Definitions of systemic & structural racism in healthcare. Round Table. (Systemic Bias & Systemic Racism in Healthcare 2/4)

For the second episode in our mini-series exploring systemic racism in healthcare, our panel explores different definitions of bias, stereotyping, systemic racism, and structural racism, and how these behaviors intersect with social determinants of health. Perspectives from both patient and professional viewpoints are addressed. The panel also discuss solutions such as bias training, cultural competency, language competency, self-reflection, and mentoring.

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Dr. Elena Rios serves as President & CEO of the National Hispanic Medical Association, (NHMA), representing 50,000 Hispanic physicians in the United States.

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Dr. Johnson: Welcome to the second installment of our miniseries, Exploring Systemic Bias and Racism in Healthcare. I'm Dr. Charla Johnson, and you are listening to the Health Disparities podcast, which is a program of Movement Is Life.

In our last episode, we took a deep dive into different types of unconscious bias, what they are, how we measure them, their consequences, and actions we can take to unlearn bias. In this episode, we have a round table discussion to continue that exploration in a more conversational format. We are all experienced healthcare practitioners, and so I'm sure we can all share real experiences relating to that subject from the frontline, so to speak. My background is in the specialty of orthopedic nursing and in nursing informatics, and I'm the Director of Clinical Information Systems and Nursing Informatics at Franciscan Missionaries of Our Lady Health System in Baton Rouge, Louisiana. And I'm really pleased to be joined by Dr. Melvyn Harrington, orthopedic surgeon and Vice Chair of Community Engagement and Health Equity at Baylor College of Medicine in Houston. Welcome, Dr. Harrington.

Dr. Harrington: Thank you. Happy to be here.

Dr. Johnson: I'm also delighted to be joined by Dr. Elena Rios, who serves as the president and CEO of the National Hispanic Medical Association.

Dr. Rios: Thank you. It's great to be here.

Dr. Johnson: So, let's get into our subject and start with sharing what we see as definitions and bias, and then perhaps there are a couple of examples of how unconscious or implicit bias might be expressed. Firstly, maybe how a patient might experience bias and also how a patient might express bias. So, let's start with you, Dr. Harrington.

Dr. Harrington: Well, implicit bias is something that we all have. It's something in our subconscious, that's why we call it unconscious or implicit bias, and it affects our treatment of others based on those biases. We see it in healthcare as it can lead to adverse effects and treatments of patients. For example, a lot of it can be simple stereotyping based on the patient's race, ethnicity, gender, body habitus. There’re huge implicit biases against the obese. And so just the way that people are treated based on those biases can adversely affect their healthcare even on the patient side. For example, as an African American orthopedic surgeon, patients will often ask me after I have talked to them about scheduling their hip or knee replacement, gone through the risks of surgery, and talked about the whole process, they will ask me if I'm the surgeon. Don't know if that is a

microaggression, implicit bias or just a basic question because I'm in a complex academic center with lots of different people. But it does play a role in how we as providers are perceived.

Dr. Johnson: Thank you. They say that the brain makes decisions up to like 10 seconds before we even know that we're even processing information and responding to it. And so, I believe that we do default into our unconscious thoughts, and we do that more. We lean into that more when we're overwhelmed or stressed and juggling multiple things. And I think that just describes the everyday life of a healthcare provider, what you're having to do in the world as you're dealing with patients. So, thank you for giving us those descriptions. Dr. Rios, please add your thought.

