

Racism and Healthcare: Representations of the 'Other' in Health Services

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Abstract

The healthcare field, renowned to be humanitarian and egalitarian, has for a longtime remained sealed off from sociological studies focusing on racism and discrimination ethics. However, studies illustrate another face where prejudices based on certain origins specific to skin color reveal themselves. These expressions are present, in part, in care receivers, who refuse to be approached or touched by caregivers of 'unappealing' skin colors. They can also be observed in prejudiced and stereotypical representations that healthcare professionals harbor, which then translate into unequal healthcare treatments. These are the realities of health services that we wish investigate here by reviewing various studies conducted in France. Firstly we will evoke the kinds of situations that exemplify the expressions of certain forms of racism present in patients of nursing care. Secondly, we will explain how patients then mimic the racism that health care professionals themselves practice.

Keywords: Racism; Healthcare; Representations; Care giving Relationships; Health Services

When it is The Patient Who Demonstrates Racism

In countries where immigration is seen as important, health and social-medical services recruit staff member's that support this image of society. Immigration rates of those originating from the southern hemisphere are already elevated in many northern countries, but in France, the metropolitan territory also includes nationals of overseas territories and departments (in particular the French Caribbean), whom are heavily recruited in public services, and by extension, hospitals, beginning in the 1960s-70s. [6] The white majority of patients within these services do not always perceive this phenomenon in the best light.

The nursing assistant of Mrs. M. —a resident in a housing establishment for elderly dependent people, made her voice known, denouncing acts of physical violence, in which she played the role "of an African, accompanied by a person with of a burnt face." Additionally, she bumped the painting that had been repositioned that morning by those working the daytime shift... Interrogated in the setting of a rushed investigation conducted by the Commission of Users, Mrs. M. Orally confirms that the night caregivers brutalized her and deliberately threw her personal possessions on the ground in an aggressive manner. The resident said to have felt fearful with the black caregivers because of their disturbing physical appearance. Concerning the nursing

assistant, Mrs. Sisonke—whom Mrs. M. Formally accuses of acts of brutality, she says: "I don't like her look, she scares me." The other caregivers working that night, Mrs. Triode (nurse), Mrs. Koumba (nursing assistant) and Mrs. Dupont (nursing assistant), support their coworker and state that Mrs. M. Demonstrated aggressive behavior by taking shots at Mrs. Sisonke near her thorax at the time of the incident. Following this complaint, reviewed by the consensus of the serving doctor and the nursing manager, it is decided that Mrs. Sisonke is no longer allowed to work with this resident.

This observation, which was collected during our research on healthcare relations in social-medical structures, is not uncommon. We can understand the decision granted to be the result of an analysis that does put Mrs. M. In the right, but appears nevertheless as the best guarantee of protection for the patient. The supervisors of health services presume that given the age of Mrs. M., no mention of the law inhibits her "fear" of "people of color." It is as if the caregivers are obliged to tolerate racist behavior, either because the patient is elderly, comes from another generation, or suffers from mental issues.

Minority Caregivers: Role Reversals in Care Relations

In France, which is recognized today as a country of established immigration, is more or less restricted in its capacity to self interrogate its pluralistic composition and those interethnic relations, which are generated within healthcare services, as within all work organizations, programs, or services. Furthermore, health-based organizations and social services represent reservoirs of employment for minorities – composed of migrants, originating from overseas departments, but also from children and grandchildren of migrants born in the French metropolis. As spaces that harbor interethnic relations, these environments are also places where everyday racism can interfere. Certain articles have dealt with patients committing racism against minority caregivers in a hospital or social-medical setting. [1,7] Hostility is one common form of racist expression, even if the designation of the "other"—and what constitutes his or her status as different, do not necessarily need to be formally aggressive in order to signal racism. "Racism is defined as something that can be applied to the foreigner, the foreign, the other, the

heterogeneous, as opposed to the homogenous, the standard, the me. Praise or contempt, admiration or persecution, are two sides of the same coin" [22]. In health and social-medical facilities, racism against patients takes place in an asymmetric relationship of caregivers vis-a-vis care receivers, ideal for domination based relationships. [6,18,19] However racism can express itself equally in another sense, for example racism committed by care receivers against their caregivers. [23] We heard many repeated recounts of patients insulting personnel because of their origins or their skin color, rejoining there within observations concluded by other research teams in France [1,25], as for example those that have already been redressed in national contexts. [26] Non racialized and racialized caregiver often explain that the relation with the patient, which is, in theory, preferential to health care professionals—those considered to be the keepers of knowledge, seems to reverse itself in a relationship where it is a "white" patient who acts as the "master" and the "black" health worker who is then dismissed to a domestic stature. [20,24]

