



Healthcare Inferno: Exposing Medical Bias and Recounting Stories

“So early in my life, I had learned that if you want something, you had better make some noise.” (Malcolm X, *The Autobiography of Malcolm X*, 1965)

This essay explores medical/healthcare bias, its harms, and how it has personally impacted my health and been exacerbated by my social identities. This topic is important because healthcare bias is under-recognized and causes people to suffer and even die. My goal is to educate readers on healthcare bias and inspire healthcare professionals to work on their biases.

Keywords: stigma, healthcare, discrimination in medical care, endocrinology, health aspects, quality of care, discrimination against overweight persons, physical-appearance-based bias, prejudices, obesity, stereotyping.

Introduction

This essay seeks to present a comprehensive understanding of healthcare bias and highlight its harmful impacts. This paper will examine research surrounding the topic. The research I analyze will focus on biases that pertain to race/ethnicity, gender, and weight. I chose to focus on specific biases as they are representative of my personal

experiences with healthcare bias. Conceptual baggage I had during the research process was some of the words that authors used within their work when discussing weight bias in healthcare. Despite its medical origins, I find the word “obese” to be a little stigmatizing. Usually, this word has a lot of negative connotations around it like being lazy or gluttonous. The relationship I have with the research is that healthcare bias impacts me immensely. I have received poor treatment at the hands of healthcare bias. I decided to research healthcare bias because I want to contribute to combatting this issue. I argue that healthcare bias is harmful for marginalized people and communities.

Healthcare bias refers to the discriminatory beliefs and practices that healthcare professionals and institutions exhibit and implement in their practice. These biases can take several forms that include racial/ethnic bias, gender bias, weight bias, sexual orientation bias, socioeconomic bias, and geographic bias (where access to care is based on where one lives). This issue is particularly pressing for marginalized patients as they are disproportionately affected and thus face devastating consequences. Furthermore, when examining this issue through an intersectional lens, it appears

that healthcare bias is even more dire for individuals with multiple oppressive identities.

The perpetration of biases in healthcare leads to serious consequences including misdiagnosis, inadequate or inappropriate treatment, decreased access to care, poor health outcomes, increased healthcare costs and most unjust, death (Sutin et al., 2015, p. 7). This is particularly true when examining the issue through an intersectional lens, as individuals with multiple oppressive identities face compounded effects due to the intersection of these biases. People dying at the hands of bias is unjust and highlights the urgency of addressing healthcare bias. On a societal level, healthcare biases contribute to systemic inequalities and reinforces social injustice. Dismantling healthcare bias requires increasing awareness and advocacy. For the well-being of all people, it is crucial that we advocate for an equitable and adequate healthcare system that benefits everyone.

Healthcare Bias at a Glance

In healthcare, the prevalence of bias and its harmful impacts has been documented in numerous studies. Fitzgerald and Hurst (2017) published a systematic review that examines implicit bias in healthcare professionals.

Fitzgerald and Hurst conducted this research to answer the question, “do trained healthcare professionals display implicit biases towards certain types of patients?” (p. 3). Fitzgerald and Hurst examined forty-two articles in this systematic review, with a majority of studies focusing on racial/ethnic biases. However, ten other biases including gender, age, and weight were also inspected in this systematic review. Fitzgerald and Hurst found that most studies examined in their systematic review provided evidence that healthcare professionals were holding biases. Three studies provided significant evidence that there is a connection between high levels of implicit bias against Black people and negative interactions with Black patients. Four studies found a significant connection between high levels of pro-white implicit bias and treatment responses that favored white patients (Fitzgerald and Hurst).

Overall, Fitzgerald and Hurst’s systematic review suggest that implicit biases affect clinical judgement and behavior. For example, bias was manifested through diagnosis, treatment recommendations, number of questions asked of the patient, or number of tests ordered. Most of the studies used the Implicit Association Test (IAT) to measure implicit prejudice and implicit

stereotypes. Nine IAT studies combined the IAT with a measure of physician behavior or treatment decision (Fitzgerald and Hurst). Limitations in the work included small sample sizes from certain studies, failure to report response rates, and failure to control for participant knowledge of the purpose of the study. Additionally, limitations of the field include the lack of established methodology and difficulty in comparing results due to varying methods and terminology used by different authors (Fitzgerald and Hurst). Including this systematic review to be a part of this essay is purposeful because it provides a comprehensive view on different types of healthcare bias and provides a quantity of evidence to support healthcare biases’ prevalence and impact.