Dr. Rios: Yeah, well, I think bias has to do with the issues around your values. A person's values come from their family, come from their upbringing, come from places that they've lived. And oftentimes, people that live in a certain area of the country, let's say, that is not very heterogeneous, have bias because they don't know about other people. So, if it's all a black community, they may not know how to deal with white people. If it's a Hispanic community, they may not know how to deal with black people. I'm just saying that anybody can be biased based on how they've grown up and also their values. And I'll just say that we usually translate the word bias into treating people with stereotypes. Stereotyping is I guess a generality about people. And without understanding that you should respect where people come from and the culture and the values that the person has, it's very easy to get into the problem of using a stereotype and not even knowing how you're affecting the other person that you're communicating with or trying to communicate with. And I think that that's the problem with using stereotypes. When you're in a conversation such as a doctor-patient conversation or in training and medical education, using stereotypes can often offend someone who recognizes the stereotype. We see implicit bias all the time, and honestly, it can be in direct verbal communication, but it can also be informal communication, nonverbal communication, the way your tone of voice, the white coat syndrome where a doctor uses a white coat and patients just can't talk because they're in shock or in awe. And there's also informal body language like standing up and having the patient sit down at an exam table and towering over a person makes that person feel very, I'll just say it's very humbling to a person who's sick and again, doesn't want to speak up or answer questions. They're not very comfortable in a situation where

they feel that there is some change in communication pattern that they're not used to.

Dr. Johnson: I would add that from a nursing perspective. And then from an informatics perspective, I think about the electronic health record and when biased, I can see when a clinician opens the record and what they first thing they see in the medical record or diagnosis. So, it could be obesity and the comorbidities associated with that and metabolic syndrome and anxiety and depression and all those things. And then they look over at the BMI, and they've already began to kind of shift and form opinion around that patient before they've even had a chance to even examine the patient or focus on patient-centered care. And I know for me, from an informatics space, I really hope that those collection of social determinants of health data can actually begin to kind of peel back some of those biases because when we begin to ask the why have we gotten here that maybe that in itself can help? And that's what I'm encouraged about as a nurse in informatics, as we go into that new space.

And expand on this a little further, when we see underrepresentation of African Americans and Hispanics in the healthcare workforce, is bias acting as a gatekeeper in that situation? And how big would that problem be, Dr Rios?

Dr. Rios: Well, the medical profession is a, I'm going to say an old boys' network. It is a professional group that is usually determined by the admissions process to medical school. And the admissions faculty or others who are part of the admissions process may triage people with bias, again, implicit bias just because they don't understand where that person came from or the value of the person's application. If they don't look at the application with a holistic viewpoint and they're just looking at grades or MCAT scores or looking at what university, they came from. So, there becomes this implicit bias in admissions. The other issue with admissions is most of the faculty in our medical schools are not Hispanic or black. In fact, there's very probably one to 2% of faculty that are on admissions committees are black or Hispanic. So, there's a lot of ignorance, just the way the system's set up for bias to increase and be a gatekeeper, like you said, for keeping us out or keeping the black and Hispanic medical students at an underrepresented level compared to the population that is growing. Hispanics are going to be one out of four Americans in the next 10 years, and by 2060, they're supposed to be one third of the United States

population, and we're never going to catch up when only 6% of the doctors are Hispanic.

Dr. Johnson: Dr. Harrington, your thoughts?

Dr. Harrington: I think it is both implicit and explicit bias and really lots of systemic factors in terms of just getting into the healthcare fields. It starts with education, which already in this country has huge historical systemic disparities and problems and barriers. And so, the challenges, number one, starting at the early ages of getting kids through grade school and high school and even into college and then trying to get kids from college interested in the sciences and into medical school and the health profession. Those systemic issues are a major issue. And then when I look at what I do in terms of residency selection and choosing medical students who are applying for orthopedic surgery residencies, we are the least diverse field in medicine. So, a lot of our selection process becomes much more subjective and less objective. And so implicit and some explicit biases certainly play a role in who gets selected for various surgical fields.

Dr. Johnson: I had a thought when you were saying that where I was a mentor to a young man in his master's program, African American and he told me was sharing his story with me, and he said that when he went to college, he was on, he had the academics and he was on an athletic scholarship, but he was wanting to be pre-med and his enrollment to that program, they denied him and they steered him towards nursing and said that if he passed the nursing courses, then they would allow him to go pre-med. And I think about what bias was going on there to lead him away from his calling, his profession, and I'm thankful that nursing has him, but then I think what his dream would've been in how someone stifled that. So, you're right, it does impact that. Dr. Rios, how about you? I noticed that in Maryland it's one of the first states to pass legislation requiring bias training every two years. So, what are your thoughts on implicit bias training?

