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LIBERATION IN THE EXAM ROOM: RACIAL JUSTICE AND EQUITY IN HEALTHCARE

As health care providers, we want the best for our patients. This includes equitable treatment and health outcomes. Good intentions are important, but how do we ensure that the impact on the patient matches our good intent? Committing to health equity requires us to deepen our understanding of structural racism in all the spaces we occupy. Knowing that we are a small group of people, we have made a humble attempt to outline key areas where our racial justice practice needs to shift in the health care setting. We share this tool knowing it is a work in progress. We recognize, however, that racial justice work is active, collaborative, and urgent, and we invite all to join the movement.

How to use this tool:

This document, along with the assumption document and glossary (below), is intended to start a robust racial justice and equity process. It is not designed to be used as a standalone document, but as a starting place.

1. Suggestion 1: Bring this document (and the assumption doc and glossary) to your next team meeting. Discuss the team's level of understanding and commitment to the structural analysis provided. Dedicate a portion of the next meetings to learning, discussing, and problem solving.
2. Suggestion 2: Use the resources in this document to design an orientation process for new staff, or to help frame topic areas for staff trainings.

3. Suggestion 3: Use the document to help design organizational compacts, mission statements and community advisory board agreements, so that the core areas are shared publicly and begin to be ingrained in the workplace culture.

1 Know the history of structural racism and White supremacy in medicine and public health.

a. The history of eugenics and social construction of race in medicine

Scientists, physicians, anatomists, etc. have attempted to distinguish differences in the anatomy, biology, and genes among different populations from various regions of the world to identify and justify a supreme White racial group. Though unscientific and untrue, this racial ideology was and continues to be used in various ways to provide and restrict access to resources.

Structural Racism and Health Inequities in the USA: Evidence and Interventions (Bailey et. al., 2017); Race, Medicine, and Health Care in the United States: A Historical Survey (Byrd & Clayton, 2001)

b. Genomics and the difference between racial categories (socially constructed) and migratory patterns of people (genetic links).

It's scientifically proven that there is more genetic variety within racial groups than between them. Scientists suggest studying ancestry instead of race in genomic research would be more beneficial.

Taking Race out of Human Genetics (Yudell et al., 2016); Genes Don't Cause Racial Health Disparities, Society Does (Silverstein, 2015); Invited Commentary: "Race," Racism, and the Practice of Epidemiology (Jones, 2001); Race - The Power of an Illusion (Documentary)

c. The history and current manifestation of racism in research

Historically, health practitioners, researchers, and hospitals have exploited, manipulated, and deceived marginalized communities for data which is not used to benefit the community or shared with the community after the research has concluded.

"Normal exposure" and inoculation syphilis: A PHS "Tuskegee" doctor in Guatemala (Reverby, 2011) Medical Apartheid (Washington, 2006) (book) Racism and Research: The Case of the Tuskegee Syphilis Study (Brandt, 1978)

2 Knowing and Training Yourself

a. Racial Identity Development

Familiarize yourself with racial identity theorists, particularly Dr. Janet E. Helms' People of Color Racial Identity Model and White Identity Racial Identity Model (Helms, 1995; 1990).

b. Key racism and health concepts

Racial discrimination and perceived racial discrimination can have significant health outcomes for people of color even when socioeconomic status & education are adjusted for.

Very Low Birthweight in African American Infants (Collins et. al., 2004);Differing Birth Weight among Infants... (David & Collins, 1997); Racial Differences in Physical and Mental Health...(Williams et. al., 1997); Using "Socially Assigned Race"... (Jones et. al., 2008)

c. Racialization verses self identification

How someone racializes, (external perception, not internal identification), has significant material impact on health. Across almost all health indicators, Black people fair worse than White people, with other POCs falling somewhere in between.

