Race, Racism and Whiteness Training to Improve Health Equity

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INTRODUCTION

Disparities that impact communities of color are reported in the management of many diseases. Blacks receive a lower standard of care than whites when being treated for breast cancer, orthopedic problems, cardiovascular disease, pain, and end of life care among others. In 2002, the Institute of Medicine (IOM) released their report Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care, showing that racial disparities exist in health care and that provider bias, stereotyping, and prejudice are contributing factors. Little progress has been made in decreasing racial health inequity over the past thirteen years. A Medline search of "healthcare disparities and race" yields over 5200 articles since 2003. In many reports, discrepancies held when correcting for insurance and socioeconomic status. The 2013 National Health Healthcare Disparities Report (NHDR) shows that disparities for Americans are not improving and some are becoming worse. For example, blacks and Hispanics received worse care than whites for 40% of the quality measures used in the NHDR. Blacks had worse access to care than whites for 32% of access measure, while Native Americans and Hispanics had worse access to care than whites for 40 % and 60% of measures, respectively.

Providers may attempt to reconcile these disparities by citing differences in genetics and socioeconomic status. The sequencing of the human genome, completed in 2003, has proven that there is no scientific basis for race. However, lower socioeconomic status does affect access to care, as being uninsured was the strongest predictor of quality of care in the NHDR. But, when correcting for uninsurance and socio-economic status, blacks still receive worse care than whites. A 2010 study in our community reported similar results. Blacks and Native Americans in Minneapolis and St. Paul have a significantly shorter life expectancy than whites, even after correcting for socio-economic status.

Racial health care inequity is most certainly a multifactorial problem. Barriers to health care equity include the health care system (insurance, funding, white-majority providers), the patient (poor health literacy, fear, mistrust), the community (awareness, advocacy), and health care providers (unconscious bias/stereotyping, lack of awareness of racism and lack of education around issues of race, racism, and whiteness). For example, at my institution the perception of race and racism affecting care was significant. This was seen not only in our sickle cell patients and families of color, but also in our white staff members.

Unconscious biases are common. They are rooted in stereotyping, a cognitive process where we use social categories to acquire, process, and recall information about people. This process helps us organize complex information. Humans tend to rely on stereotyping when we are busy and under heavy cognitive load. Health care providers often work under conditions that are ripe for stereotyping. Consciously reducing this can be difficult. The IOM made a series of recommendations for eliminating racial/ethnic health care disparities. These include increasing awareness of racial disparities among providers, implementing cross-cultural education for professionals to include avoiding stereotyping, and pursuing research to identify sources of racial disparities and assess promising intervention strategies. Although diversity and cultural competency curricula are part of most training programs, education specific to the effects of race and racism on health care is lacking. Physicians receive little to no training on the topic of race and racism. At our institution, physicians received an average of 52 minutes of racism training. Training on issues of race and racism is not consistently occurring at any level of physician training (or any health care provider for that matter) including continuing medical education. As a result, awareness of racism and its impact on healthcare delivery remains low. A national survey found that 29% of physicians (and only 4% of white physicians) felt that patients are treated unfairly based on race, while 47% of the public felt this way. This lack of awareness and education also holds true in other areas of health care such as nursing and public health, for example.

METHODS

To help address this issue Dr. Heather Hackman and I developed a training module for health care providers to address issues of race, racism, and whiteness (the overwhelming presence of white centrality and normativity in our society). We incorporate issues germane to health care into previously reported foundational approaches to addressing these issues in training and educational settings.

The training consisted of three 3-hour sessions over a 3-month period. The first addressed race, the second addressed racism, and the third addressed whiteness. Participants completed a 5-point Likert scale survey before and after the training. Results were compared using a two-sample correlated Student's t-test. This study was granted exemption from formal review by the Institutional Review Board and was funded by the Internal Research Grant Program of Children's Hospitals and Clinics of Minnesota.

We compare the results of this study to those we have recently published.