Dr. Rios: I think it's very worthwhile. I've been a part of the bias training, or I should say anti-bias training. I was on a board of directors of a local company that was one of the first companies to actually do it for all of their staff and the board of directors. The idea of having a safe space for people's hidden biases to come out. People don't realize that they have bias until you go through a training like that where you are asked to think hard about your

upbringing and to also learn how to deal with issues of disrespect to others, really how to be more respectful and how to also discuss the issues with others in your space at your hospital or in your medical school or your clinic, so that you all feel more, just say, I think it's a feeling of pride that the organization that you're a part of that has gone through this training is able to move forward and move beyond these issues that come up from not talking about them. You don't realize how many people have bias towards someone else because that other person is something, is a different type of person that they just hadn't been around and didn't know. And it's not just racial bias or we're talking about it racial and ethnic bias, but there's also biases just from somebody who's in rural America versus somebody who's urban. So, there's lots of ways that we find out. We identify different biases and stereotypes that we all have. It's not negative. I think it's just the way we've been brought up.

Dr. Johnson: So, Dr. Harrington, could you talk about what's happening in your institution and how do people generally respond to this bias training?

Dr. Harrington: I think it's really variable. I'm fortunate that Baylor College of Medicine is one of the most diverse health science institutions in the country, so it's actually pretty well received, but there are pockets of resistance. There are some people who don't necessarily believe that it exists. We try to encourage training for everyone. We encourage everyone, particularly those of us who are involved in any hiring selection processes, whether it is for faculty members, graduate education, or med school admissions to complete training, and it's part of the medical school curriculum, but there is still some resistance. And I know there have been concerns expressed in different areas of whether implicit bias training actually encourages stereotyping or potentially makes things worse rather than better. But I think it's still a positive for people to be aware that they may have biases, because I think that's the big thing is that the vast majority of folks who want to do the right thing may not realize that there are implicit biases, and it can hopefully positively affect their decision-making process in the future.

Dr. Johnson: Right, right. Thank you. I do know that with CMS, their mandate for hospitals to begin IAT testing to their commitment to health equity, that is one of the areas that I know healthcare organizations, the inpatient hospital settings, are having to demonstrate and have evidence for their commitment to health equity using things like DEI and what type of

training, culturally sensitive training and things like that as part of these initiatives. So, I'm hoping that the awareness would make a difference, but like you just said, there are concerns that does it actually cause the pendulum to go the other way? For the next part of our discussion, I want to tease out some differences between structural and systemic bias in general and in particular structural and systemic racism. Dr. Rios, how do you explain systemic racism to someone who needs an introduction to the concept?

Dr. Rios: Well, coming from medical education and training, I think it's about the health system. And some people say we don't have a health system, but we do. We have, again, it's a profession of doctors and nurses and also our allied health colleagues, and we work in hospitals and clinics and medical practices and that all have rules for workflow, for efficient workflow. And I think the system that is set up within these different places like medical education for example, have bias or racist tendencies. One of the most obvious one, if you go to any hospital in the country, these large hospitals, the top layer of leadership, whether it's the board of trustees or the c-suite, the CEOs, COOs, all those vice presidents are usually white, are usually people who have been able to get educated. They didn't come from poor backgrounds, they went to higher education and they learned how to network with others, go to conferences, and they learned how to be introduced to people so that they could apply for jobs and get hired in a way that Hispanic and black people who are not educated and not part of the upper echelons in our communities where they would be introduced to leaders of hospitals, and I'm talking just community hospitals if you want to say university, hospitals, whatever. But there's a whole networking, I'll say game for want of another word, but there is a networking game within medical, the medical system or the health system, the same with the CEOs of insurance companies and probably the upper management of pharma companies and other major institutions within healthcare. It's a network and it's also who's invited to the network, and that's why we call it systemic bias because the whole system is a top-down approach. Decisions and programs are set up by people who don't realize they're biased, and that's the importance of having more focus now on diversity and training and education. There's a lot of needs that will change the system, the health system, or any other system. Training and professionalism is very siloed. So, doctors are all focused on critical thinking for the purpose of making a diagnosis and treating patients the best way they can using laboratory and imaging and using management