Racism without Racists (Bonila-Silva, 2006)

d. Understanding the role of Implicit Bias in racial justice work and dismantling racism

Implicit Bias is "the the bias in judgment and/or behavior that results from subtle cognitive processes (e.g., implicit attitudes and implicit stereotypes) that often operate at a level below conscious awareness and without intentional control" (www.ncsc.org). Implicit Bias reflects the systemic inequalities present in society and is patterned to benefit privileged groups. Being aware of Implicit Bias is critical to racial justice work and is one of the best ways to counteract the negative impact of Implicit Bias. See number 5a for a practice suggestion and www.obhilab.com.

e. Self observation/shifting from cultural competency to cultural humility

Being aware of your own positionalities (race, ethnicity, gender, sexual orientation, class, etc.) in different contexts can help alleviate any implicit bias or power differentials from transpiring. According to Tervalon and Murray-Garcia, "cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations."

Cultural Humility Versus Cultural Competence... (Tervalon & Murray-Garcia, 1998)

Treating and Precepting with RESPECT (Mostow et. al., 2010)

f. Socioeconomic difference does not explain racial inequities

There is a breadth of research and evidence that shows that while class is very important to health it does not close the inequity gap. In fact, structural racism produces class status. Excellent training available from The Racial Equity Institute: www.racialequityinstitute.org.

3 Know your community's history and resources

a. Social Determinants of Health

"Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes" (Centers for Disease Control and Prevention, n.d.).

Unnatural Causes (documentary), Charts from Camara Phyllis Jones (http://minorityhealth.hhs.gov/assets/pdf/checked/1/camarajones.pdf), Rethinking the Social History (Behforouz et. al., 2014)

b. Knowing your community – history

Being cognizant of the history of the community that you are working with, including ethnic enclaves in the diaspora, will better enable providers to recognize root causes of issues such as trauma. It will also enable them to be more conscientious of the possibility of distrust among researchers and health practitioners due to a history of medical exploitation and abuse.

Fit to Be Citizens? Public Health and Race in Los Angeles (Molina); The Spirit Catches You and You Fall Down (Fadiman); Community Tool Box: Windshield and Walking Surveys

c. Investing in your community - active participation

Make the conscious decision and effort to engage and organize in the community that you serve to build trust and a deeper understanding of the community's experiences.

d. Knowing your community's resources: A strength-based and cultural wealth approach

Recognize that the individual and the community at-large already have existing strengths and resources that are relevant to the community. These strengths and resources can be leveraged to improve their overall well-being (Saleeby 2008, 1996). Yosso (2005) states that people of color can use their cultural wealth to access resources that are relevant to their experiences.

Whose Culture has Capital? (Yosso, 2005); The Strengths Perspective (Saleeby, 2008)

e. Examples of using community knowledge for patients

The community knows their community best. Using existing models such as working with community lay workers or promoters to disseminate interventions or information can be more effective than dissemination from providers or other outsiders.

Texas-Mexico Border Intervention... (Sixta & Oswald, 2008); Evaluation of a community health worker pilot intervention to improve... (Islam et al., 2013)

f. Is your practice set up to connect patients to resources?

Develop a practice that provides and collaborates with organizations in the community that address inequities across the social determinants of health. See Rishi Manchanda,Health Begins

4 On your team

a. Acknowledge consistent areas of implicit bias out loud, not just to yourself, so the whole team is influenced.

b. Remind your team and yourself not to personalize the critique of systems.

b. Exploring racial justice affinity work as a tool for robust professional engagement in racial justice work.

c. Explicitly name power differentials and introduce alternative ways of centering voices, views, & people that are often silenced.

d. Acknowledge that people are experts in their own lives and realities.

e . Begin to practice naming your racial and gender identities at all meetings you attend at your workplace to start changing norms and making the implicit explicit.

5 In the exam room — making the implicit, explicit.

a. Setting the stage — visual cues

Create a safe and welcoming environment for your patients that celebrates and acknowledges their identity, culture, etc. Ex. Pride flag, Black Lives Matter poster, posters in the preferred language of patients, or a poster stating that people of all documentation statuses/races/gender identities/religions etc are welcome.

b. Asking Better Questions

-About identity: "I don't want to assume anything about your identities. How do you identify racially, ethnically, culturally, and what are your pronouns?"

