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Black Lips Don't Turn Blue:

A Womanist Critique of Discriminatory Language in Medical Education

Alison Lawrence

RELG 204: Womanist Christian Ethics

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Childcare Lesson One: when [white] babies can't breathe, they turn blue. This is called cyanosis, a condition in which, as the name implies, a person develops a bluish color around the eyes, lips, and fingertips due to a lack of oxygen in the blood. In emergency medicine, cyanosis is a primary indicator of severe respiratory distress that, if left untreated for more than a matter of minutes, leads to death. Recognizing this blue color saves lives. White lives, that is. But what of the Black babies, whose blue may be indistinguishable from their normal color? At best, most medical textbooks will add the answer as a one-sentence afterthought—at worst, cyanosis of dark skin is never mentioned at all. In America, Black people are gasping for air, but nobody recognizes the signs.

Universalizing language in medical textbooks, as in the case of cyanosis, acts as a silent perpetrator of racial and gendered disparity. It leads providers to see gender and race differences in symptoms as abnormal or insignificant in comparison to the white, male “standard,” ultimately resulting in a lower quality of care. Applied to the mainstream formatting of current medical resources, Emilie Townes’ definition of womanist ontology and Stacey Floyd-Thomas’ womanist virtue ethics enable me to demonstrate the limitations of medical education that presumes whiteness and masculinity as the norm. I argue that more diverse and inclusive presentations of medical conditions in non-white, non-male bodies are the first step in achieving equitable healthcare outcomes. First, I will explain statistical data on healthcare disparities attributed to gender and racial bias. Next, I will introduce examples of normative textbook language and discuss their harmful implications for patients through the lens of virtue ethics.¹ I will then employ Townes’s womanist ontology of wholeness to further critique the isolated treatment of gender and race-specific information when it is present, and advocate for not only the inclusion of this information, but also a presentation that does not undermine its

¹ Stacey Floyd-Thomas, *Mining the Motherlode*, (Cleveland, Ohio: Pilgrim Press, 2006).

significance.² Finally, I will conclude by applying the above methods to propose more inclusive changes that would better educate healthcare providers on patient differences.

As a medical practitioner, I am invested in confronting the medical system's role in perpetuating racial and gender injustice with the aim of ultimately improving healthcare equity. Heart disease, a leading cause of death in the U.S., serves as a startling model of racial and gendered disparities in medicine. According to the American College of Cardiology, Black people die of cardiovascular disease at rates 33% higher than white people; similarly, women are less likely to receive the same quality of cardiovascular care as men, resulting in 25% higher death rates.³ These startling statistics are present across nearly all medical disciplines and spaces, from prehospital emergency care to inpatient treatment. Interestingly, the study concludes that 69% of gender disparities in healthcare could be prevented "if women received better quality of care."⁴ The article points to low physician awareness of race and gender disparity as a potential cause of these trends, yet fails to suggest meaningful, system-wide remedial measures beyond vaguely calling for more awareness and "better care." By doing so, they automatically deflect the blame for these statistics and assume that nothing internal can be done. Similarly, emergency medicine researcher Jamie Kennel points out that "many people try to chalk up differences in care to differences in income," citing socioeconomic factors such as poor working conditions or limited access to insurance as reasons for poorer health.⁵ Despite the relative truth in each

² Emilie Townes, "To Be Called Beloved," in *Womanist Theological Ethics*, eds. Katie Geneva Cannon, Emilie M. Townes, Angela D. Sims, (Louisville, Kentucky: Westminster John Knox Press, 2011), 183-202.

³ "One Size Does Not Fit All: The Role of Sex, Gender, Race, and Ethnicity in Cardiovascular Medicine," *Cardiovascular Magazine*, American College of Cardiology, published October 19, 2020, accessed March 2021, <https://www.acc.org/latest-in-cardiology/articles/2018/10/14/12/42/cover-story-one-size-does-not-fit-all-sex-gender-race-and-ethnicity-in-cardiovascular-medicine>

⁴ Ibid.

⁵ Jamie Kennel, "Investigating EMS Treatment Disparities by Patient Race/Ethnicity for Traumatic and Painful Emergencies," published May 31, 2018, accessed March 2021, <https://www.ems1.com/paramedic-chief/articles/study-paramedics-undertreat-complaints-of-pain-from-black-asian-patients-sYO4PXsXsdp0B4mN/>

explanation, both still fail to hold the medical field itself accountable for system-wide inequities. In order to take active steps towards equality, medicine might take on a womanist perspective that challenges not individuals, but rather the systems in place beyond the problem itself that are rooted in racism and sexism. It is time that the medical field examines its own systemic role in the production of inequality, which will inevitably lead to the discovery of direct sources of patient harm as well as concrete solutions to rectify centuries of flawed treatment. One of these sources of harm, which constitutes the focus of this paper, is the biased presentation of information in medical education.

