

Addressing racial bias in wards

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Abstract: Health disparities fall along racial lines, in part, due to structural inequalities limiting health care access. The concept of race is often taught in health professions education with a clear biologic underpinning despite the significant debate in the literature as to whether race is a social or biologic construct. The teaching of race as a biologic construct, however, allows for the simplification of race as a risk factor for disease. As health care providers, it is part of our professional responsibility and duty to patients to think and talk about race in a way that is cognizant of broader historical, political, and cultural literature and context. Openly discussing the topic of race in medicine is not only uncomfortable but also difficult given its controversies and complicated context. In response, we provide several evidence-based steps to guide discussions around race in clinical settings, while also hopefully limiting the use of bias and racism in the practice of medicine.

Keywords: racism, racial bias, inequality, health justice

Introduction

Concerns over racial inequity have struck a chord for many across the country ranging from police violence¹ to suboptimal care² to the education of future health care providers.³ Community members of medical institutions have gathered to share their thoughts, fears, and responses, including the ways in which racism can be combated within our hospital systems and training programs.⁴ The well-being of our patients requires that we take a stronger stance against legal and social discrimination.⁵ Though many professionals in and outside of health care may opine that politicization of the clinic may complicate delivery of health care, we believe and seek to demonstrate that our hospitals are already politicized by nature of historical influences on institutional practices and processes. To help the medical community become advocates against all forms of discrimination in our medical schools, hospitals, and clinics, in this paper, we propose a conceptual framework. This framework is based on a careful review and synthesis of the available literature, using a modified Delphi method in its construction. This framework represents what the authors believe is an evidence-based approach to address racial bias in clinical settings.

Reinforce that race has limited genetic explanation while engaging learners and health professionals in addressing patient barriers to health

Health disparities fall along racial lines due to structural inequalities. These foundational inequities inform persistent biases and racist ideas that in turn influence

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systems and policies, limit health care access, and permeate the delivery of medical care.⁶ Despite the importance race plays in the health of patients, learners historically receive minimal training on how to understand and discuss race within the context of medical practice.⁷ In this paper, we refer to non-white, racial and ethnic groups as people (or communities) of color, and use “black” to denote individuals with black skin phenotype. The need for these definitions reflects the fluidity of these terms internationally. This further illustrates the need for researchers to be clear and explicit in their understanding and use of race, which is often lacking in biomedical research.⁸

While the American Anthropological Association has recognized race as a dynamic, evolving construct influenced by sociocultural, political, and historical context for decades, biomedical research continues to use race as a static biologic variable.^{9,10} One recent study showed that a significant percentage of medical students still believe in biologic differences between races, such as that black skin is thicker and has fewer nerve endings leading to increased pain tolerance.¹¹ In addition, race corrections, such as those utilized in spirometry, are routinely performed without question, despite evidence that these practices perpetuate and are rooted in belief of essential differences between races born during eras of plantation slavery.¹² Such use of “race” rhetorically neglects the structural inequities underlying the racial and ethnic disparities apparent in nearly every aspect of health care, from prevention and prevalence to mortality.¹³

To illustrate this point, the demonstrated higher asthma prevalence among non-Hispanic blacks¹⁴ should not lead health care providers to assume black patients are innately more likely to have asthma than white patients in neighboring examination rooms. Conceptualizing race as a biologic and “inherent risk factor” for clinical diseases pathologizes race and implies that racial health disparities are due to biologic difference and/or inborn predisposition to disease. This perspective fails to consider the vast socio-structural powers that intersect to marginalize populations of color, increase adjacency toward risk and disease, and produce health inequity.¹⁵ Thus, evidence of asthma disparities might urge consideration that ongoing residential segregation leads to differential exposure to environmental pollutants, community stress, and reduced resources which disadvantage neighborhoods of color and lead to heightened disease burden.¹³ Discussion of race in the context of racial health disparities should include engagement with inequality, rather than reducing it to an aspect of internal constitution.

