Implementing an Interprofessional Anti-Racism Training With Community Partners During a Pandemic: Outcomes and Recommended Strategies

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ABSTRACT

Background: Motivated by racial injustice and COVID-19 disparities, health care and medical education are accelerating efforts to address racism and eliminate health disparities.

Methods: In consultation with a community partner, an interprofessional physician-led team prioritized and completed an 8-hour anti-racism training adapted for online delivery during a pandemic.

Results: Sixty-four percent of enrollees (25/36) completed the survey, 98% rated the training as valuable, 92% would recommend it to a colleague, 88% reported it would improve their clinical care, and 68% thought their ability to create an inclusive environment increased.

Discussion: Virtual anti-racism training is a valuable learning experience. Tools for adapting trainings on high-risk or emotionally charged topics to a virtual format are offered by participants and session leaders.

BACKGROUND

The year 2020 marked the convergence of 2 visible and public causes of mortality for Black, Indigenous, and People of Color (BIPOC) populations in the United States: racism and COVID-19. These syndemic problems (synergistic afflictions contributing to excess burden in a population)[1] illuminate stark and well-established health disparities in our society,[2] motivating health care institutions and medical education programs to accelerate efforts to examine and implement solutions to reduce structural racism and implicit bias.[3] Anti-racism efforts have become a priority at every level of our health care organizations, from individual to institutional. Health care team members crave increasing awareness and knowledge of racism's negative influence on patient care and efficacy.[4] Medical educators and learners nationally recognize that knowledge and value gaps exist and point to the need to advance structural competency, health equity, and social responsibility in our medical education programs.[5,6] There is strong demand to grow understanding, produce sustained anti-racism efforts, and minimize missteps along the way.

Attempts to address racism within heath care and medical education are gaining strength and recognition nationally, while local and state governments increasingly recognize racism's impact on the health of their constituents. In spring 2019, Milwaukee County, Wisconsin became one of the first municipalities to declare racism a public health crisis. The pandemic has since laid bare the public health crisis that Milwaukee County named. BIPOC populations represented disproportionate numbers of COVID-19 cases, hospitalizations, and deaths in the first months of the pandemic, a trend repeated across the United States. The well-being of Wisconsin, and of the nation, resides in addressing racism within our health care systems and educating our current and future clinicians to identify, act on, and resolve this public health crisis. Many professional society association websites and MedEdPORTAL offer educational resources. This paper reports the findings from an anti-racism educational intervention for students, residents, and family medicine faculty who are working on the front lines of the COVID-19 and racism syndemic.

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METHODS

Since 2013, a select group of medical students completing their clinical training with a focus on urban and public health in Milwaukee have completed the local, community-based YWCA Unlearning Racism workshop as a face-to-face, 8-hour immersion course adapted for health care professionals.[7] In late summer 2020, a multidisciplinary team of Milwaukee-based family medicine residents, faculty, pharmacists, and medical education team members partnered with the medical students and the YWCA to complete Unlearning Racism adapted for virtual environments. Two 4-hour virtual sessions separated by 1 week combined large- and small-group education and discussion and individual reflection time (Table 1). Attendance was required at both sessions for enrollment.

Table 1. Virtual Unlearning Racism[7] 2-day Education Session Outline

Time (Min)	Topic	Virtual Engagement Strategy
	Day 1	
60	Introductions, overview, ground rules, and ice breaker; review goals and objectives	• Large group share (participants videos on; all share during ice breaker)
75	Definitions and history of racism; history of racism in Milwaukee	• PowerPoint presentation (with questions in chat) • Listening pairs (random breakout) • Journaling (individual)
75	Race and racism in medicine and research; historical and current day mistrust	• PowerPoint presentation • Video clip • Small group discussion (random breakout) • Journaling
30	Group debrief: Process emotions and experience of day 1; content that inspired and/or continue to struggle with/process	• Large group share
	Day 2	
120	Privilege, implicit bias and whiteness; the influence of white norms on care and outcomes	• Individual reflection • Small group discussion (by affinity group) • Large group discussion • Video clip
60	Case studies: patient experiences of implicit bias and structural racism illustrating value in reflection, dialogue and patient-centered care	• Journaling • Small group discussion (random breakout) • Large group discussion
30	Closing reflections: implications of learned material and impact for patient care and clinical practice	• Journaling • Large group discussion
30	Group debrief: Process emotions and experience of day 2; identify next steps	• Large group share

All available family medicine residents from postgraduate years 1 through 3 (PGY1-3) (N = 20 determined by duty hours and clinical obligations) were enrolled as part of their scheduled, protected didactic time. Family medicine physician faculty (N = 18), family medicine-affiliated faculty pharmacists (N = 6), and medical education staff (N = 8) were given the option to attend. The second-year medical students (N = 16) were enrolled as part of their required course curriculum.