Racial and Ethnic Bias in Healthcare

Racial and ethnic bias are one of the most prevalent forms of bias observed and experienced in healthcare. Maina et al. (2017) investigate this form of bias in healthcare by reviewing ten years’ worth of studies on the topic. Thirty-seven studies were used and the total number of participants among all included studies was 10,013. All studies assessed implicit bias among at least one type of

provider such as physicians, healthcare students, mental health counselors, nurses, genetic counselors, and occupational therapists. The majority of study participants were female (averaging 58%) and White or Asian. Bias related to race/ethnicity was assessed using ten types of Implicit Association Tests (IATs). The Race IAT, which compares bias against Black versus White adults, was used in 35 studies. Twenty-six studies reported that most healthcare providers have some level of pro-White/anti-Black bias. Results from the Ethnicity IAT, which compares bias against Hispanic versus White adults, showed slight pro-White/anti-Hispanic bias. Maina et al.'s work provides a sweeping collection of evidence to support the prevalence of racial/ethnic bias in healthcare. After reviewing the findings from their study, one can conclude that people of color are faced with adversity when it comes to their health.

Weight Bias in Healthcare

In recent years, weight bias in healthcare has become a hot button issue as more people speak on their experiences. Considering that people of diverse body size are marginalized in society, one can speculate that disparities in healthcare will be present. In efforts to provide a

comprehensive look at weight bias in healthcare and its harmful impacts, I review several pieces of literature. Lawrence et al. (2021) published a systematic review and meta-analysis on weight bias among health care professionals. This systematic review is important as it highlights the validity of weight bias in healthcare by pointing out evidence from other studies. Previous studies about weight bias have produced mixed results, which is what prompted the authors of this article to conduct their research. Lawrence et al. reviewed forty-one studies ranging from 1989 to 2020. Evidence of both implicit and explicit weight bias among health care professionals such as medical doctors, nurses, dietitians, and others was found. Additionally, this review found that weight bias exhibited by healthcare professionals (HCP)s negatively affects the quality of care and may cause less use of health care services by clients who are overweight or obese (Lawrence et al., 2021). Individuals who are overweight or obese often face weight bias during their consultations with healthcare professionals, which can lead to internalized weight stigma and increase the risk of depression, anxiety, stress, and even suicidal thoughts. Fruh et al. (2016) add to this finding by providing readers with an overview of obesity

stigma and bias. Fruh et al. focus on acknowledging that weight bias does exist and how it is a barrier for patients to receive the healthcare they need. For example, Puhl et al. (as cited in Fruh et al., 2016) report weight bias resulted in women gaining more weight by binge eating to cope. Another study highlighted by Fruh et al. was conducted with 358 nurse practitioners about their attitudes towards people who were overweight. Nurse practitioners reported holding negative attitudes towards overweight people such as them not being as successful as others, not fit for marriage, messy, and not healthy. Additionally, Fruh et al. highlight another study exploring the biases of 620 Primary Care Physicians (PCPs) The study indicated that half of PCPs found their patients to be awkward, unattractive, ugly and non-compliant.

Seymour et al. (2018) conducted original research that supports the findings from the systematic review by Lawrence et al. (2021). The purpose of the research study was to determine whether healthcare professionals in the U.S. exhibit weight bias towards patients with obesity and the effect it has on the quality of care they receive. Participants were healthcare professionals over the age of 18 in the Midwest. Open-ended responses to hypothetical patient

scenarios and the Attitudes Towards Obese Persons scale were methods utilized to measure quality of care and weight bias among the participants (Seymour et al.). Multiple findings are addressed. First, findings indicated that healthcare professionals with higher levels of weight bias had lower quality of care towards patients with obesity compared to those with lower weight bias. When healthcare providers were presented with hypothetical scenarios involving patients with and without obesity, responses were similar however specific recommendations were made to patients with obesity. Healthcare professionals with high weight bias were found to offer less empathetic advice, such as prescribing pharmaceutical intervention over lifestyle modification. Seymour et al. suggest this could contribute to weaker practitioner-patient rapport and affect the quality of care delivered to patients with obesity. While the study had a large sample size and valid data collection methods, its limitations include a sample not representative of all healthcare professionals and the use of hypothetical data collection.