It is important for physicians and educators to familiarize themselves with the controversies around employing race as a genetic factor and embed lectures, discussions, and the use of race-based medicine and guidelines within historical context. For example, Bidil became the first US FDA-approved race-based pharmaceutical in 2005, though evidence that supported its use failed to compare its efficacy between racial populations and did not fully correct for social determinants of health.¹⁶ Acquainting faculty and students to the limitations of race-based medicine can be introduced using case studies discussing the history of race corrections in lung and renal function, and the use of race in the atherosclerotic cardiovascular disease risk calculator¹⁷ and Joint National Committee (JNC) 8 treatment guidelines¹⁸ for hypertension. Broadening our comprehension of “race” within the complexities of citizenship, social inequality, and law helps us develop critical perspectives in interpreting medical studies who employ labels such as “white”, or “black” which are ill-defined, region- and generation-specific, and thereby variable, despite their mobilization as scientifically technical terms. In this way, clinicians can become better equipped to evaluate the implications of race-based research in clinical decision-making.

Engage colleagues in conversations about bias

Most physicians would not willingly endorse racist practices and do not believe they provide unequal care. However, several studies illustrate that physicians, like most Americans, harbor implicit biases, defined as “attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner”, that lead to disparities in communication, counseling, and interventions.^{19,20} Simulations studies have shown that providers are less likely to offer aggressive interventions, such as cardiac catheterization or systemic thrombolysis, to patients of color, when all other clinical circumstances are identical.²¹ These biases have impact at a national level. A nationwide study from 2014 found that within the same hospitals, patients of different race received different treatments for myocardial infarction, congestive heart failure, and pneumonia.²²

Evidence of implicit bias (and its negative impact on quality of care) among health care professionals has been widely documented in literature in the USA,^{23,24} thus, addressing bias should be actively pursued to improve the quality of medical delivery systems. As with any behavior change, individuals need to become aware of their undesirable behaviors in order to address them. van Ryn et al found that having completed

the Black-White Implicit Association Test was associated with decreased levels of implicit bias in medical students over time.²⁵ Clinical departments should encourage dialogue surrounding racism, bias, and stereotyping among trainers and trainees. There are many resources that document histories of medical racism that could be referenced or read in order for trainees to gain understanding and empathy for the legacies of medical abuse.^{26–28} Forums such as Grand Rounds provide opportunity to invite experts to help lead discussions that elucidate physician roles in disparities. Department-wide mortality and morbidity conferences can challenge how bias negatively impacts patient care. In addition, hospitals could institute Implicit Bias Rounds or Ethics Rounds for providers to focus on cases in which bias may have affected the care of a patient. Beyond isolated special sessions, however, sustainable improvement requires longitudinal discussions on racial health disparities to be embedded across broad arenas of institutional practice and culture.

Evidence demonstrates that system-wide interventions that increase literacy and engagement on bias can effectively change behaviors, culture, and commitment toward equity in academic institutions.²⁹ In addition to formal modules and workshops, exploring and addressing bias must also occur in the wards. There is evidence that two provider actions – individuating (conscious removal of data points not relevant to patient care, such as race, when determining a diagnosis and treatment) and perspective taking (putting yourself in your patient’s shoes) – can diminish racial disparity in patient care.²³ Physicians should openly discuss with their team how racial identifiers can lead to hasty generalizations and negatively influence the clinical encounter. This allows for integrated learning that can teach providers to become more thoughtful and intentional in how they perceive – and ultimately care for – their patients. These actions represent tangible change and build the foundation for broader institutional advancement toward equity.²⁹

Address your language (and the language of others)

Negative patient talk is often pervasive among physicians and reinforces what is known as the hidden curriculum – a learning environment in which derogatory language is normalized and stereotypes are reinforced for trainees.³⁰ For example, patients of color are often more likely to be discussed in diminutive, objectifying, or presumptive terms.^{30–33} In addition, physicians often perceive black patients as at increased risk for nonadherence, substance abuse, and inadequate social support, as well as possessing lower intelligence.⁶

These preconceptions can shape physician communication and treatment decisions. For example, persons considered noncompliant receive less follow-up care.³³

One way to address these harmful preconceptions and barriers to effective patient communication is to consider language choices. Providers should refrain from attributing disparities to the individual behaviors or attributes of patients who belong to racial or ethnic minority groups. Conversations about health disparities should be contextualized within larger structural inequalities of our health care system, with recognition that many of these stereotypes were born out of historically discriminatory policies that concentrated poverty among marginalized populations.³⁴ Taking this a step further, a concrete step practitioner can take (and teach learners) is to strike “noncompliance” from their medical terminology. Ultimately, this encourages more contextualized and precise history-taking and documentation. The recognition that unequal systems create realities that impact a patient’s ability to be adherent or non-adherent with their medical plan in turn can reduce the negative effects of racism or bias.