Medical textbooks are the final determinants of what information makes it into clinics, hospitals, and operating rooms. It is thus critical that the right facts are not only included, but also presented accurately. However, race and gender-differentiated information tends to be buried in subscripts, mentioned as afterthoughts, or treated as abnormal—if the information is even present at all. Such dismissive presentation results in a normative and exclusionary approach to patient care by creating a universalized standard for illness that paints deviations from this norm as less significant. In 2008, Swedish researchers Petra Verdonk, Anja F. Dijkstra, and Antoine L. M. Langro-Jassen examined internationally-accepted medical textbooks across various disciplines in an effort to “review the availability and accessibility of gender-specific knowledge in current textbooks” in their groundbreaking study “Gender bias in medical textbooks: examples from coronary heart disease, depression, alcohol abuse, and pharmacology.”⁶ They found that the vast majority of these books only contained gender-specific information that was either hidden in subtext or placed in separate sections; alarmingly, symptoms of illness specific to women were rarely integrated equally alongside those of men. The study concluded that such inaccessible

⁶ Petra Verdonk, Anja F. Dijkstra, Antionette Langro-Jassen, “Gender bias in medical textbooks: Examples from coronary heart disease, depression, alcohol abuse and pharmacology,” *Medical Education* 42: 2008, 1021-1028.

information about gender difference “may influence gender inequities in health care” by leading physicians to de-prioritize symptoms that deviate from the male norm.⁷ Although Verdonk’s study deals specifically with gender, these biases rarely occur in a vacuum. Their effects are instead compounded by the interrelated identities of individuals, thus requiring examination through an intersectional lens.⁸ For this reason, in the following paragraphs I adopt a womanist perspective that sheds light on how the normative formatting of textbooks reinforces disparity in the context of both gender *and* race.

By presenting the white male body as the standard model for all patients, medical textbooks universalize the experiences of a specific group and thus cause healthcare providers to dismiss crucial differences between patients. Stacey Floyd-Thomas’s virtue ethics emphasizes the damage that universality in normative ethics can cause for groups who are not represented in the “normal” standard, and this ethic may be applied to the assumption of universal applicability in medical textbooks.⁹ Essentially, normative ethics takes on the perspective of the dominant group in society and subjects *all* groups to its definition of moral virtue without accounting for differences among individuals that may affect their outcomes.¹⁰ Holding all people to the same standard inevitably causes disadvantaged groups to be unable to compete fairly with their privileged counterparts, resulting in further inequality. Similarly, normative language in textbooks attempts to apply white-male-specific information to all patients, regardless of differing physical and biological factors such as race and gender. In a vast majority of textbook descriptions of illness, race and gender are either only briefly mentioned or never even brought up. The language used is consistently race-neutral and gender-neutral, even when the topic being

⁷ Verdonk et. al, “Gender bias in medical textbooks,” 1026.

⁸ Kimberle Crenshaw, “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Femenist Theory and Antiracist Politics,” *University of Chicago Legal Forum*, vol. 1989 (1): 1989, 139-167.

⁹ Floyd-Thomas, *Mining the Motherlode*.

¹⁰ Floyd-Thomas, *Mining the Motherlode*, 34.

discussed has known differences between groups. For instance, alcohol is known to affect the female body differently from the male body, yet Verdonk's study found that "in the pharmacology textbooks, the effects of alcohol on the body are discussed without mentioning sex."¹¹ By not bringing up sex differences, it is assumed that these effects apply to both men and women equally, even though it is well known that this is not the case. Furthermore, across all textbooks the study analyzed, "cases featuring men outnumbered those featuring women in a manner that seemed unrelated to the actual prevalence of conditions," causing the importance of the male experience to be conflated until it was interpreted as the only relevant model.¹² In terms of race, the findings are similar. One might assume that dermatology is the most obvious field where skin color would constitute a substantial point of difference in diagnosis of conditions; however, a quick flip through *Dermatology: A Handbook for medical students and junior doctors* reveals images of skin conditions on white skin only.¹³ There is not so much as a mention of how these symptoms would appear differently on dark skin, and the book's apparent focus on white skin is never acknowledged. In both instances, gender and race are ignored as possible considerations when diagnosing and treating illness, even though each section is actually discussing only the experiences of white males. The dominant group is thus universalized, creating a normative response to diversity.

Approaching illness from the viewpoint of a single group has harmful consequences for those in the outgroup. Floyd-Thomas argues that "universalizing...bring[s] about the desired ends for members of the privileged class...[but does] not result in the desired ends of success or freedom for members of communities of the dispossessed."¹⁴ Because the normative language of

¹¹ Verdonk et. al. "Gender bias in medical textbooks," 1024.

¹² Verdonk et. al. "Gender bias in medical textbooks," 1026.