tools like medications and radiation or what have you, chemotherapy. So, there's not a whole lot of time to think about racism. I don't think people even think about it, and that's why the importance of training. In terms of the structural racism, I think people do know a little bit more about that, but they don't, again, it's not front and center in the day in the life of a doctor or a nurse who are focused on their patient and patient care, clinical care. Structural racism to me is what we call the social determinants of health. The idea that wherever you work, play, live, pray, church, all of those institutions within your community or all of those drivers of health impact the life of that person. And usually, we think of social determinants of health or social drivers of health for the patients, about the patients. So, how often the doctor thinks about what the patient is going through, I think, is dependent on how the relationship between the doctor and the patient is. So, how long they've known each other, perhaps they get into more small talk, learn about their family, their family situation, the challenges, the stressors. So to get back to the concept, structure to me means poverty or not having food to eat, good food to eat, nutritious food, having too many sodas that cause you to get more obese faster or to have overcrowded housing with intergenerational housing, we saw the COVID-19 virus spread through a lot of neighborhoods with older people living with younger people, and it was the younger people that went out and worked or went out and socialized with their friends and then brought it back to the elderly who had more chronic conditions. And unfortunately, in our communities, a lot of families saw death of elderly patients. And then there's lack of transportation, lack of childcare, all kinds of issues because of low-income jobs or financing problems, you have a lot of issues that we call structural. It's the way the structure is set up in our society. There is a reason why people are in poverty. They don't have the education to get a better job, or they can't get the financing from banks to buy a home. There's just a lot of different issues surrounding structural, what we call structural racism, what I think is structural racism.

Dr. Johnson: Dr. Harrington, how would you describe structural racism and how is it different from systemic racism?

Dr. Harrington: Well, I think that systemic racism is something that's sort of built into the system. It's based on, for example, the prior laws in the country that may have had a racist bias or rules that have been enforced and have been in place over time. I think the structural racism is sort of what has become sort of the accepted norm, and a lot of that is based on those

prior rules and laws and things, but it's sort of what has been accepted by society as just sort of the way things are, which is not necessarily correct.

Dr. Johnson: Dr. Harrington, what are some examples of bias that you have personally witnessed in practice?

Dr. Harrington: I think probably one that I see quite commonly is a bias against obesity. There's documentation within the orthopedic literature showing that obese patients have higher complication rates after surgery, and so many of us have developed screening processes and even cutoffs for body mass index or weight candidates to be surgery. And we see patients all the time who are shipped around and sometimes even ignored because of the weight. I think one of the biggest challenges is obesity is a problem that is challenging for all of us. And one of the things that we try to do to mitigate the bias and the problems is finding solutions for the patients, rather than just saying, you're overweight, go away. It's like, okay, you're overweight. These are the concerns that we have with obesity and potential complications, and then here, let's try these things to help work on that medically optimized rather than just focusing on weight.

Dr. Johnson: Yeah, thank you. I saw some literature that talked about obesity from a bias standpoint, and it said that the perception was that laziness, and they were less likely to comply with medical treatment. So, the complexity of when you see someone that's obese and then you're already in your mind as a clinician thinking they're not going to comply with what I'm giving, so am I even going to give them the treatment. I mean, you can see how that could stop care, delay or impact the type of care that is delivered. I know in healthcare also in the literature I've seen, especially around the orthopedic space and musculoskeletal space, talking about women in pain, the bias are with women in pain where women are more demonstrative, so therefore their pain rating scale is really not what it says, so we're not going to give them as much versus a man, he's more stoic, so therefore his painting rating scale isn't really what he says either, so I'm going to give him more or offer him different treatments. So just that bias just with pain and gender. And I know that I've seen where in African Americans, so if you throw race in there where African Americans are typically can be prescribed less pain medicine for the same pain rating. And so, you just wonder about those inequities. I also saw from, and I think through these lenses around social determinants like the lower social economic status, when you are perceived as someone less responsible,

less intelligent, less rational, less compliant. If you have an age patient, then you're discounting their pain as well. It's just normal aging, so then you discount their level of rating pain. So yeah, there was interesting how bias can really impact, and to me as a clinician, the awareness of the bias, and do I have a bias when someone's giving me, sharing something with me, what am I thinking? Right? We lean into those unconscious thoughts before we've even had a chance to process. So, reflecting I think is key, right? That stop, pause, think to really overcome those biases.

