patients and professionals and the macro-processes of population-level inequalities is a missing step in our reasoning at present. The process of constructing these models is hindered by the ambiguities around what we mean by ‘racism’.

Black patients who encounter disrespect from health care professionals are not explicitly being told that they are an unworthy group because of their skin colour. The understated nature of the disrespect puts it on a par with the disrespect of other marginalized or stigmatised groups. However, this disrespect, albeit subtle, must be interpreted in the cultural and social context where Blackness has been denigrated and disparaged both interpersonally and institutionally over time. The disrespect that has been found in the health care system cannot be interpreted as causing the population-level inequalities, but can be seen as evidence that ‘race’ exists as a category of meaning at the micro- as well as the macro-level.

The re-conceptualisation of racism so it can be operationalised constructively and fairly is a key task for research in this field. Recasting ideas around racism in a way that is useful for the 21st century represents an urgent and difficult challenge. The urgency comes from the rootedness of concepts of racism in 19th and 20th century ideas which inform their meaning for both recipients and perpetrators of racism. Disrespect from White professionals is interpreted in the light of racism that was institutionalized in the twentieth century, but is now illegal. Historical context is crucial for understanding the experience and perpetuation of racist inequality, but there is also a need to examine how racism works now. Physicians who contribute to cultural discordance with Black patients are not 19th century-style racists and doubtless know that racism is wrong. The health-damaging effects of 21st century subtle

racism differ dramatically from the operation of 19th century institutionalized segregationist racism. It is unclear whether training in 'cultural competency' is the best means of addressing contemporary racism.

The suggestion that some racist effects take place unconsciously also raises problems for education as the key response to contemporary racism. How can the further education and training of health care professionals, recommended by Peek et al. (2010), work at the level of the unconscious? Are we to consider interventions that tap into our subliminal prejudice? Is this realistic or constructive? Racism is illegal, but if we are capable of being racist unconsciously, how can it be regulated? If we agree with this paper that some racism in operation is internalized, do Black as well as White health care professionals require their subconscious re-training?

Sociological approaches to racism in health care settings should offer some leads in how best to tackle this problem. However, our theoretical conceptualisation of racism lacks subtlety. We have perhaps failed to attend to Miles's suggestion that we demonstrate the determinate influence of racism through appropriate historical work (Miles, 1989: 87). While the interpersonal nature of racism has been studied, its sociological and its social nature has not been adequately addressed. In health care settings we do not have the appropriate empirical or theoretical material to be able to give a convincing account of how subtle racism at the interpersonal level joins up with population-level inequalities. The painful politics of racism has made this examination difficult: the extremity of racist

abuses in the past can distract from sober reflection on the social meaning of contemporary racism. However, a failure to update our thinking has risks for physicians and patients alike. Racism is a shared system of knowledge which informs individual beliefs, but also cultural, political, economic and institutional aspects of our social system. As long as we see the solution to racism lying only in educating the individual, we fail to address the complexity of racism and risk alienating patients and physicians alike.

References

- Bradby, H. (2002). Translating culture and language: a research note on multilingual settings. *Sociology of Health and Illness*, 24(6), 842–855.
- Bridges, L. (2001). Race, law and the state. *Race and Class*, 43(2), 61–76.
- Cooper, L. A., Roter, D. L., Johnson, R. L., Ford, D. E., Steinwachs, D. M., & Powe, N. R. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of Internal Medicine*, 139(11), 907–915.
- Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., & Nelson, C. (1999). Race, gender, and partnership in the patient–physician relationship. *JAMA*, 282(6), 583–589.
- Feagin, J. R., Vera, H., & Imani, N. (1996). *The agony of education: Black students at white colleges and universities*. New York: Routledge.
- Marmot, M. (2004). *Status syndrome*. London: Bloomsbury.
- Miles, R. (1989). *Racism*. London: Routledge.
- Peek, M., Odoms Young, A., Quinn, M. T., Gorawara-Bhat, R., Wilson, S. C., & Chin, M. H. (2010). Race and shared decision-making: perspectives of African Americans with Diabetes. *Social Science & Medicine*, 71, 1–9.
- Rocheron, Y. (1988). The Asian Mother and Baby Campaign: the construction of ethnic minority health needs. *Critical Social Policy*, 22, 4–23.
- Waitzkin, H. (1991). *The politics of medical encounters: How patients and doctors deal with social problems*. New Haven: Yale University Press.