¹³ Nicole Yi Zhen Chiang and Julian Verbov, *Dermatology: A Handbook for Medical Students & Junior Doctors*. (British Association of Dermatologists, 2014), 1-72. [https://www.bad.org.uk/library-media/documents/Dermatology%20Handbook%20for%0medical%20students%202nd%20Edition%202014%20Final2\(2\).pdf](https://www.bad.org.uk/library-media/documents/Dermatology%20Handbook%20for%0medical%20students%202nd%20Edition%202014%20Final2(2).pdf)

¹⁴ Floyd-Thomas, *Mining the Motherlode*, 34.

textbooks is tailored to a specific, privileged group, it is not able to accommodate the nuanced experiences of individuals who do not fall into the categories of white or male. Furthermore, instead of simply creating a lack of resources for unprivileged groups, normative rhetoric causes harm; for instance, it has historically “dismissed and/or devalued black women's experiences [and] humanity.”¹⁵ Nowhere is this harm more directly apparent than in the medical field, where a devaluation of women and people of color’s experiences of illness results in physical suffering and, far too often, untimely death. When healthcare providers assume women experience the same symptoms as men or that skin conditions show up on black skin the same as white skin, they will fail to recognize problems because the patient does not present as a white male would. The experience of Dr. J. Nwando Olayiwola, a family physician and parent, is an example of the consequences of universalized patient practices: “I took [my child] to the doctor who was great, but didn’t know what he was looking at, so I showed it to a colleague of mine. Turns out my son had eczema. Eczema on a Black child looks different than on a white child. No fault to the doctor who saw my kid, but he had not seen enough of dark skin in text books and only had white skin as a norm for diagnosis.”¹⁶ Unfortunately, Olayiwola’s experience is a best-case scenario compared to many patients with fatal illnesses, whose symptoms are often recognized too late. While people who fit the white, male standard automatically receive highly informed care, women and people of color are placed at the mercy of a system that isn’t tailored to their needs. Without accurate, inclusive, equally-presented education on differences in signs, symptoms, reactions, and protocols for race and gender groups, even physicians with the best of intentions

¹⁵ Floyd-Thomas, *Mining the Motherlode*, 34.

¹⁶ Cathay Cassata, “This Med Student Wrote the Book on Diagnosing Disease on Darker Skin,” *Healthline*, Healthline Media a Red Ventures Company, 2020, accessed April 2021, <https://www.healthline.com/health-news/this-med-student-wrote-the-book-on-diagnosing-disease-on-darker-skin#Breaking-through-health-disparities>

will fail to recognize appropriate treatment for diverse patients and cause unnecessary suffering or death.

In response to the harm of normative thinking, womanist virtue ethics suggests a holistic approach to the unique circumstances of each marginalized group in society where “analysis of the context,” or a person’s unique position due to their identity, is prioritized.¹⁷ Applied to medicine, this analysis involves the consideration and inclusion of race and gender differences in textbooks in an effort to combat the damage of assuming universal applicability of white male experiences. To protect women and people of color from biased medical care, race and gender-specific information must be included in every relevant context, which will require de-centering the white male as the standard for medical information in favor of an inclusive, holistic description of conditions. Malone Mukwende’s *Mind the Gap*, a handbook of both descriptions and pictures of illness specific to black skin, is a groundbreaking example of a medical resource that flips the normative script by centering its information on the experience of non-white patients.¹⁸ The project emphasizes diversity and equity in medicine, its goal being “to [improve] standards of care for all patients by raising awareness of our expectations and making sure...doctors are equipped to treat the diversity of patients.”¹⁹ Page six of this handbook addresses cyanosis by placing an image of cyanosis on black skin alongside an image of non-cyanotic black skin.²⁰ Though the patient’s lips are gray instead of blue, the difference in color is so easily distinguishable that a physician trained on this book would recognize respiratory distress immediately. By prioritizing a group that is not a part of the norm, Mukwende’s book makes a stride toward equality in medicine that has never been seen before in

¹⁷ Floyd-Thomas, *Mining the Motherlode*, 35.

¹⁸ Malone Mukwende, Peter Tamony, and Margot Turner, *Mind The Gap: A Handbook of Clinical Signs in Black and Brown Skin*. (St George's, University of London, 2020). 1-7. <https://doi.org/10.24376/rd.sgul.12769988.v1>

¹⁹ Mukwende et. al, *Mind The Gap*, 2.

²⁰ Mukwende et. al, *Mind The Gap*, 6.

any widely-recognized medical textbook. In the spirit of a holistic womanist approach, other medical textbooks must follow *Mind The Gap*'s lead and include information and figures that are representative of all types of bodies.