-About experiences in the health care system: "Many of my patients experience racism in their health care. Are there any experiences you would like to share with me?"
-About life experiences:"Are there important life events that you've experienced that has or is currently affecting your health?"
-Ask relevant follow up questions to the patient. To the best of your ability, make sure they feel heard and that you address their concerns or past negative experiences, and incorporate what they share into your care plan.

d. Better Responses and Power-sharing

Bear witness with authenticity, and thank them for sharing their story. Take a position-- they did not deserve what happened. Reflect injustice, trauma, pain, anger as well as patient's dignity, strengths and validity of concerns. In the face of structural racism as well as persistent interpersonal racism, how can the two of you work together regarding the patient's/family's own health and welfare? Clarify your commitment to a partnership addressing their goals and needs. Incorporate what they share and their other priorities and preferences into jointly constructed and feasible care plan.

c. Deep Listening

-Deep listening is "listening to understand, not to respond." So often we listen just to prepare our own response/argument back. Deep listening makes people feel heard.

d. Your Role as a Provider

-"It is my job to get you. You shouldn't have to work to get me. If I miss something important or say something that doesn't feel right, please know you can tell me immediately & I will thank you for it." Follow through on that promise to listen to and respect a patient's concerns or critique!

e. Use measurement tools to advance racial equity

- Structural racism and health inequities in the USA: evidence and interventions (Bailey et. al., 2017)
- Racial Justice PDSA (Plan, Do, Study, Act) https://deming.org/management-system/pdsacycle
- Racial Equity Impact Assessment http://www.racialequityalliance.org/tools-resources/
- Community organizing tools such as power analysis http://www.racialequitytools.org/resourcefiles/LCAT_Take_Action_Create_Change_-_Community_Organizing_Toolkit.pdf

Resources for Further Training:

Critical racial justice trainings organizations: Government Alliance on Race & Equity (GARE), Race Forward, Black Lives Matter (www.blacklivesmatter.com), The People's Institute for Survival and Beyond (www.pisab.org) & Racial Equity Institute (www.racialequityinstitute.org)

In the summer of 2016, the Racial Reconciliation & Healing team (www.racialrec.org) and the Executive & Medical directors at Southern Jamaica Plain Health Center hosted a series of meetings with physicians and other medical professionals from the greater Boston area. The focus of the meetings was to integrate a racial justice framework into healthcare. This document emerged from that process.

For more information or to participate in the Liberation In the Exam Room please contact Abigail Ortiz, MSW, MPH, at aortiz3@bwh.harvard.edu

Liberation in the Exam Room: Assumptions

- Racism: A system of advantage based on race.
- Prejudice: Preconceived judgment or opinion, often based on limited information.
- In US society, the system of advantage operates to benefit whites as a group, but racism, like all forms of oppression, hurts everyone.
- Because of the prejudice and racism in our environment when we are children, we cannot be blamed for learning what we were taught (intentionally or unintentionally). Yet now that we are grown, we have the responsibility to identify, interrupt, and change the cycle. When we recognize that we are misinformed we have a responsibility to get accurate information and adjust our behavior.
- Each of us is at a different place in the journey and we will have mutual respect regardless of where we perceive each other to be.
- Change is possible both individually and institutionally.

Beverly Daniel Tatum, Learning About Racism, 1992

Liberation in the Exam Room: Glossary of Terms for Southern Jamaica Plain Health Center

Health Disparities: Differences between the health of one population and another in measures of who gets disease, who has disease, who dies from disease, and other adverse health conditions that exist among specific population groups in the US.[1]

Health Equity: The opportunity for everyone to attain his or her full health potential. No one is disadvantaged from achieving this potential because of his or her social position (e.g., class, socioeconomic status) or socially assigned circumstance (e.g., race, gender, ethnicity, religion, sexual orientation, geography).

