Breaking Down the Web of Structural Racism in Medicine: Will JEDI Reign or Is It Mission Impossible?

Soon after the first reported US case of coronavirus disease 2019 (COVID-19) in January 2020, the pandemic piled on centuries of adversities from systemic racism and social injustice in communities of color. Then, on May 25, 2020, George Floyd, an unarmed Black man, died from being pinned at the neck to the ground in handcuffs by a hand-pocketed White police officer, sparking outrage globally, effects of which were captured in a Black community study.1 A flurry of antiracism statements ensued, but in February 2021, the Journal of the American Medical Association posted a podcast and tweet asserting that “no physician is racist.”2 My experience tells me differently. It seemingly was a volley from broader counterantiracism efforts in academic health centers (AHCs). Systemic racism dates to the slavery and Jim Crow eras, and racism is sustained by a web of societal structures that maintain supremacy of one group over another and requires those with the social-political power to give up or share privileged positions to dismantle it. Proxy racism is entrenched and abounds in institutional cultures and, without radical change, antiracism fatigue will set in, leaders of the movement will be undermined or placated, and outrage will shift to business as usual. In this issue of Mayo Clinic Proceedings are two timely calls to antiracism action.3,4 Ung et al3 aptly connected the vicious cycle of social injustices and health disparities to practices that “perpetuate the toxic intergenerational stress.” Strand et al4 implored the pain medicine community to use its position to improve quality of care for Blacks. Both commentaries echo uncertainties about the medical community’s commitment to its oath to uphold justice, equity, diversity, and inclusiveness (JEDI). Ung et al3 foretold the Journal of the American Medical Association events noting, “If past is prologue, then lamentably institutional stasis is the more likely outcome.”

It is saddening that some question the link between racism and health inequities that have been worsened by COVID-19. A landmark Institute of Medicine report provides convincing linkages between racism and health injustices, restricted access, and lower quality of care for people of color.5 The denial of care to Blacks and migrant farmworkers while serving at a federally qualified health center was the catalyst for my academic career. In one incident, while calling to refer a patient to an otolaryngologist, I was told point-blank that “[he] don’t see N*****.” I have observed variations of that in my journey through AHCs. I have served as Associate Vice Provost for Diversity, as the first Black chair of a clinical department at an Ivy-League university (2014–2018), and lead community engagement and health equity efforts. A number of years past, I listened on speakerphone with an emeritus dean as someone told him that I was “blacklisted...and it is really hard to recover.” The sitting dean’s response was that “people [should] be more civil about community [benefit] issues. In other instances, I listened as my community was disparaged, and when asked, the response was, “it is not you,” although I knew differently. Black medical trainees are unduly scrutinized — attempts to help often do little more than imperil careers of “upstanders” while perpetrators are rewarded with obvious or discernable institutional complicity.

COVID-19’s sustained negatively disproportionate impact in communities of color stem partly from their overrepresentation in service jobs.6 Improving working conditions in environmental services is critical, but...
overrepresentation of people of color in such positions in AHCs should be seen as a product of racism and not be celebrated. Often the argument is that there are no qualified people of color for senior leadership roles, but institutions find who they seek and cultivate. Academic health centers should be places of psychological safety, and mistakes are part of learning, but they can be career-ending for Blacks — the adaptive psychological hypervigilance is physiologically toxic. As depicted aptly in “Fund Black Scientists,” the success of leaders at institutions has less to do with innate capabilities and more with the institutional commitment to their success. Even when at the table, Blacks may be excluded from the (social) circles where decisions are made. With limited social capital, simply having fair rules at meetings do not enable inclusivity.  

Health care delivery should be designed with equity as the North Star, but structural barriers make health care less accessible for people in underresourced communities. People of color may be labeled as non-compliant and hard-to-reach to reinforce stereotypes and referred to in dehumanizing ways such as “cherry-picking” or “lemon-dropping.” The victim-blaming absolves health systems, payors, and policy-makers of accountability. Although individual clinician responsibility is critical, clinicians often receive inadequate support and burnout is common. Health systems are driven by rankings and performance expectations of oversight bodies. Meaningful payment reform can address inequalities, but only if there is parity between government and private insurance, and incentives are designed to not deprioritize the health needs of groups that are economically and socially disadvantaged.

Unlike COVID-19, racism is an endemic condition with many variants. Elie Wiesel once said: “What hurts…most is not the cruelty of the oppressor but the silence of the bystander.” It is shamefully tragic that many people die for no reason other than their race/ethnicity, whether from preventable cancer or heart disease, end-stage renal disease, inability to afford lifesaving medications, or intentional violence. As a Black American male, I belong in a group with the highest risk of dying from most preventable causes, and advanced degrees offer no immunity against that risk. I join with Ung, and Strand, and their colleagues to call on everyone to seize the moment and work together to transform our institutions to ones in which JEDI flourishes for collective good. Margaret Meade once wrote, “Human nature is neither intrinsically good nor intrinsically evil… it will depend upon how they are reared…to trust and love and experiment and create, or to fear and hate and conform…what kind of human beings they will become.” Knowledge about racism is acquired early in life as exemplified by the doll experiment and education about racism should start from the cradle, be tailored to individuals, and use lifelong learning and learning systems approaches.

Lest we forget, many people of color find themselves in the intersection of many isms beyond racism. It has been said that neutrality in situations of injustice means you endorse the injustice. Robert F. Kennedy once said, “Each time a man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope, and crossing each other from a million different centers of energy and…those ripples build a current which can sweep down the mightiest walls of oppression……” We need to generate and propagate ripples of hope on antiracism in society and AHCs.

Structural racism is a public health and human rights crisis. Like all overt and covert acts of aggression, it affects everyone. As suggested by Ung, Strand, and their colleagues, antiracism requires multilevel strategies across the lifespan. We need shared empathy for the suffering imposed on a group of people and respect for the unique talent and insights everyone brings, yet empathy and respect seem to be in short supply. Institutional commitment to JEDI is critical to success, but antiracism activities often exist on the fringes, and champions are often marginalized. Institutional commitment to antiracism should be apparent from serving as a bridge organization for collective impact — its leaders are visible in the community, understand community
priorities, and model accountability. Because entrenched cultures sustain racism, even the best-intentioned actions may fall short unless we are decisive. To be effective, we must call it what it is and acknowledge that it exists by intentional design. That is part of reconciliation, but placating language (eg, “unconscious” or “unintentional”) only serves to normalize racism — people who are unconscious do not exhibit racism or bias. I recommend that all health institutions create an academic department on antiracism and community health that is funded as part of community benefit to catalyze systemic learning and change for the good of all. It is the right thing to do.8

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REFERENCES