Racism and bias in health care: As a doctor, I’ve been an object, observer, and offender

By Kulleni Gebreyes

As an African American physician, there’s a lot I can say about bias, racism, and health inequity. I’ll start with the obvious.

We’re in the midst of a multigenerational public health crisis, rooted in racism and made more acute by the COVID-19 pandemic. Racial and ethnic minority groups throughout the United States experience higher rates of illness and death than white people across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease. Average life spans are shorter for individuals in communities of color. The pandemic has deepened and spotlighted measurable disparities in COVID-related mortality and vaccination rates.

Health inequity is a systemic failure, often originating not only from limited access to appropriate treatment at the point of care but also from barriers to well-being in the social determinants of health (also known as the drivers of health). If we are to achieve health equity—which I define as the fair and just opportunity to fulfill our human potential in all aspects of health and well-being—society has to address all barriers to health and well-being together. We need to consider access to clinical trials, representation in research, and the systemic barriers to diagnosis, treatment, and cure.

That’s the obvious. The rest of the health inequity problem is rooted in our quieter day-to-day personal choices. Although I’m quite sensitive to bias and inequity, I’m not immune to making mistakes in this realm. Not only have I witnessed bias in action in my work, I have unintentionally perpetrated it.

That’s how insidious health care inequity can be. If you’re part of the system and that system has a problem, well, you may also be part of the problem. As am I.

Let me explain by sharing my experiences with racism and bias—as an object, an observer and, yes, an offender.

Me as an object of bias

I’m a Harvard-educated and Johns Hopkins–trained emergency medicine physician. In my clinical practice, I used to wear a white coat and a stethoscope around my neck. Pretty good giveaways as to why I’m in a hospital. One busy morning in the emergency room, I walked into an examination room and introduced myself as “Doctor Gebreyes” to a patient with chest pain. He looked at his wife in confusion and then turned to ask me, “So when is a real doctor coming to see me?”

There were hundreds of variations on this encounter over the years. Each of these patients clearly saw my name tag and credentials but had difficulty understanding my value. These interactions were a constant reminder of how my race, and perhaps my gender, can impact the way I am seen and treated in daily life outside of the hospital.

Me as an observer

As painful as such slights were, I sometimes failed to assert myself when I witnessed my colleagues displaying bias toward someone else.

Case in point: One busy day in our emergency department, a colleague walked out of a room referring to a patient who was crying in pain as being in “status dramaticus,” a term that suggested the patient was overly anxious and exaggerating the level of pain. When I heard that term, I automatically knew that the patient was a woman. As I consider my colleague’s comments, I now wonder how that label influenced how her pain was, or perhaps was not, managed.
Over the years, I heard many other derogatory expressions based on gender, income, and ethnic stereotypes that were disguised as humor. I would usually react with a simple chuckle or mild disapproval. I rarely spoke up to call out how these comments betrayed the trust and could potentially impact the treatment of those who implicitly trusted us to provide care.

Me as an offender

In my first role after I transitioned out of clinical care, I began advising the country’s top health care organizations in navigating complex challenges, a role in which I got the chance to help improve access to affordable, high-quality care. Although I always relied on data to guide decision making, I have learned there can sometimes be large pitfalls between intention and impact.

A few years ago, I was dining with my close friend Jackie. She was frustrated about clinic closures that were disproportionately creating medical deserts in communities of color. She explained that the analysis did not examine the structural, institutional, and historical bias in the system and society. As she spoke, I was stunned to realize I had guided similar analysis and decision making. I was concerned that I may have used inherently biased frameworks that had profitability as a primary goal and did not place equity at the center.

My work today

I have reflected deeply on my role as an object, observer, and offender. I have wrestled to resolve how I can live up to my values in my daily choices and within my professional life. I have found an answer in my role as the leader of Deloitte’s Health Equity Institute, where we are committed to placing health equity at the center of everything we do.

I lead a team focused on examining the impact of racism and bias in health care. I conduct equity-based diagnostics to guide business, government, and community leaders seeking to make a difference. In collaboration with these leaders, I bring healing to individuals and communities who are seeking to fulfill their full potential in health and well-being.

Specifically, I work with leaders to explore and advance health equity through four channels:

- **Organizations:** How can leaders promote and advance inclusive hiring, equitable benefits programs, and cultural competency?
- **Offerings:** Is equity being incorporated into all products and services? Do benefits reward equitable access, outcomes, and experience of care?
- **Communities:** Is the organization investing locally and acting as a good partner to the community where employees live, work, pray, and play?
- **Ecosystem:** How are leaders seeking to amplify their positive impact through their vendors, partners, and policy agenda?

As an institute, we also work to generate data and insights around racism, bias, and socioeconomic factors that create disparities in health outcomes. We identify leading practices for advancing equity. For example, we recently gathered and analyzed nationwide data to identify vaccine deserts across the United States, making it easier for authorities to establish vaccination sites where they are most needed. Many businesses, governments, and nonprofits are hungry for more such guidance. It feels good to be in position to involve people in order to help people, on a systemic scale.

The courage to change

I have dedicated many hours to replaying the moments I have experienced as an object, an observer, and an offender of racism and bias and the potential impact on health equity. I am not proud of all my choices.

But instead of withdrawing in shame, I am sharing my story and committing to be a better leader. I am respectfully calling on all of you—clinical, business, government, and community leaders within and outside of the health care industry—to confront the hard truths about yourselves and your actions. I am inviting you to join me in reflecting on our past and committing to a better future where we collectively and consistently advance health equity in intention, action, and impact.

Let’s commit to healing. This time, we must do better. This time, we must get it right.

Kulleni Gebreyes, M.D., is the leader of Deloitte’s Health Equity Institute. A physician leader with experience across the commercial and public sectors, she is also the U.S. health care consulting leader in Deloitte’s Life Sciences and Health Care practice.

Kulleni Gebreyes, M.D., is the leader of Deloitte’s Health Equity Institute. A physician leader with experience across the commercial and public sectors, she is also the U.S. health care consulting leader in Deloitte’s Life Sciences and Health Care practice.