RESULTS

Thirty staff from Children's Hospitals and Clinics of Minnesota participated in the training. Of these, eighteen completed the course with pre- and post surveys. We received demographic data on seventeen, and we report the results for these participants. Of the seventeen, there were two males (both white) and fifteen females (fourteen white and one Asian). The mean age of the cohort was 45.1 years (range 25-63). There were five physicians in the group. Others included nurses, social workers, interpreters, and child life specialists.

Following our training, awareness of racism increased significantly in all participants. **Table 1 and Figure 1.** In fact, the change was even more striking than that found in our initial cohort of much younger (mean age 31.9 yrs) physicians-in-training. **Table 2.** However, we found no change in feelings of self-efficacy in caring for patients as we saw in our first study.

The pre- and post survey asked four primary open ended questions: 1) Define race, 2) Define racism and give examples of racism and healthcare delivery, 3) Define white privilege and give examples of white privilege in healthcare delivery, and 4) Give examples of the impact of racism on your ability to deliver quality healthcare. For participants who completed both pre- and post surveys (n=18), we looked for common themes as well as changes in answers after the course.

The biggest theme that arose when looking at changes in answers after the course was that some participants moved to a more systematic understanding about the nature of racism and white privilege. The pre-survey showed that while most participants had some level of understanding about race, racism, and white privilege, many individuals did not demonstrate understanding/awareness about the differences between race and ethnicity, the social construction of race, or the systematic nature of racism and white privilege. After the course, participants were better able to articulate the deeper, systemic nature of white privilege and give examples of how this affects healthcare delivery. **Figure 2.**

Table 1. Survey results

Statement	Pre (95% CI)	Post (95% CI)	P-value
I am aware of the ways racism operates in the US.	3.88 (3.57-4.19)	4.53 (4.26-4.79)	0.001
I am aware of the ways racism operates in health care specifically.	3.59 (3.22-3.95)	4.59 (4.33-4.85)	0.0002
I am as effective at caring for white patients as I am at caring for patients of color.	3.24 (2.81-3.66)	3.00 (2.55-3.44)	0.4
I feel well equipped to care for patients of color.	3.24 (2.81-3.66)	3.41 (3.04-3.78)	0.4
The impact of racism on my ability to deliver quality care is:	3.06 (2.56-3.56)	3.29 (2.86-3.73)	0.3
I am aware of the ways White Privilege operates in the US.	3.82 (3.50-4.15)	4.53 (4.26-4.79)	0.001
I am aware of the ways White Privilege operates in health care.	3.65 (3.24-4.05)	4.41 (4.15-4.67)	0.003
Racism is a problem at Children's.	3.94 (3.56-4.33)	4.53 (4.26-4.79)	0.003

Responses were scored as very low to very high (1-5), or strongly disagree to strongly agree (1-5). POC= people of color, CI= Confidence Interval.

Figure 1. After the training the amount of change reported was...

Questions measuring self-awareness, understanding and opinions about race, racism and white privilege