Abbott et al.(2023) highlight evidence that healthcare professionals are prone to weight bias. Specifically, the study examines implicit weight bias among

healthcare professionals who specialize in treating obesity and their views on alternative approaches that do not primarily focus on weight. Weight bias in obesity services is under-researched, which is why the authors undertook this research. The methods of this study included inviting obesity specialist healthcare professionals to a webinar about non-weight focused approaches in obesity services and then examine their bias using the BiasProof mobile device test (Abbott et al.). This test is based on the Implicit Association Test. Eighty-two out of 113 HCPs contributed their data to the study. Out of 82 HCPs, 51% held an implicit bias about people who are overweight. These research findings are important to highlight because even in specialties that are meant to help overweight people, bias is still prevalent.

Mortality Risk and Weight Bias

Weight bias has devastating effects, which on the extreme end can include risk of mortality. Sutin et al. (2015) examine weight discrimination and mortality risk in their work. The purpose of this research was to examine if there was a link between weight bias and risk of mortality similar to how there is a link between weight bias and declines in physical and mental health. The methods of this research included taking data

from the Health and Retirement Study (HRS) and the Midlife in the United States (MIDUS) study. Participants were re-interviewed every two years in the HRS and completed a 30-minute telephone interview, self-administered questionnaire that included the discrimination measure in the MIDUS. Sutin et al. found that weight discrimination was associated with an increase in mortality risk of nearly 60 percent in both the HRS and MIDUS participants after controlling for demographic characteristics. The study also found that the risk of mortality was slightly stronger for Black participants than for White participants (Sutin et al.).

Of all the literature reviewed in this paper, Sutin et al.'s, research may be the most important to highlight. Their findings indicate an urgency to combat weight bias in healthcare.

Gender Bias in Medical Research

Gender bias is another form of bias that can be found in healthcare that also extends to medical research. Gender bias refers to the unequal attention and resources given to medical conditions that primarily affect women or are perceived as being related to women. Polycystic ovarian syndrome (PCOS) is considered a women's disease and largely under-researched. Brakta et al.

(2017) examine PCOS and the amount of funding that is delegated towards it. Brakta et al. found that PCOS research may be underfunded when compared to funding awarded for research in similar diseases. During the 10-year funding from 2006-2015, PCOS research received \$215.12 million compared to \$454.39 million for rheumatoid arthritis (RA), \$773.77 million for tuberculosis (TB), and \$609.52 million for systemic lupus erythematosus (SLE) (Bratka et al.). Funding for PCOS was primarily provided by one NIH Institute/Center, whereas SLE and RA received funding from at least two Institutes/Centers. Additionally, more Research Project Grants were awarded for RA, SLE, and TB than for PCOS (Bratka et al.). Brakta et al. acknowledge that diseases that affect women are more likely to be underfunded. However, it is also noted that “PCOS is ... a metabolic disorder, with substantial and well-documented metabolic origins and metabolic and cardiovascular morbidity, which are not areas of interest” to some institutes (Bratka et al, p. 4423).

Considering that bias in healthcare is becoming more discussed and researched, additional efforts and strategies have been suggested to combat it. Vela et al. (2022) published work that not only examines negative

explicit and implicit biases held by healthcare providers but also how these biases affect patient-clinician communication, clinical decision-making, and institutionalized practices. Additionally, Vela et al. examine the strategies meant to combat healthcare bias and whether they are sufficient. Vela et al. found that current efforts to address healthcare bias include educating healthcare providers about the existence and impact of bias and teaching them skills to manage it. However, these interventions were found not to be effective as they did not lead to sustained changes in behavior or changing the clinical or educational environment (Vela et al., 2022). This may be due to the discriminatory practices prevalent in the healthcare work and learning environment that reinforce the biases being targeted.

