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A commitment to health equity: Reflections on why; One journey toward how

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Abstract

Many health care practitioners and educators feel stymied as to how to address the pervasive and persistent problem of health care disparities between racial and ethnic groups. The closing plenary for the 37th Forum for Behavioral Science in Family Medicine held in September 2016 reminded participants of the urgent need to attend to health inequities and provided both a theoretical framework as well as some sample resources for where to begin.

Keywords

health equity, racism, social justice

Introduction

In 1966, Martin Luther King, Jr, asserted "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." Yet, 50 years later, profound racial and ethnic inequities continue to run rampant in medicine. Inequities describe disparities that are strongly and systemically associated with certain social group characteristics such as education, wealth, or race.[1] In 2002, the Institute of Medicine report *Unequal Treatment* found that, after reviewing over a hundred studies, racial and ethnic minorities receive lower

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quality health care than nonminorities, even when income, insurance status, and medical conditions are similar.[2] Today, the age-adjusted death rate for blacks in the United States is 20% higher than for whites while the infant mortality rate for blacks is more than double that for whites.[3,4] The moral and economic imperative for intervention is clear, especially considering the rapidly changing demographics of the United States, where public schools have been majority non-white since 2014.[5]

The theoretical lens that shapes my own work as an educator and clinician committed to health equity is based upon concepts of racism. There is a growing body of evidence that racism is a significant social determinant of health.[6] Racism is a uniquely compelling being: difficult to measure, inescapable, both deeply private and brazenly public, and, finally, taboo. Dr Camara Jones, President of the American Public Health Association, describes three types of racism: personally mediated racism (prejudice and discrimination by individuals), institutionalized racism (differential access to services and opportunities by race), and internalized racism (acceptance by members of the stigmatized race of negative messages about their own intrinsic worth).[7]

Personally mediated racism

Personally mediated racism is perhaps what people think of first when racism is mentioned but also the form that many individuals feel most hesitant to openly discuss when challenged with self-examination. This form of racism can be further explored through understanding of two types of bias: explicit and implicit. Explicit bias is defined as a prejudice directly expressed by the perpetrator who is fully conscious of his/her bias; for example, ''I prefer white people to Latinos.'' Implicit bias, on the other hand, manifests as an indirect, unconscious bias and may be subtly expressed; for example, an individual sits further away from a Latino than a white person in a cafeteria. As we are generally unaware of these thoughts and actions, we are often in a poor position to critique our own shortcomings and often feel defensive regarding this discussion. *Unequal Treatment* concluded that, ''although myriad sources contribute to these inequities, some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to the differences in care ... often despite providers' best intentions''.[2] Studies do confirm that most health care providers do have implicit or unconscious biases that generally are more favorable toward white people than people of color and show this does negatively impact patient–clinician interactions and health outcomes.[8]

The Accreditation Council for Graduate Medical Education (ACGME) developed Professional Milestone Category-3, which evaluates whether a family medicine resident ''demonstrates humanism and cultural proficiency.'' But, can we ever be culturally proficient? Studies show that cultural competency is not enough to reduce biased decision-making in medicine.[9] Many would

promote a move toward cultural humility, which is a lifelong process of learning not only about those "other" to us but also about ourselves. Cuban American author Anais Nin insightfully said, "We don't see things as they are, we see things as we are." To fully appreciate personally mediated racism, we should challenge ourselves to consider not merely explicit biases (the most blatant and socially unacceptable form of racism) but also explore our own implicit biases that are pervasive in the cultures and communities in which we live and were raised. An excellent resource to explore our own internal biases is a website developed by Project Implicit, a collaboration between researchers from multiple institutions including University of Washington, University of Virginia, Harvard University, and Yale University (Table 1).[10] This collection of self-directed implicit association tests, takes about 20–40 minutes to complete and provides immediate feedback about the participant's preference for certain social groups in areas such as race, age, gender, and religion. The rationale for the framework developed is provided on the website.

Self-awareness of our biases is a starting point toward changing these biases. This has enormous implications for caring for patients in an increasingly diverse world. Moreover, those who teach underrepresented minority clinical learners may find that their unconscious biases manifest themselves as the "soft bigotry of low expectations," to use a phrase popularized by President George W. Bush. Educators with unexamined implicit biases can unwittingly promote a sense of tokenism where underrepresented minority learners feel they are merely filling a quota and not valued for the many attributes they bring to the table, some of which are and which are not related to their racial identity. This can further propagate internalized racism described below. Until we assertively explore our individual biases we may be doing far more harm than we can begin to imagine.

Table 1. Sample teaching tools for combating racism.