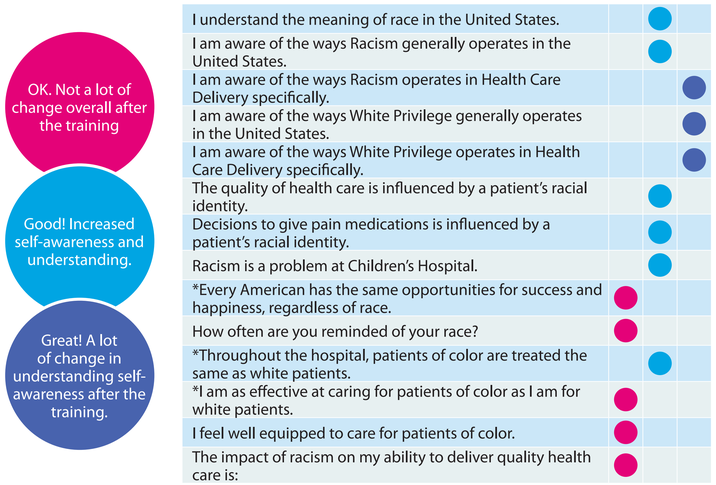

Table 2. Survey results of previously published younger cohort

Statement		Pre (95% CI)	Post (95% CI)	P-value
My awareness level of issues of racism in the U.S. is:	ALL	3.42 (3.05-3.79)	3.89 (3.51-4.28)	0.018
	WHITE	3.40 (3.04-3.76)	3.40 (2.91-3.89)	0.5
	POC	3.44 (2.66-4.22)	4.44 (4.04-4.84)	0.033
The impact of racism on health care delivery is:	ALL	3.89 (3.62-4.16)	4.52 (4.28-4.76)	0.001
	WHITE	4.00 (3.67-4.33)	4.50 (4.13-4.87)	0.018
	POC	3.78 (3.21-4.29)	4.55 (4.15-4.95)	0.011
I am as effective at caring for white patients as I am at caring for patients of color.	ALL	4.10 (3.71-4.48)	3.10 (2.54-3.65)	0.001
	WHITE	4.00 (3.41-4.58)	2.50 (1.66-3.34)	0.004
	POC	4.22 (3.58-4.86)	3.78 (3.27-4.29)	0.084
I feel well equipped to care for patients of color.	ALL	3.84 (3.43-4.24)	3.36 (2.99-3.72)	0.012
	WHITE	3.70 (3.02-4.38)	3.00 (2.41-3.58)	0.012
	POC	4.00 (3.45-4.54)	3.78 (3.44-4.12)	0.223
The impact of racism on my ability to deliver quality care is:	ALL	2.58 (2.04-3.12)	3.58 (3.03-4.12)	0.005
	WHITE	2.70 (1.94-3.45)	3.90 (3.37-4.43)	0.006
	POC	2.44 (1.49-3.39)	3.22 (2.14-4.29)	0.121

Responses were scored as very low to very high (1-5), or strongly disagree to strongly agree (1-5). POC= people of color, CI= Confidence Interval.

Figure 2.

"Subtle issues…this is where I feel the pressure of what institutional racism does, as I participate in these racial behaviors and am not even aware of it."

– a participant discussing racism

"There are many, many systemic policies and procedures in place within healthcare that negatively impact our ability to provide adequate care to people of all races. Until we eliminate systemic racism, none of us can be as effective at caring for patients of color."

– a participant discussing how racism impacts their ability to deliver quality health care

"I work hard to be aware of the old racial narratives as they whisper in my head and to put them aside in my interactions with people of color."

– a participant discussing how racism impacts their ability to deliver quality health care

DISCUSSION

Race affects health care delivery and is an independent factor in health care disparities. However, physicians often fail to see this. Health care providers receive little training around issues of race and racism. A recent study at our institution found that physicians had received an average of 52 minutes of racism training per person or 1.4 minutes/person-year. As a result, awareness of racism and its impact on healthcare delivery is low. Surveys by the Kaiser Family Foundation showed that only 29% of physicians felt that our health care system treats people unfairly based on race, while 47% of the public felt this way. This is especially true among white physicians. Only 4% of white physicians felt that our health care system frequently treats people unfairly based on race, while 41% of black physicians felt this way. A recent study from our institution found similar results. Half of patients/families saw race as affecting health care, but less than one-third of staff perceived this.

Following our training, awareness of racism increased significantly in all participants. This was even more striking than that seen in our much younger initial cohort. This is reassuring that this work may be effective at any time during one's career. However, we did not see the striking results in deconstructing white providers' previously held beliefs about race and racism as we did in our previous cohort. This may be because the majority of the current cohort was non-physicians, and as such they have a different role in care delivery.

Finally, we would like to underscore that while the presence of more significant training for providers regarding racism will help to lessen the racial disparity in health care, the opposite is also true. The absence of substantial training in medical and nursing schools on issues of race and racism will serve to perpetuate and potentially exacerbate racial health care disparities. If providers do not take responsibility for addressing the impact of race and racism in the provision of care, the responsibility for doing so falls on patients of color. This allows the dominant white group to avoid any responsibility and places the perceived source of racial differences squarely on the target population. Until racial issues are honestly addressed by members the health care team, it is unlikely that we will see significant improvements in racial health care disparities for Americans.