All French public services in France are obligated to adhere to the Charter of Laicity in order to remind patients that, they "can not reject a public official or other patients, nor can they demand an adaptation of the functioning of a public service or of public equipment." However, in most cases, this charter is not at all invoked, and the most common form of conflict resolution resembles most often the case of Mrs. M. Victims of racism committed by patients, who are the primarily concerned, are also quite often the first to excuse their aggressors. In this way, Judith recounts, "A patient didn't want a black nurse. I did not take this personally; it was just an elderly person." Chiefs of health services and nursing managers concede that they rarely remind patients or residents of housing establishment for elderly dependent people that they are citizens who are subject to the same laws and constitutional principles as the caregivers, and that in this way they could not maintain racist comments with impunity. [16] In the end it appears, from the boards of direction of these structures and hospital service agencies, to the doctors themselves, that professionals experience difficulty in admitting the existence of racism in the caretakers' remarks and behaviors, to the point where the frequency of the racism renders it banal. [24]

The Racialized Health Worker, a Constrained Silent Victim

Evasion strategies, which consist of attributing racist compartments to the pathological aspect of the patient, concerning his or her personality or even his or her level of education, compose a psychological economy that allows for the creation of an all-encompassing hasty set of rules, which are efficient and hardly costly to conflicts. Yet, in addressing patient requests, the pretense that in order to thoroughly administer care, one must distance oneself from the person receiving the care – despite the argument around the protection of the victim – reveals itself as a strategy, which in the end blames the patient. When hostile conduct is condemned and sanctioned within social interactions, it allows for those who are the victims to file complaints and demand atonement. The condemnation of the aggressor and the

acknowledgement of the aggression, allow the victim to be able to preserve his or her self-esteem, to maintain his or her dignity. On the other hand, the absence of such denunciation, or its avoidance based upon the state of health of the aggressor, or on his or her advanced age, condemns the victim "to bow down to defeat." It is a strategy that ties the racist and the racialized in a power spiral, where the impossibility to condemn the aggressor causes the victim to negate his or her self, as a separate entity.

The remarks made here are not to judge the choices made in healthcare services by the respective management in response to certain patient behaviors. Our intention is rather to invite the reader to distance him or herself from moral judgment in order to investigate those mechanisms from upstream. The strategy brought to light in the example mentioned earlier, is less the product of philosophical clinical reflection, but more of an organic response made in the moment, due to the urgency, to which reflection is always deferred, present in healthcare services, which are known to be overwhelmed; typically the first response is to act. In the end, these difficulties to recognize and identify racist practices as such and therefore to sanction them restrict those who are victims, leaving them to just "make do." Even worse, our blindness and deafness towards these questions then mutes the victims. However care receivers are not the only ones to indulge in racist attitudes. Caregivers are equally imbued in the way that they depreciatively view those who are considered to be "different" because their origins.

The Representations Of The "Other" In Clinical Practices

"Why aren't you doing your research elsewhere, on doctors who refuse those who have AME or CMU? At our establishment, [discrimination] is not possible, we follow a protocol, we give treatments and that's all!" Defends the doctor of a University Hospital Center where we were hoping to set up a project examining the way they doctors acted towards their patients. [12] This excerpt illustrates that even the idea of the existence of racism in French hospital environments appears to be inconceivable for healthcare professionals. At the same time, the majority of the French population today agrees that the racism and ethnic and racial discriminations intervene in diverse sectors of the French society (access to employment, to lodging, or other services or resources still). However the health sector remains under examined and benefits overall from a blank check, even if certain studies show that in this setting, as in with elsewhere, racism and racial discriminations infiltrate and orient health worker practices. [19,29] The first works in this matter addressed the difficulties surrounding judiciary access to healthcare, while the most recent are concerned with the quality of healthcare and ongoing interactions between caregivers and care receivers. The ideal caregiver, in theory, must treat all healthcare patients in an equal manner, void of intrusion of racial, or any other form of discrimination based upon additional criterion prohibited by French law. In healthcare services, this question is in reality very delicate, provided that the state of health – risks related to patient history, reactions to therapeutics – can legitimately establish a differential treatment between two sick individuals. It