However, achieving equality in medicine requires more than the simple inclusion of diverse information, as the mishandled presentation of gender and race-specific information can label minority experiences as “other” or less significant because they do not fit the norm. In response to the categorizing of certain groups as “other,” Emilie Townes’s ontology of wholeness characterizes the human body as an intersection of multiple identities and experiences that are all connected to one another. A perspective of wholeness means that race and gender cannot be considered tangential aspects of a patient’s identity or health and therefore must be taken into consideration along with all other patient information.²¹ Yet many medical textbooks, despite including at least some gender and race-specific content, discuss them in a separatory manner that presents them as “other” instead of equal to symptoms experienced by the dominant group. For instance, *Prehospital Emergency Care* is a widely-used textbook for EMT training that actually does include a mention of race in its discussion of cyanosis.²² However, an entire paragraph is dedicated to the blueness of the skin without ever using the word “white,” and then differences in black skin are brought up as a vague afterthought. For example, one section reads, “Cyanosis, a bluish gray color, is a late sign of hypoxia and may be found in and around several parts of the body, including the lips, mouth, nose, fingernail beds...and oral mucosa... In a dark-skinned patient, the fingernail beds may appear more pale than cyanotic.”²³ In this example, whiteness is assumed while dark skin is treated as an outlier.

²¹ Emilie Townes, “To Be Called Beloved,” 184-186.

²² Joseph J. Mistovich and Keith J Karren, *Prehospital Emergency Care*. 11th Ed. (Pearson Education Inc, 2014). 224, 293, 532-534.

²³ Mistovich and Karren, *Prehospital Emergency Care*, 224.

Similarly, the book's discussion of heart attacks discusses all signs and symptoms in a section that never mentions gender, and then includes female-specific signs in a section labeled "nonclassical or atypical findings (not necessarily uncommon findings)," framing female symptoms as non-standard—even though the heading itself acknowledges that they *are* common for women.²⁴ Verdonk argues that such othering language and structure undermines the significance of differences and labels diverse symptoms as "aberrations of a [white] male norm."²⁵ Though the information is present, when race and gender are brought up as afterthoughts or in separate sections while the general descriptions of illness are described in the context of a universalized standard, the former is interpreted as less important than the latter because it is "other." According to Townes, this "other" can "lean heavily toward reductionism," diminishing the wholeness of the individual into categories that only capture parts of a person's experience.²⁶ Treating a patient as parts instead of as a whole, complex person affected by race and gender differences denies them equal care and once again subjects marginalized groups to unnecessary suffering. In order to truly provide a holistic representation of women and people of color in medicine, diverse information must not only be included in textbooks, but also presented in a manner that is equal to the dominant white, male standard so as not to diminish its importance.

The creation of a truly diverse and inclusive system will require a subversion of the traditional white male-centered structure of medical education. Mukwende reminds us in the opening of *Mind the Gap* that medicine's failure to protect diverse bodies will continue "if medicine does not decolonize its curriculum."²⁷ This decolonization process means that

²⁴ Mistovich and Karren, *Prehospital Emergency Care*, 534.

²⁵ Verdonk et. al, "Gender bias in medical textbooks," 1025.

²⁶ Townes, "To Be Called Beloved," 200.

²⁷ Mukwende et. al, *Mind The Gap*, 2.

universalized standards must be rejected in favor of a qualitative approach to medicine that integrates the diverse identities of each patient. For a field that relies on the old saying, “Treat the patient, not the monitor,”—or in other words, focuses on the interacting biology of each patient instead of just their symptoms—the consideration of patients’ race and gender identities should be as natural as considering a patient’s age and preexisting conditions. Inclusive, integrated medical resources are the key to producing a new generation of physicians that are equipped to treat diverse patients equally. Therefore, information on racial and gendered differences in medical cases must be included in every description of illness where these differences are relevant. The only cases where universality is employed should be when the symptoms described are the experience of *all* patients, and whiteness or maleness should never be the assumption. Furthermore, when diverse information is included, it must be placed in direct and equal conversation with the experiences of the dominant group. Instead of including women’s heart attack symptoms in a separate section under a minimizing label, gender-specific information must be woven into the general discussion of signs. Instead of relegating black expression of cyanosis to a single sentence, racial differences must be discussed as soon as its appearance on white skin is brought up, and images of both skin types must be included side-by-side. These systemic changes will require constant vigilance and attention to detail—but they are also well within our reach.

The ultimate goal of diversified medical education is to eliminate the need for resources like *Mind The Gap*, because truly inclusive textbooks will automatically include comprehensive, diverse information in every conceivable situation. This means that discussions of inclusivity do not end at race and gender equity. The diversity of the human body is infinite. Transgender bodies, intersex bodies, non-heterosexual bodies, disabled bodies, and all other marginalized

bodies are equally deserving of the highest level of healthcare, and their experiences are not to be dismissed. It is only when every body may be represented in its entirety that we will *all* be able to breathe safely. Only then will our colors, whatever they may be, return to normal.

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