My Experiences with Healthcare Bias

At the age of nineteen, I was thrust into a world of uncertainty and difficulty when I first learned about PCOS. It was during a routine check-up that I mustered the courage to confide in my doctor about the nagging symptoms that had plagued me for years: fatigue, thick facial hair, and rapid weight gain. They proposed it could be PCOS and ordered blood tests to investigate further. After a

month of waiting for results, I received a voicemail from my doctor's office asking me to call back urgently to discuss my results. It was then that I learned that I had elevated testosterone levels, a telltale sign of PCOS, and that I needed to see an endocrinologist for further evaluation. The news was bittersweet, to say the least. On one hand, it was daunting to learn that something was indeed wrong with me. On the other hand, it was a relief to finally have a name for the constellation of symptoms that had eluded me for so long. It was a ray of hope that I was one step closer to finding the treatment I needed and deserved.

As is often the case with medical specialists, getting an appointment with an endocrinologist was no easy feat. I had to endure months of uncertainty, wondering whether I had a disorder that could significantly impact my life. As I awaited my appointment with the endocrinologist, my nerves were frayed. My past experiences with doctors had been less than satisfactory, with many dismissing my concerns as nothing more than a result of my weight. I was worried that this visit would be no different. The appointment began with a medical student taking down my history and symptoms. Surprisingly, this part of the visit went smoothly, and I felt a glimmer

of hope that I would finally get answers to my health struggles. My hope was short-lived as the endocrinologist entered the room. He was an older gentleman, short in stature, with a bald head and bulging blue eyes. His grin was pointy and revealed a set of gapped buck teeth. He started the conversation off on a positive note by complimenting my desire to become a social worker.

The true appointment began with the endocrinologist turning his attention to the medical student, asking her to recount my symptoms. She dutifully ran through the assessment she had conducted earlier, and the endocrinologist responded with an air of irritation and disgust, asking for her diagnosis. When she tentatively responded with "Cushing's," he scrunched up his face and rolled his eyes, clearly unimpressed. In a dismissive and disparaging tone, he sneered, "That's it? That's all you have to say. That's the only thing you could pull from your vast medicinal repertoire?" I was shell shocked; how could he degrade his student like that? The look of sadness and shame on the student's face was palpable as she struggled to come up with a response. But she was cut off before she could even utter two words, with the endocrinologist interrupting her mid-sentence. It was clear that anything

she said would be inherently wrong. After rudely silencing his own medical student, the endocrinologist turned back to me and asked why I was there. When I mentioned that my doctor thought I might have PCOS, he responded with a dismissive laugh and asked me why I thought that was the case. Despite my attempts to explain my pressing symptoms, he insisted that I simply needed to lose weight and reach a size 10. When I brought up my abnormally thick facial hair, he giddily dismissed it as a product of my Puerto Rican heritage, saying that "lots of women are hairy." As the appointment drew to a close, he asked if I snored in my sleep, and used my affirmative response as evidence that I did not have PCOS, but rather sleep apnea. In his eyes, the most important thing was for me to lose weight, and he seemed to believe that curing my sleep apnea would magically allow me to do so. I left that appointment feeling worse than when I came in. At the time, I lacked the language and understanding to recognize that what I had experienced was healthcare bias. All I knew was that I felt dismissed, defeated, and hopeless. It seemed as though I would never find the answers or the adequate treatment that I so desperately needed.

After my disappointing experience with the first endocrinologist, I spoke to

my primary care physician, and they set me up with a new one. Unlike the previous doctor, this endocrinologist took one look at me and said that I most likely had PCOS. He asked me about my diet and exercise habits, and when I told him that I ate healthy and exercised regularly, he didn't believe me. He then recommended that I start with eating 1,200 calories a day, then drop to 800, and eventually down to 500 calories. Hearing this was hard, and I felt a sense of shame and unworthiness. At this point, I just wanted to leave the appointment as soon as possible. Everything he said went in one ear and out the other. I left feeling frustrated and overwhelmed. Awaiting me were more calls, more waiting, and more difficulties. It has now been two and a half years since that appointment, and I have yet to return to an endocrinologist because of what I have experienced.

Healthcare bias has left me feeling alienated from the treatment I need and deserve. I fear the future dismissal I will face on my journey for treatment. After researching this issue, I realize just how prominent it is as many patients face similar situations. In the medical field, there is still much work to be done to ensure that patients are heard and treated with the respect and dignity they deserve.

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