Develop teaching service policies around informed consent and pain management

The informed consent process is a fundamental part of medical care that positions patients to participate actively in their medical treatment plan, promoting stronger doctor–patient relationships. The USA has a history of conducting research and performing procedures on communities of color without written or verbal consent.^{35,36} Furthermore, studies demonstrate that patients with limited English proficiency are less likely to have documentation of informed consent.³⁷ In teaching hospitals, students and residents may be more likely to practice unfamiliar procedures on disadvantaged groups who do not understand medical training structures, face language barriers, and/or have a reduced ability to self-advocate for their wishes and needs.

To prevent a patient’s education, race, or economic background from influencing the decision to allow a trainee to practice a procedure, health care providers should pre-determine which procedures are appropriate for medical student- and resident-level participation, and ensure that when a learner partakes, this information is included in the informed consent discussion. Providers can also ensure that in all non-emergent situations, professional interpretation is used for any patient with limited English proficiency regardless of whether a patient defers the service, recognizing that embarrassment, shame, or desire not to inconvenience may impact a patient’s willingness to request an interpreter.

In addition to informed consent, teaching service policies around pain management should be amplified, given that it is an area associated with significant disparities. For example, when compared to white Americans, people of color are significantly more likely to receive inadequate or ineffective pain management.^{38–42} A recent study found that medical students with higher implicit bias scores felt more unease in treating a Hispanic patient's pain complaints and were more likely to refuse to prescribe an opioid analgesic to a Hispanic patient.⁴³

Pain management is an integral part of all medical specialties and provides a concrete access point to initiate discussions on racial biases that can be applied to other clinical situations. Educators can introduce curricula that require learners to confront their biases and consider how these perceptions are influenced by both media and historical representations of minorities and pain. Such curricula should include common clinical stereotypes of minority groups (i.e., the perception that black people feel less pain, exaggerate pain, or are more likely to abuse drugs) as well as the negative consequences of provider bias on pain management. Furthermore, efforts should be made by educators to model physician–patient interactions that emphasize collaborative, rather than paternalistic, approaches to pain.

Strive for cultural humility, not competence

Culture is ever-changing and can be understood as learned belief structures shared among groups of people.⁴⁴ Individuals are fluent only in their own cultures, and for that reason, physicians may explain away gaps in knowledge or miscommunication by citing cultural differences that are deemed “abnormal” or “incompatible” with routinized practice. This conceptualization pathologizes culture and renders it a barrier to care.^{45,46} Cultural competency curricula often assume that providers may learn patients' cultures the same way they amass medical knowledge, assuming that culture can be deconstructed to “dos and dont's”.⁴⁶ This is reductive, given the nature of culture as a dynamic and deeply individual process. It is crucial to shift goals away from cultural competence, toward cultural humility – a framework that relies on self-critique and recognition of power dynamics – in order to recognize the limits our own experiential backgrounds have on our understanding of our patients'.⁴⁷

Patients traverse and enter our places of work in moments of great pain and grief, and as such, hospitals must exemplify not only a professional commitment toward safety and well-being but also a visible and physical one. Verbal confirmation

and physical signage that indicate explicit support of marginalized identities and communities are important. These may include having printed information in languages reflective of the surrounding community, and/or explicit confirmation that medical care does not involve law enforcement or immigration affairs. It is crucial that we uplift and support community activists and public health workers, as embodying respect toward a diversity of professions, disciplines, and their respective expertise ensures a practical application of continued cultural humility. Lastly, improving racial diversity of medical professionals will be essential to reducing the cultural barriers between patients and their doctors, reducing bias, and in changing the perception of “whiteness” as the dominant culture of medicine.

Conclusion

Openly discussing the topic of race in medicine is difficult and uncomfortable given its controversies and complicated context. We believe, however, that navigating these conversations can be eased through the continued practice of critical dialogue, normalizing the process of accepting responsibility and learning how to rectify errors that may occur. As health care providers, it is part of our professional duty to patients to talk about race and inequality in a way that is cognizant of the broader historical, political, and cultural context. We must use our power to advocate against inequity and for safety and well-being in and out of the hospital, and in doing so, practice due diligence in elevating and listening to the complicated narratives that constitute our patients' lives. It is our hope that these steps will aid in opening the door to such discussion as we believe thoughtful dialogue represents the first step toward improving racial bias in clinical settings.

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