Race Matters: Addressing Racism as a Health Issue

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ABSTRACT

Background: Racial health disparities in Wisconsin are profound. Racism occurring within the health care field contributes to disparities. Anti-racist education was identified as a need at 2 family medicine residency programs in urban Milwaukee, Wisconsin.

Methods: A 3-hour program was developed and implemented 3 times over 3 years, engaging around 100 participants at 2 residency programs.

Results: Thirty-five post-program surveys were completed. Respondents indicated improvement in knowledge, attitude, and awareness of anti-racist health concepts.

Discussion: The program established a baseline from which to develop anti-racist health care providers. Presenters reflect on the importance of addressing racism as a health issue, getting to know the community served, supporting team members of Color to thrive, and for health care institutions to address racism in an intentional manner.

BACKGROUND

A resident physician asks a 9-year-old Black boy whether he is in a gang. "G-A-M-E?", his mother asks. "G-A-N-G", the resident replies. The mother takes her son's hand, stands up, and walks out of the clinic. A White attending physician complains in the resident team room after examining a child readmitted for asthma exacerbation, "These people never pick up their meds." A White attending physician tells residents that when barriers to care emerge, "Don't work harder than your patients." Another White attending physician remarks that he isn't surprised to hear about a local school shooting because "more black kids go there now." A White attending physician describes a resident's pattern of racial insensitivity as "using the wrong word choice." Yet another White attending physician declares repeatedly that discussion of race and racism is an inappropriate political issue. A Black staff member is told that their Black Lives Matter mask is "too political" to wear. A White attending physician stops attending anti-racism meetings after hearing the perspectives her Black colleagues share. A White resident announces "Keisha Fried Chicken and Watermelon Andy are back again" when assigned to see a Black couple worried the woman's water may have broken. A White nurse rolls her eyes when relating a Black laboring mother's complaints that the epidural isn't working.

Racism operates in myriad ways to erode health of patients and communities of color. Structural and institutional racism contribute to health disparities by distributing social resources that contribute to health along racial lines—in Wisconsin this includes the racial wealth gap, vulnerability to law enforcement/criminal justice system mediated violence and harm, and lack of access to healthy food, safe outdoor space, health insurance and health care resources, stable housing, quality education, and living wage employment opportunities. Overt interpersonal racism—interpersonal actions emerging from conscious bias towards a racial group—contributes to racial health disparities in manners both as blatant as disproportionate state-sanctioned violence or as subtle as some of the examples above. Implicit racial bias—unconscious bias towards a racial group—affects quality of health care provided. Suboptimal care may occur when providers associate their patients with characteristics such as being noncompliant, uncaring, stupid, lazy, wasteful, threatening, malingering, demanding, ungrateful, or underserving of their time. The prevalence of implicit racial and ethnic bias amongst health care providers is similar to that of

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Table 1. Resident Post-Session Qualitative Feedback, Grouped by Theme and Subtheme

Learner Education Gains	
Subthemes	**Themes**
• Redlining and its effect on patients and communities • Historical background of segregation and racism in Milwaukee • Institutionalized racism	Historical context
• Limited access to food and quality health care directly impacts health outcomes • Maternal mortality and morbidity statistics • Infant mortality statistics • Racism and chronic stress lead to disease pathology	Awareness of health disparities
• Addressing implicit bias is critical to provide quality care • Understanding the different forms of racism is necessary to recognize how implicit bias effects care	Implicit bias
• The depth of systemic racism in our society penetrates the patients that we serve and care for	Racism in our communities

Table 2. Learner-Reported Intention for Personal Change, Grouped by Theme

Learner Intentions for Change	
Comments	**Themes**
• Help improve minority representation in medicine • Provide positive encouragement surrounding educational/careers goals during well child visits	Support diversity and inclusion
• Get to know my patients on a cultural level • Make a connection with my patient despite our differences • Ask patients about their experiences in the world	Provide effective cross-cultural care
• Address social determinants of health • Assess barriers to treatment • Ask about stress in all patients • Focus on serving my patients	Intensify patient-centered approach to care
• Speak up when witnessing racism, explicit bias, or implicit bias • Recognize my unconscious or conscious bias	Increase anti-racist interpersonal behavior
• Get involved in the community where I practice • Become more aware of what happens outside of my world • Work on opportunities to become community engaged	Be a more community-engaged provider

the general population,[1] correlates with lower quality of care provided,[1] and undermines patient-provider interactions, treatment decisions, treatment adherence, and patient outcomes.[2] Implicit bias may also sap and disrupt efforts to make structural or systems-based progress towards health equity—or squash efforts before they begin.