Dr. Harrington: Yeah, I think that's where the implicit bias training, even though there is certainly resistance against it, I think just being aware so that you stop before you, stop and think before you make your snap judgment bias.

Dr. Johnson: Right. Dr. Rios, your thoughts.

Dr. Rios: It's very disappointing that people become disenchanted with going back to see a doctor if they become disrespected and feel like they're being biased. And I think that that's the ultimate disappointment in the health system, the way it's set up now. So, if we have more people from the community, the community health worker movement, the idea of having navigators, the idea of having bilingual doctors, bilingual nurses, I mean, who would've thought we'd need bilingual anything in this country? Because everybody talks English, but in fact, it's the second largest, the country with the second largest language is Spanish. And I think we have more Spanish speakers, at least Spanish speaking in the home, and most people that are elderly revert back to the language that they come from that they had when they grew up. They feel more comfortable with Spanish. I'll just talk about the Latino population who have been native Spanish speakers or come from other countries, or even Puerto Rico, which is the United States, but they're very much more comfortable in speaking Spanish in the Caribbean, right? There's a real importance to having bilingual staff, bilingual services, but you can't expect every doctor to be able to pick up a second language as an adult but I do think that it is important. Medical education should include Spanish language. It has become more of an elective with students, students who know Spanish and teaching other students. But I think that medical schools, especially in those communities with large Spanish speaking patients, should have medical education training. And the healthcare system sees more older patients that end up with the chronic disease where they have to come in more regularly to see the doctor to get treatment. And we don't realize that

that's another bias that everybody in medical school is very young and the nurses are young, the hospital workers are young, and then you got all these old people coming in for care, and that's just another need that needs to be a challenge and a need that needs to be looked at.

Dr. Johnson: Dr. Harrington, have you experienced where you feel like you were biased against? I know you mentioned a comment where someone asked, were you even the doctor part of the care, but where someone has said they didn't want you part of their care because of your race?

Dr. Harrington: Fortunately, not that often. Ironically, one of the situations that I sort of found humorous was when I was in practice in Chicago years ago, and we had an African American woman was one of our residents, and a patient said that he did not want her taking care of him. And the ironic thing was that it was a young African American male patient, and so my colleague who was the attending for the patient was not having it. And so, his humorous approach to it was to ask me to go and talk to the patient to see if the comment remained the same. And when I approached the patient, he was perfectly okay with having the African American woman physician and myself and the others as his care team. But yeah, so I do get the comments. I have not had fortunately any direct comments. Now, there are some folks who probably came to see me once and didn't come back, but I may not have known about that.

Dr. Johnson: What I've seen in the literature is around organizations are really beginning to develop processes to determine actually how to respond to those type of requests. When a patient says they don't want someone as their caregiver, they develop some type of an algorithm. Is it a cultural or religious reason or would their care be compromised in some way if the request was not granted? And it's kind of hard to believe that we actually have to put processes in place to manage this, but there are different types of requests as well as behaviors or aggression or harassment that clinicians face as well that could be based on these, on racist attitudes.

Dr. Harrington: I would say probably one of the more common things that I get asked, particularly if I'm asked to refer a patient to another physician, one of the common things I get asked is, oh, do they speak English well, if I'm sending them to someone with a more foreign sounding name, they're like, oh, I want a doctor who speaks English. That's always one of the more common things that I see.

Dr. Johnson: But when you peel that on your back, sometimes you really have to look at that lens too, where it's coming from. Is it coming from a space of I only want an English speaking, or if you have an aged person who has hard of hearing, it's very difficult when someone's speaking clear Anglo-Saxon English versus culturally someone different. I know my husband has a speech challenge right now, and that is actually someone who's hard of hearing. It's very, very difficult. He's speaking clear English, but there is just a little bit of a slur with it, so you have to peel those onions back because we can't feel that it could be that way. So, what extent do you think healthcare professionals understand this balance between structural and systemic racism? Do you think we understand it enough?

