

Module 3. Race
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Objectives:

1. Discuss race as a social construct and understand the levels of racism.
2. Increase awareness of how racial bias contributes to health disparities.
3. To become aware of one's inherent biases and how these might impact your own behavior as a provider.

Case:

A 39 year- old English-speaking Black male presents to an inner-city emergency department. He had spent the day moving into a new apartment. This evening as he unpacked his boxes, he started to feel some shortness of breath. He had noted earlier that there was a significant amount of construction dust covering the floors of the new apartment and he had been sneezing all day. He had a history of childhood asthma and had memories of many nights in his childhood spent in the emergency department for breathing treatments, but had mostly outgrown the asthma as he became older. Tonight was different as he felt gradually progressive dyspnea - he felt as if the childhood asthma had returned with a vengeance. Patient waited, hoping it would go away. He was hesitant to go to the hospital because he remembered the disparaging looks given to his mother when he presented to the ED as a child. They always seemed to imply that his uncontrolled asthma was her fault. He carried this negative feeling about healthcare into adulthood and tried to avoid medical care unless absolutely necessary. Finally, the patient could barely breathe and started to think he might die, so he went to the nearest ED.

He walked into triage and said that he needed help and couldn't breathe. They told him to sit and wait his turn. He tried to explain repeatedly to the triage nurse that he could not breathe and was finally given a room in the ED. He was placed behind a curtain where he could not see anyone and no one came to evaluate him. He walked out of the curtain area to the desk and again said, "I can't breathe, can you help me?" to which the clerk responded, "You're walking so you must be breathing." Finally, a white male physician appeared to evaluate him. He took the patient's history and said, "You are fine; it's a panic attack, I will order some Ativan." without listening to the patient's heart or lungs. The patient replied that he did not feel anxious. The patient thought about the traumatic experiences he had in the past - surviving 9/11, two motorcycle accidents - and never had a panic attack. Could he be having one now? And wouldn't it be a coincidence that it felt just like his asthma and occurred just after an environmental trigger? As the physician left the curtain area, he said to the nurse- "That guy looks fine, discharge him after the Ativan." The patient decided to leave the ED and took an Uber to a nearby university hospital emergency department where he was evaluated and treated immediately with nebulizers for an asthma exacerbation. The patient, being highly educated with two Ivy League degrees, filed a formal complaint to the CMO of the initial hospital for poor quality care and disputed his bill. The CMO is puzzled as this provider usually has excellent Press Ganey scores and is known to be a competent clinician. This patient, however, denies ever being given a Press Ganey evaluation to fill out. On further investigation, the CMO learns that the clerks choose which patients receive the Press Ganey cards and generally choose based on "who looks educated enough to follow the instructions."

Discussion Questions:

1. Was the care provided at the first hospital appropriate?
2. How did race impact care? Did it lead to different care? How did age play into the care?
3. How might this experience impact the patient's interactions with healthcare professionals in the future?

Teaching Points

1. Racism is not necessarily overt. Implicit bias describes the phenomenon of having a preference for or an aversion to a group of people without conscious awareness that the preference exists.
2. Health care professionals (just as all other individuals) are often unaware of their own implicit biases. In healthcare there is risk to the patient when a provider, unaware of his/her bias delivers a different type of care to a certain group based on his/her implicit bias. Often the discussion of implicit bias in the United States focuses on the negative implicit bias against Blacks harbored by other racial groups based on the years of racism that was normalized in our culture. This is an important example that is pervasive and has many societal and health repercussions. Implicit bias by definition, however, can be based on other group characteristics, not only skin color.
3. On the population level, the medical encounter is often cited as a potential source for persistent health disparities in the United States. Actions fueled by implicit bias on the part of the provider may be perceived as blatant racism by the patient. On the patient level, interactions like these contribute to continued mistrust of the healthcare system and worse patient outcomes for minority groups on the population level.

Practical Questions

1. Have you considered what your own implicit biases may be?
2. How can we become more cognizant of our own biases so that they do not influence medical decision making?

Consider recommending the Harvard Implicit Bias test that can be taken on-line free of charge:

<https://implicit.harvard.edu/implicit/takeatest.html>

Recommended Screening Question(s):

The LA County Health Agency SBDOH workgroup has not developed any recommended screening questions for implicit bias. To screen for patient's race and ethnicity, it recommends:

1. What is your racial and ethnic background?
 - American Indian or Alaska Native
 - Asian
 - Black or African American
 - Native Hawaiian or Other Pacific Islander
 - White
 - Hispanic, Latino, or Spanish Origin
 - Mexican, Mexican American, Chicano
 - Puerto Rican, Puerto Rican American, or of Puerto Rican descent

- Cuban, Cuban American, or of Cuban descent
- Another Hispanic, Latino, or Spanish origin
- Multiple Race, including Mestizo
- Other

Paired Reading

Jones CP. Levels of Racism: A Theoretical Framework and a Gardener’s Tale. Am J Public Health 2000; 90:1212-1215.

Discussion Points from the Reading:

1. The three levels of racism discussed in this article include: internalized, personally mediated and institutionalized.

Level of Racism	Definition
Institutionalized	Differential Access to the goods, services and opportunities of society by race.
Personally Mediated	Prejudice and Discrimination where prejudice means differential assumptions about the abilities, motive and intentions of others according to their race.
Internalized	Acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth.

2. How do the three levels of racism described in the paper relate to the case above?
 Personally-mediated racism predominates in the interaction between the patient and provider. The provider provides substandard care, likely on the basis of his unconscious bias. Institutionalized racism exists in that the system of evaluating provider performance is limited to those who look "educated" according to the ward clerk, which very likely has a racial skew. This is an example of how an individual's (ward clerk's) implicit bias becomes institutionalized racism.
3. Can you think of examples of each from your own experience of the three levels of racism? How might they impact health outcomes?

Additional Readings

1. Hagiwara N, Slatcher RB, Eggly S, Penner LA. Physician Racial Bias and Word Use during Racially Discordant Medical Interactions. Health Commun 2017;32:401-8.
2. Black Man in a White Coat by Damon Tweedy, MD
3. Seeing Patients: Unconscious Bias in Health Care by Augustus A. White III, M.D.
4. The documentary 13th by Ava DuVernay (<http://www.avaduvernay.com/13th/>)