is also useful to specify that a differential treatment only becomes discriminatory if such a treatment is illegitimate and arbitrary. Illegitimate because its justification does not correspond with its foreseen objective and its means of effectuation; Arbitrary because the orientations and therapeutic decisions are based upon assumptions that presuppose behaviors or capacities on the basis of subjective criteria, prejudices or stereotypes. The idea conveyed in gynecology services, of longer lasting gestation for black women, which in turn give rise to specific protocols, is an excellent example. [30]

Racial Categories in the Knowledge Clinic

The history of medicine teaches us that medical knowledge built itself on categories of race. [17] Groupings such as “Blacks,” “Africans,” “Whites,” or “Caucasians”, which proceed these racial categories—composing epidemiologic categories [4]—root themselves once again in representations and prejudices that are susceptible to affect the practices that healthcare teams employ. [3] Throughout this process there is noconsciousness of the arbitrary character of these categorizations, nor of their perverse effects. It is more so the specificity of the environment that causes this absence of critical reflection, in the sense that the healthcare field is not perceived and does not perceive itself as a producer of inequalities, and even less so of racism. [26] France's good reputation rests in the notion that doctors and nurses exercise unbiased engagement, spurring from a humanist ethic and universal and equality based principles that are reaffirmed each time by oaths and professional codes and shared throughout the healthcare field. Diffused additionally throughout the entirety of society, this image of the healthcare world is not contradicted by the perceptions of those patients interrogated outside of a set experience. The specificity of the healthcare organizations 'mission (centered on the well-being of the other, education and healing) and deontological principles and advanced bodies of thought (egalitarianism, humanism) appear as a sufficient bulwark for preventing all racist prejudices and discriminatory practices. Diverse studies establish nevertheless that the representations and prejudices of caregivers from the majority group, saturate, like it or not, care-based relationships --be they within the hospital field or within a city consultation. Thus it is not uncommon to hear in health services that such and such patient hasno“cortex” and, as if by chance, this remark is often referring to those persons whom are categorized as black or as “African” or “Caribbean.” [12,29]However, a developed cortex is specific to the human species; to tell a person that he or she has no cortex, re-issues the idea that he or she belongs to an inferior species, otherwise known as another race! Studies conducted in France demonstrate that these prejudices, the question of minimal access to healthcare apart, can nonetheless strongly affect the quality of, and significantly modify, therapeutic trajectories of patients. [5,9,27,28,29]

Racist Scenarios in Healthcare Relations

The great inquiry, “Trajectories and origins, a study on the diversity of France's populations” (Toe) realized by researchers of the National Institute of Demographic Studies, shows for the first

time in France on such a scale, the effects of foreign “origins” on the social trajectories of immigrants and their descendants, thus including those persons born in French overseas departments and their children born in the French metropolis. The analyses testify to the particularly negative effects of foreign ancestry and skin color concerning access to goods and resources in the country. The healthcare segment of the study discusses the discriminations that minorities experience throughout their interactions with healthcare professionals. Immigrant women, in particular those originating from Sub-Saharan Africa, the Maghreb, and from Turkey, and women originating from French overseas departments, declare two to four times more likely to have been ill-received by caregivers (doctors, nurses, nursing assistants, mid-wives) in comparison with women from the majority group. This feeling of being treated less well is also observed in men native to French overseas departments, a Sub-Saharan African country, Morocco or Tunisia. All of these migrants declare to have been treated less well because of their origin and/or their skin color. Amongst the descendants, women born to parents originating from Sub-Saharan Africa or from the Maghreb or Turkey are two times more likely to declare to have felt treated less well than women from the majority population. This rate is even higher still for men of the same groups. [9] The data from this quantitative study has been corroborated alongside the following conducted biographical interviews. [10]