Dr. Harrington: I don't think anyone in our society as a whole understands it enough or recognizes it or maybe necessarily even wants to understand it. I think training is good, so people recognize it. Really, I think to change it is more of a societal issue.

Dr. Johnson: I think it'd be nice if we can get to a place where we could actually have a dialogue about race in a place, not a safe space, because that's not it, right? Because it's not about that. It's more in a place where people can just be comfortable to share their thoughts and ideas so that they can listen to understand someone else's perspective and be heard, and then to allow reflection, then to process their own growth. I don't think that's a one and done. I don't think I can take a training and think differently. I think I need to take a training, gain awareness, reflect, apply it, reflect, improve. I think it's a cycle. I don't think we'll, like you're saying, I don't know that we'll ever get there because it's like everything else. It's a cycle or an evolution of change. Do you think our patients, I know we speak different language for sure. So, do you think our patients understand structural and systemic racism?

Dr. Harrington: I think some of probably our older minority patients do just having grown up when the implicit was totally explicit. So, I think they understand, and I think a lot of it is understanding the history and the actual racist laws that were in effect that caused so much of the disparities in things from the redlining to the Voting Rights Act, all of these things that were just part of the US system growing up. So, our younger folks, I don't think they have that history. And so, I think it does need to be taught in schools and just at

a bigger level so that people are aware of where things started and why things are the way they are.

Dr. Johnson: Right. Dr. Rios?

Dr. Rios: Yeah, the National Hispanic Medical Association prides itself in bringing together experts who are doctors who take care of Hispanic patients. They may not be Hispanic themselves, but I think what we've been able to do is have doctors come together and understand what's most important, what we call cultural competence in training each other to take care of other Latino patients at different ages, whether it's the pediatric population or the geriatric population. And we do that in different ways, one of them is having webinars, and I'll give you an example. We've had webinars on vaccinations and how to get more people to think about the importance of vaccinations, especially adults. In this country, children are mandated to have vaccination to go into schools. There're some exceptions, I guess some religious exceptions, but for the most part, adults were never a focus. And we learned through the pandemic how important it was for essential workers who are adults to be able to get more healthcare and more vaccination to avoid hospitalization. So, we've had webinars, quarterly webinars with doctors who take care of Hispanic patients on how they talk to them about prevention and vaccinations as an example of prevention, how to get people to understand that they should see a doctor. And it's hard because many people in our communities don't have insurance. So even talking about Medicaid this year with the Medicaid unwinding, we have a lot more doctors that are interested in being speakers at community events. So, we're always dominating doctors to do things, to be able to educate other doctors or groups of people who can tell patients, those who are becoming patients, to go to the healthcare, the importance of getting healthcare. So that's just one example. I mean, we have mentoring and leadership development programs, mentoring of pre-med students, mentoring of medical students, mentoring of residents to help them advance in their careers. We're always able to find doctors ahead of them, medical students for pre-meds, residents for medical students, etcetera, who all want to share the kinds of biases that they've seen or the cultural nuances that they've had to use in communicating to patients and in working with their own doctors and attendings, and how to understand that they have to speak up and not be humble like we're all trained to be, and to really become better at being at the table when it comes to decision-making about their patients or decision-making in

committees as they become leaders and that type of thing. So, we've been very involved with advancing careers, and like you said, it's important that we help our own people get higher level positions so they can have jobs for others in their communities.

Dr. Johnson: Many thanks to Dr. Harrington and Dr. Rios for sharing your perspective today. It's been fascinating and it really brings home how embedded systemic racism is within our healthcare system, and more broadly a structural racism within society as a whole. We will continue to explore this subject in our next episode where we discuss specific examples of systemic racism and race-based clinical decision making that are impacting specific populations negatively. Then in our final episode, we will explore initiatives that are tackling bias. So, until then, thank you to our listeners for joining us. Be safe and be well.

(End of recording)