These components of racism lead directly to Wisconsin's extreme racial health disparities—including the highest excess death rates in the nation for Black and Native American people at every stage in the life course and the highest Black infant mortality rates in the nation. The Wisconsin Public Health Association declared racism a public health crisis in 2018.[3]

We created a health care provider-focused anti-racism educational program with objectives to increase understanding of the impact of racism on health, to increase awareness of learner-implicit bias and demonstrate how this may influence patient care, and to stimulate longitudinal discussion and development towards addressing racism as a health issue. We share below the process undertaken to develop and hold this program, program outcomes, and reflections.

METHODS

Recognizing an unmet need, team members from 2 family residency programs in urban Milwaukee, Wisconsin began initiating dialogue around the effect of racism on health within their family medicine residency programs. These discussions revealed varied responses and wide ranges of awareness of the issues or readiness to participate in discussion and action. It was felt that providing foundational educational enrichment would help to establish a base from which to pursue these discussions and, ultimately, impact patient care.

A 3-hour Racism Theme Day was established, including a 2-hour interactive workshop and a 1-hour community panel discussion. Themes and activities included viewing Dr. Camara Jones' "Allegories of Racism" video,[4] facilitators sharing personal experiences regarding race and racism, interactive identity exploration activities, and description of historical factors leading to modern-day segregation. This was followed by discussion of how these historical and current factors result in health disparities. Participants' knowledge of the extent of health disparities was explored, and facilitators welcomed discussion about how to become informed. The workshop portion concluded with evidence-based descriptions of how racism results in health disparities, a personal story of implicit bias and an interactive implicit bias activity, and calls to action for participants and residency programs to commit to anti-racism. A forum for community leaders from various sectors—including health care, education, and business—completed the session by sharing perspectives on the impact of racism in their respective areas. An anonymous, voluntary postsession evaluation was developed in similar format and manner to evaluations conducted for other components of the residency didactic curricula.

RESULTS

The workshop was presented 3 times to family medicine residents from 2018 to 2020, with 30 to 40 participants per session—approximately 100 total. Session evaluation was circulated at the conclusion of each workshop. A total of 35 participants completed the survey from 2018 to 2020, a response rate similar to other didactic evaluations at our programs. The survey included quantitative and qualitative prompts around meeting learning objectives, education gains, and effect on self and future practice. The Medical College of Wisconsin Institutional Review Board approved and oversaw this study. Results were compiled, analyzed by themes, and are displayed in Tables 1 and 2 and the Figure.