Topic	Articles	Videos
Combating personally mediated racism		
Implicit bias	Penner et al.[11]	Project Implicit[12]
Combating institutionalized racism		
Equity toolkit and roadmap	Multnomah County[13] Chin et al.[14]	Health and Human Services Office of Minority Health[15]
Combating internalized racism		
Race as a social construct	Tsai et al.[16]	Roberts[17]
Life-course effects of the social construct of race	David and Collins[10] Lu and Halfon[18]	California Newsreel[19]

Institutionalized racism

Institutionalized racism is critical to address, particularly for those in leadership positions. This requires assuring a framework of social accountability such that metrics are intentionally reflecting people's desired health outcomes: health inequities between racial and ethnic groups being an excellent example of a social metric that needs to be attended to and eliminated. Positive examples do exist. Back in 1997, studies showed that African Americans were 32% less likely to undergo bypass surgery and 13% less likely to undergo angioplasty than whites for coronary artery disease.[20] Since then, however, there has been a dramatic improvement in door-to-balloon time for angioplasty for white people suffering from heart attacks and for African Americans due, in part, to attention to disparity data and deliberate equitable interventions.[21]

So how can we assure more examples of equitable interventions are developed? Diversification of the people sitting at the table making decisions would be a highly effective strategy but with health professions lagging significantly in their ability to train a more diverse workforce to-date in the United States, I propose that institutions, while working on diversifying the workforce, need to concurrently apply an equity framework in development of quality improvement and/or research endeavors. Such tools provide a structured checklist that considers all components necessary to assure an equitable outcome. One example is the Equity and Empowerment Lens that is being used by the local government of Multnomah County, Oregon (Table 1).[13] This model provides a structured series of questions to assure that proposed interventions are more than well intentioned but are examined critically from an equity stance. For example, it challenges the user(s) of the tool to consider who may be inadvertently negatively impacted by the intervention; what environmental impacts may drive further inequities; what processes and polices may be excluding having the necessary voices present in the intervention's inception and development; etc.

Internalized racism

Finally, let us consider the impact of internalized racism. My goal as a physician and educator is to empower people, as much as help them. Many of the people of color whom I care for and teach already begin with a sense of poor self-worth and confidence. Reflecting upon my own experiences as a first-generation Korean American growing up in Appalachia, I was a victim of explicit as well as implicit racist stereotypes, by my peers and also my teachers. For example, I remember loathing my exceedingly straight black hair that would not conform to the styles of the 1980s. Now living in the midwestern United States, I am frequently teaching to a majority white audience amongst whom I may find a couple of people of color or perhaps one underrepresented minority. If we teach only that certain racial and ethnic groups are perpetually on the wrong end of disparities, we have enormous potential to reinforce internalized racism.

Similarly, our patients may find themselves born into a racially or ethnically segregated and failing community. They may witness innumerable friends and family members confronting multiple complex chronic diseases and early death, which could lead to their own apathy and resignation about their own health outcomes and even a belief that they are biologically different, or even inferior, to their white peers.

Empirical studies of stereotype threat by African American social psychologist Claude Steele and others demonstrate the implications of internalized racism. Stereotype threat is a situation when a person feels at risk of confirming a stereotype about his/her social group. For example, when a group of students were asked to specify their race before the Scholastic Aptitude Test, blacks performed significantly worse than whites compared to when this stereotypically "threatening" condition was absent.[22] In other words, we are all aware of the stereotypes that surround us and these stereotypes have been shown in numerous studies to decrease the performance of members of the stereotyped group. Imagine the threat to underrepresented minority medical students and residents who often see their racial and ethnic groups portrayed negatively. For this reason, I no longer teach about health disparities without an active conversation about race and racism. Further understanding of stereotype threat would be of advantage to all providers.

One of the most egregious teachings in medical schools is implying that race is a biologic construct. Even board questions still assert that African Americans respond better to certain classes of blood pressure medications than others. One needs only to look to President Barack Obama and consider that he is described as African American or black but is genetically biracial. Deconstructing race thus can be both enlightening for many and empowering for some. Table 1 shows sample articles and videos that can be used to stimulate conversation about race as a social construct and about the life-course effects of the social construct of race (i.e., racism).

Conclusion

I have been championing diversity, inclusion, and equity efforts at my institution for three years. Our ongoing work engaging and challenging faculty, clinical learners, and staff across our statewide department are chronicled at https://inside.fammed.wisc.edu/2020-diversity-initiative. At this website, you'll find our Diversity, Equity, and Inclusion Committee's mission and values statements and a vision framed around the acronym TRUST (Tracking, Recruiting, Unlearning/learning, Sustaining/retaining, and Training/transformation) from which our short- and long-term interventions and dashboard are based. Lectures, podcasts, and compelling articles and data used to engage our department may be sampled here. I have learned that intentionality, courage, and sustained effort are critical to inspire and stimulate change and invite you

to join me in an open discussion of race and racism in medicine and a collective commitment to health equity.

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