A brief (< 3 minute) 7-item evaluation was developed. Using single best answer, Likert scales, and narrative response formats, the survey included interprofessional role, overall reaction to the training, and several items focused on behavior (ie, application and implementation) consistent with Kirkpatrick's evaluation model.[8] Upon course completion, participants received an email link to the online survey and 2 reminder emails over the subsequent week. Due to curricular reporting requirements, medical students answered a single item on the session's efficacy and comments items for each half-day session as part of their required comprehensive course evaluation. Survey software (SVMK Inc, dba SurveyMonkey, San Mateo, California) provided descriptive statistics. Narrative responses were analyzed independently by 2 authors to identify themes, with any inconsistencies resolved through discussion consistent with standard qualitative methods.

Educational initiatives consistent with medical student/resident education accreditation requirements, like this project, have been determined by the sponsoring institution's Research Subject Protection Program not to constitute human subject research.

RESULTS

Overall, 52 individuals participated in the Unlearning Racism curriculum: 100% (20/20) of PGY1-3 residents, 50% (9/18) of family medicine physician faculty, 67% (4/6) of pharmacy faculty and students, 38% (3/8) of medical education staff, and 100% (16/16) medical students. The 7-item survey completion time averaged 2 minutes (per survey tool report) by 69% (25/36) of participants: 8 physician faculty, 15 residents, and 2 pharmacy or clinical education team members.

Overall, respondents were very positive about the 8-hour curriculum, with 96% finding Unlearning Racism valuable, 92% indicating they would recommend the session to a colleague, and 88% anticipating improvement in their clinical care (Table 2). For 68% of respondents, the session's effect on their ability to create an inclusive environment for learning and patients moderately or significantly increased. When examined by role, physician faculty consistently rated all items except 1 higher than residents, with residents typically having a higher standard deviation. The ability to create an inclusive environment for learning and patients was the only item on which residents and faculty ratings were equivalent. Pharmacist and clinical educator respondents were aggregated due to sample size and had the highest ratings of all groups.

In response to the item: "We want to create an inclusive envi-

Table 2. 'Unlearning Racism' Curriculum Overall Evaluation Survey Results and by Respondent Role and Kirkpatrick Item Level[8]

Items and Rating Scales â `	Overall % 2 Highest Scale Values (Strongly Agree + Agree)	Overall Mean (SD)	Mean by Role (SD)				Kirkpatrick Level[a]
			Physician Faculty	Resident	Pharmacy/ Clinic Educator	Medical Student	
I found "Unlearning Racism" valuable[a] *(1=strongly disagree to 5=strongly agree)*	96%	4.5 (0.70)	4.9 (0.33)	4.2 (0.77)	5.0 (0.00)		1
"Unlearning Racism" will improve my clinical care *(1=strongly disagree to 5=strongly agree)*	88%	4.3 (0.65)	4.5 (0.70)	4.0 (0.59)	5.0 (0.00)		3
After attending the "Unlearning Racism" sessions, my ability to create an inclusive environment for our learners and patients has _____? *(1=decreased; 2=remained constant; 3=slightly increased 4=moderately increased; 5=significantly increased)*	68%	3.9 (0.91)	3.8 (0.66)	3.8 (1.0)	5.0 (0.00)		3
I would recommend "Unlearning Racism" to a colleague *(1=no, definitely not to 4=yes, definitely)*	92%	3.4 (0.75)	3.8 (0.43)	3.2 (0.86)	4.0 (0.00)		1
Overall session effectiveness							
Day 1 results	85%					4.5 (0.93)	1
Day 2 results	54%					3.9 (1.20)	
(1=not effective to 5=exceptionally effective)							

[a] Kirkpatrick Level: 1=reaction, 2=learning, 3=behavior

ronment for patients and learners, please share your top ideas of how we continue to grow towards this goal," 56% (14/25) of respondents provided at least 1 idea and 40% (10/25) provided additional ideas. Almost all respondents focused on the need to offer continuing learning opportunities on racism. Offerings could be in multiple formats (workshops, facilitated discussions, scripting sessions for common situations) and be inclusive and accessible to all roles (students, residents, clinic staff) and identities (eg, race/ethnicity; lesbian, gay, bisexual, transgender, and queer or questioning [LGBTQ], gender). Sessions should be led by individuals with expertise (eg, content, facilitation). The second major theme was self-awareness. Respondents emphasized the need for continuous learning, including recognizing personal biases and confronting white privilege with reflection on personal actions including language use. "Don't be afraid to talk about race" and "get more comfortable with conflict" reflect expressed awareness and actions regarding racism. Additional ideas included making personal connections, setting up a patient advisory board, and assuring that the environment structure created space for continued learning.