Health Inequities: Differences in health status and mortality rates across population groups that are systemic, avoidable, unfair, and unjust. These differences are rooted social and economic injustice, and are attributable to social, economic, and environmental conditions in which people live, work, and play.[2]

Implicit Bias: Learned stereotypes and prejudices that operate automatically, and unconsciously, when interacting with others. Also referred to as *unconscious bias.* When a person's actions or decisions are at odds with their intentions, this is implicit bias. (John Powell)

Oppression: Unjust use of power and authority.

People of Color: A political construct created by people of color to describe people who would generally not be categorized as white.

Prejudice: An unfavorable opinion or feeling formed beforehand or without knowledge, thought, or reason.

Privilege: Advantages and immunities enjoyed by one, usually powerful, group or class, especially to the disadvantage of others. **White Privilege**: Advantages and immunities enjoyed by whites in the US.

Race: A socially constructed way of grouping people, based on skin color and other apparent physical differences, which has no genetic or scientific basis. This social construct was created and used to justify social and economic oppression of people of color by whites.[3]

Racial Discrimination: Unfair treatment because of an individual's actual or perceived racial or ethnic background.[4]

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[1] Adapted from National Institutes of Health

[2] Adapted from Margaret Whitehead

[3] Adapted from *Race: The Power of an Illusion*

[4] Adapted from Massachusetts Commission Against Discrimination

Racial Justice: The creation and proactive reinforcement of policies, practices, attitudes, and actions that produce equitable power, access, opportunities, treatment, and outcomes for all people, regardless of race.[5]

Racism: A system of advantage based on race. (David Wellman)

- **Internalized Racism:** The set of private beliefs, prejudices, and ideas that individuals have about the superiority of whites and the inferiority of people of color. Among people of color, it manifests as internalized racial oppression. Among whites, it manifests as internalized racial superiority.
- **Interpersonal Racism:** The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or telling of racial jokes.
- **Institutional Racism:** Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.
- **Structural Racism:** Racial bias across institutions and society over time. It's the cumulative and compounded effects of an array of factors such as public policies, institutional practices, cultural representations, and other norms that work in various, often reinforcing, ways to perpetuate racial inequity.

Stereotype: A standardized mental picture that is held in common about members of a group that represents an oversimplified opinion, attitude, or unexamined judgment, without regard to individual difference.

Social Determinants of Health: The circumstances in which people are born, grow, live, work, play, and age that influence access to resources and opportunities that promote health. The social determinants of health include housing, education, employment, environmental exposure, health care, public safety, food access, income, and health and social services.

White Supremacy: White supremacy is a historically based, institutionally perpetuated system of exploitation and oppression of continents, nations, and peoples of color by white peoples and nations of the European continent; for the purpose of maintaining and defending a system of wealth, power, and privilege.[6]

[5] Adapted from *The Applied Research Center*

[6] Challenging White Supremacy Workshop, Sharon Martinas. Fourth Revision, taken from www.RacialEquityTools.org's glossary as shown in MP's Associates and Center for Assessment and Policy Development.

Other important terms:

Classism: Unfair treatment of people because of their social or economic class.

Sex: The biological, reproductive parts (penis, vagina, etc.) that divides people by their reproductive functions.

Gender: The state of being male or female that is socially created and is not biological.

Cisgender: When the gender a person feels they are matches what sex their parents were told at birth.

Transgender: When the gender a person feels they are differs from the sex their parents were told at birth. Gender identity is fluid; a person can identify as both male and female or identify with neither.

Patriarchy/Sexism: A system of society or government in which men hold the power and women are largely excluded from it.

Misogyny: Hatred of women.

Homophobia: Fear and hatred of gay and lesbian people.

Heterosexism: Systematic discrimination or prejudice against non-heterosexual people on the assumption that heterosexuality is the normal/only sexual orientation.

Transphobia: Fear and hatred of transgender people.

Cissexism: Systematic prejudice or discrimination against transgender people based on the belief that everyone is or should be cisgender.

Islamophobia: Fear and hatred of the Muslim community.

Marginalized Communities: A group that's confined to a lower status society. Such a group is denied involvement in mainstream economic, political, cultural, and social activities.

There are a lot of other important terms we will be adding to the SJPHC Glossary.

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