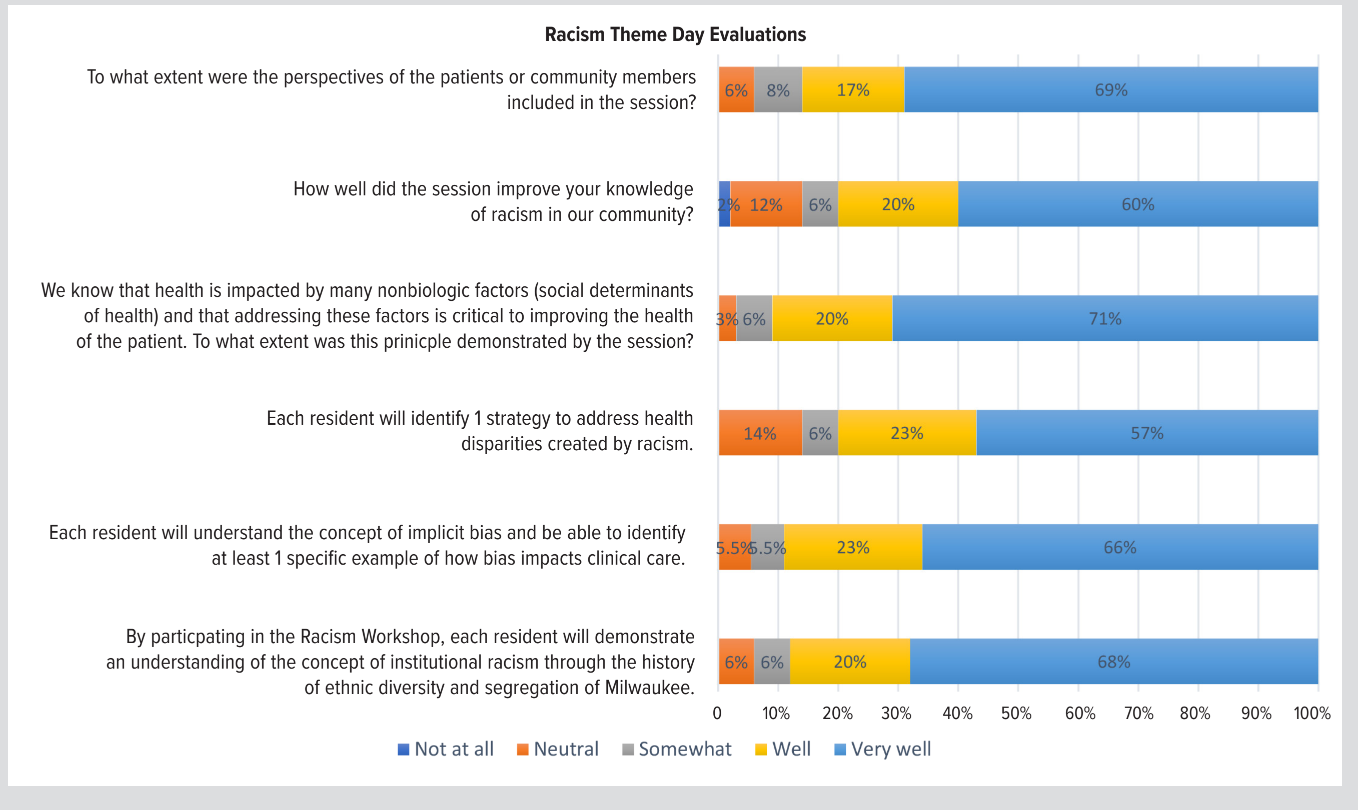

Figure. Resident Post-Session Quantitative Survey Responses

DISCUSSION

In our experience, developing providers capable of effective anti-racist care involves ingraining learners with a teachable set of knowledge, experience, and skills over the course of their training. This workshop helped established a foundation for this development to occur. The generally positive feedback displayed indicates that learners are eager for this sort of engagement and find it both an acceptable and effective use of time. Learner-expressed intention for behavior and attitude change also were encouraging. Although behavior change and patient impact were outside the scope of the study, instructors have noted an increased frequency of clinical and didactic attention to the impact of racism on patient and community health within both residency programs. From these sessions and other experience engaging in anti-racist initiatives, the authors offer the following reflections.

We must commit to addressing racism in health care—as teaching programs, learners, individual providers, and health care systems. Critical to this effort is building awareness and commitment towards anti-racist interventions to better serve our patients and communities. Although isolated implicit bias training programs lack evidence of long-term impact, we believe that introducing learners to the concept of implicit bias—in the context of other clinical and structural components of racism—is important in priming learners along their development into anti-racist providers, as well as creating an anti-racist program culture.[5]

We must get to know the community we serve. Our patients are not just individuals occupying our office, they are part of a vibrant life in the community. Learning of and visiting community institutions and events, engaging with community leaders, patronizing community businesses, and developing community partnerships will provide more context and opportunity for connection.

We must support residents, faculty, and staff of color to thrive. Although increasing diversity amongst providers serving communities of color is associated with better patient outcomes[6] and satisfaction,[7] and supporting efforts to produce a more diverse health care workforce is critical to anti-racist efforts, we must remember that diversity is not simply a number or a recruiting priority. Diversity is also creating a system in which people of color feel understood and supported, have their voices heard, advance, and lead. We recognize the importance and critical value of voices of those presenting as Black, Indigenous, and People of Color (BIPOC) and others passionate about social justice and have created spaces to elevate, learn from, and follow those voices to improve our systems and care provided. We have found this process sometimes involves operating in a less hierarchical way than other aspects of medical education, as in this case our leaders also have much to learn.

We must keep in mind that what comes from the heart reaches the heart. These are sensitive topics of discussion where it can feel

much is at stake. In our experience, discussing racism with patients, learners, and colleagues is not only acceptable, it is a welcome relief. When racism is acknowledged, humanity is affirmed, and we move forward with confidence that a mutual reality is shared. Mistakes will be made. But when approaching these discussions with positive intentions, others recognize this and respond positively, helping one to grow and find a voice in this area.

We have undertaken this work at family medicine residency programs in Milwaukee—where the need is particularly urgent—but we call on our colleagues to commit to such efforts in clinical settings of all kinds. Racism causes systematic denial of duration and quality of life to people of color in this society. This is not an issue we can afford to sit on the sidelines for. Our patients' lives depend on it.

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