The final survey item asked for general comments and thoughts. The responses indicated the virtual format was challenging for these potentially high-risk discussions. There were mixed reactions about being inclusive by role (eg, students with faculty) due to role boundaries relative to risk taking. To address these challenges, Table 3 provides a list of recommendations on hosting virtual anti-racism education derived from participants' comments and the authors' own experiences leading, facilitating, and participating in potentially high-risk virtual learning environments.

DISCUSSION

Our findings indicate that learning to address racism in health care is desired by interprofessional educators and trainees. Between 50% and 75% of those with optional participation prioritized enrolling in an 8-hour YWCA Unlearning Racism training during a pandemic. Whether required or optional, more than 90% of respondents found the training valuable and would recommend it to a colleague and recommend continuing education using multiple modalities. Tools to adapting the face-to-face training on emotionally charged topics (eg, take risks and be vulnerable) to a virtual format were offered by participants and session leaders (Table 3).

The project has several limitations. While it was diverse by roles, all participants were associated with 2 organizations and reflected a mix of required versus optional attendees. Despite the pandemic, the response rate (69%) and results may have been influenced by selection bias and/or framing effects. As responses were anonymous, follow-up to assess change at Kirkpatrick level 3 (behavior) is not feasible and may not be significant, as a single training's effects on these implicit and nuanced behaviors is difficult to quantify;[8,9] thus, we sought self-reported behavior changes. While data from prior in-person student trainings suggest no significant difference between virtual and in-person sessions, evaluation methods differed and were not directly comparable. Nonetheless, this training does provide a common language and understanding from which a group can start to affect the care of patients, as evidenced by 88% of participants indicating that the training would improve their clinical care.

The urgency of addressing racism in health care and society is clear. At a time when the clinical learning environment expe-

rienced unanticipated pandemic-related transformations, working with community partners can advance common education goals and meet accreditation requirements. Like clinical care, anti-racism education can transition effectively to a virtual format with attention to platform selection, facilitator training, and ongoing communication and actions to reinforce the safety of the learning environment. Next steps include continued partnerships with our organization and communities for continuing education[9] (eg, partnerships with academic affairs to create structural fluency milestone evaluations and recurring equity and inclusion conversations in meetings and case conferences), with opportunities to share how prior training informed participants' clinical practice.

Table 3. Barriers and Recommended Strategies for Hosting High-Risk Virtual Learning Sessions

Topic	Barriers/Challenges in Virtual Learning	Recommended Strategies
Who to invite	• Isolated trainings without sustained efforts and action may have limited impact on long-term goal of culture/system change • Diverse groups are powerful and offer breadth of experience and perspective; adds challenge to hear and see all ranks/roles/identities struggle with issue • Hierarchical structures within medical training and health care teams, as well as differences between professions and medical specialties can constrain openness and risk-taking • Mandatory participation can change group dynamics and engagement	• Set realistic session goals (eg, establish shared language) • Seek a commitment that participants can actively attend all sessions • Identify common learning segments that are optimal for inclusive interactions • If needed, cap enrollment by the number of small group skilled facilitators (< 8-10/small group) • Incorporate facilitated breakouts: mix it up with breakouts that are inclusive and others assigned by role or identity to promote deeper dialogue/learning; include report outs to enhance learning • Consider carefully the risks and benefits of optional vs mandated participation, prepare to be patient with degrees of "buy-in"
Select/optimize use of virtual platform features	• "Zoom" fatigue limits learning • Session leaders' competence and confidence with virtual platform can make or break a session • Face-to-face general session structure often can be transferred but must be adapted for virtual delivery	• Select a platform in which all participants video and names are visible (not just their signature image) • Intentionally design session to optimize interactivity including change of pace activities and frequent breaks • Pre-orient leaders to platform features (polls, chat boxes, white boards, breakouts with timers) and practice their use in advance
Continuously set expectations	• Deep learning requires risk taking, welcoming challenges and making mistakes • The limited nuanced non-verbal data in virtual environment can affect feelings of trust and willingness for risk taking	• Regularly reinforce "rules of engagement" and expectations for session (eg, discussions stay within the group, mistakes are expected and create opportunities for learning) • Cameras should remain on • Progressively structure levels of risk taking with flexibility for those at different levels • Leaders' actions must reinforce expectations (eg, *"That is a common misconception and great we can bring that out… let's discuss the evidence."*)

CONCLUSION

In a time of immense disruption to our daily personal and professional lives, health care providers and learners demonstrated a commitment to learn about anti-racism and implicit bias and desired to continue to engage in anti-racism and inclusivity efforts. Shared language, consistent vocabulary, and shared purpose are essential as we move forward toward health equity. Medical educators and trainees are ready to seize this moment.

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