Studies implemented within the hospital setting controlled conditions to be favorable to the appearance prejudices and racist attitudes. For example the work attained from the shadowing of women categorized as “Africans” in ob-gyn services, shows that this assumed origin determines discriminatory therapeutic decisions, such as the overexposure of these women to cesarean sections.[30] Other studies attest that these differences are particularly striking when one compares the therapeutic trajectory of individuals categorized as “Africans” with those catalogued as “French” [9,27]. In one study conducted in HIV-Immunodeficiency services, we asked patients to tell us about how they discovered that they were seropositive, who, and what were at the source of his or her testing. For “French” people, this procedure is undertaken in their initiative, while for “Africans” it is the doctor who most often initiates the request and, contrary to the law, the testing is often done involuntarily. Throughout their intake process, those who are assumed to have African origins have a significantly elevated probability to be put under observed surveillance, as compared to those who are classified as French. Another study executed in the psychiatric field under our direction, revealed that the caregivers projected inherited representations of colonialism on “Africans”, marking them either as violent (terrifying image of the savage), or as naïve juveniles (in line with the widely distributed image of a famous chocolate brand.) These representations provoke practices that are specific to their environment—quite often, hospitalized persons under restriction are frequently placed in an intensive care rooms. [11] Even if decisions arrive, in theory, from medical authority, the nurses on these teams also have an important power and often do not hesitate to use it. Thus in this study, as in a previous one conducted a few years earlier, it is not uncommon to observe

fairly violent interactions between an “African” patient and those nurses who finished by isolating this patient. We have heard/seen all this before in the backstage areas (offices, patient rooms) of nurse’s caricaturizing the “negro” accent. [6]

Fundamentals of Racism And Health

Concluding these studies by stating that caregivers and/or care receivers can be racist would be a simplified vision. What is sure however, is that they re-engage, consciously or not, racial categories constructed throughout scientific and political history using a racist ideological framework. Health organizations do not function on the basis of a mentality that allows for the carrying of prejudices, but instead quite the opposite. [31] Most often caregivers start with assumption of “doing one’s best”, applying a series of obstacles specific to those persons categorized as “migrants” of such and such origin—and amongst them, are further identified as “Africans” or “Maghreb”: cognitive obstacles (capacity to understand information), cultural (beliefs on sickness and the therapeutic within health) and social (standards of living and of one’s stay in France.) From unequal treatments to discriminations, the line is easily crossed, and it is, de facto, when obstacles are presupposed without being verified. In certain cases, differences in treatment are none other than discriminations. Such discriminations produced by health organizations provoke delays in care, even renouncements. They also cause other forms of “overinvested therapeutics” or orientations that single out, without being fundamentally clinic, racialized persons, blocking them outside of the common law. In this field, these categories can be so powerful “that they correspond with a well-established tendency of clinical reasoning based on typification and standardization” [21]. Healthcare providers give little time to stopping and interrogating their practices concerning the aspects that distance themselves in theory from their principal tasks and missions. In the health field, as within all social spheres of our society, categories of “race”, class individuals, branding them as a base of these traits, classing them in addition to their distinction as foreigners or immigrants. This is the case for example, of those originating from French overseas territories and departments, but also that of the children and grandchildren of migrants who settled in France in the 1960s. Racism was not born in a vacuum in the healthcare universe; it exists throughout the social sphere and is grounded in a long history. [22] If we wish to understand how racist remarks and behaviors emerge—in the same way in which responses (verbal or in action) produce themselves, it is necessary to look at the context in which these words and actions create themselves: the French society. The fact that a nursing assistant mistreats a patient, or that a person receiving care can attack a caregiver because of his or her supposed origin or his or her skin color, or make it possible to refuse his or her care, derives, neither more nor less, from the admission of racism in our society. The difficulties in combating this racism result firstly in the difficulty to signal it as such and at least four reasons can explain this. Racist practices are in a large part the product of social relationships that go beyond individuals and are situated upstream of their actions in order to serve macro sociological logics, politics and economics. [8, 28] These practices impregnate

the everyday life to the point where they become banal and therefore, invisible and inaudible. [15] The normalization of these practices causes them to fall into the notion of ordinary, the routine, favoring tolerance towards racists. [14] Lastly, because of this tolerance, the victims tend to keep silent because those who protest are labeled early on as paranoid and “trouble-makers.”

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