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SYSTEMIC RACISM IN HEALTHCARE – THE UNSPOKEN BIAS AND ITS IMPACT

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Disclaimer: This summary was prepared by Dr. Birinder Narang and not by the speakers.

Webinar Summary

My ABC's of Anti-Racism – Dr. Ramneek Dosanjh

- Dr. Ibram Kendi quote "What is the problem with being not racist? It is a claim that signifies neutrality. I am not a racist, but neither am I aggressively against anti-racism. But there is no neutrality in the racism in the racism struggle. The opposite of racist is **not** not racist, it is anti-racist. What is the difference? One endorses either the idea of a racial hierarchy as a racist or a racial equality as anti-racist. One believes problems are rooted in groups of people as racist or as anti-racist locates the roots of problems in power and policies."
- **A - Awareness**
    - Understanding the current landscape of colonization in our back yard
    - Racism permeates through health care system and society
    - Medical learners have expressed that they have participated in racialized settings and have felt oppressed in their own academic learning environments
    - Must start with our services and our own recognition and participation in events like tonight
    - Consider bias training, opportunities to reflect and sit with other cultures
- **A - Anti-Racist Action**
    - The only way to undo racism is to consistently identify and describe it, then dismantle it, giving voice to the most marginalized and racialized minority
    - Learning about truth from those populations, their perspectives and their lived experience, journey, and steps towards decolonization

    - Ensure accessible, understandable, and culturally relevant supports and materials where needed
    - Must stand up and challenge mistruths, misinformation, and bias
    - We must meet our patients where they are at
    - Create safe spaces for dialogue, welcoming of all walks of life, making them safe
- **A – Anti-Racist Allyship (Advocacy & Activism)**
    - Take learnings and impart them in our schools, clinics, hospital and in our neighbourhoods
- **B – Bias & Bystander**
    - We must acknowledge our own inherent biases and racial biases
    - Consider taking the Harvard implicit bias course or CDC Diversity/Inclusion course.
    - We must become the upstander for our patients, stand up for our patients
- **C – Culture (Courage, Change & Compassion)**
    - It takes all of us in partnership to understand our marginalized populations

Systemic Racism in Healthcare – Dr. Tatiana Sotindjo

Racial-Development Trajectory

- Racial identity follows a course of developmental trajectory
- Children as young as 3 can identify physical characteristics, may notice differences
- Early school-aged children become aware of social groups; recognize they may start to develop prejudices based on exposure to those around them
- Late school-aged children can learn more nuanced perspective, capable of other's perspectives and empathy may emerge at this age
- By adolescence values are solidified including prejudices
- Often reserve discussions of race and bias until quite late into adolescences

Racism – Adverse Childhood Experiences

- Racism is an adverse childhood event
- Part of the emotional and psychological acts of abuse and neglect on the psyche of the evolving and growing child into adulthood
- Starts in utero
    - Childhood begins in the intrauterine experience, maternal experiences of interpersonal discrimination are associated with increased preterm and low birth weight births, thought to be due to elevated cortisol in pregnancy
- 2020 CBC headline "Black babies more likely to survive if they have black doctors": study
    - Reflects American Data from 1992 to 2015 in Florida, review of 1.8 million hospital births

    - Black or Caribbean babies 3x more likely to die when cared for by a physician that was white
- In BC we still have a lack of racialized data, if we don't have the data, we don't know the truth

Physical and Mental Health Consequences – Lifespan

- Has an impact from development outcomes, including academic achievement and access to development services and even the ways in which child behave
- Can manifest into psychopathology
- In 2019, American Academy of Pediatrics published scoping review of the impacts of racism on child and adolescent health
    - Even if children do not directly experience racism themselves, they can experience adverse physiological and psychological responses
- Fear of racism, can itself be harmful and it can undermine resilience, hope and motivation
- Lancet Article
    - Police kill more than 300 Black Americans (at least ¼ of them unarmed) each year in the USA. These events might have a spillover effect on the mental health of people not directly affected
- Young adults with a parent who has been incarcerated during their childhood are more likely to skip medical care, misuse prescription drugs
- Indigenous women account of 48% of the population in women's prison
- Asian American young adults are the only racial group with suicide as their leading cause of death from age 15-24

Anticipatory Guidance

- Must create positive childhood experiences, using an anti-racism approach
- In early childhood years, use positive messaging about person's uniqueness, read books about different cultures
- Early school-age is the ideal time to discuss race, bias, diversity, and inclusion, discuss themes seen on TV or on social media, and ask the child their thoughts on community events
- Late school-age is the opportune time to discuss prejudice and bias to interrupt racism

There Is Always More Than One Story - Dr. Jaswant Guzder

Cultural Safety and Cultural Humility

- Cultural Humility – a therapeutic commitment to lifelong process of self-evaluation and self-critique, addressing power imbalances and to be aware of institutional racism, understanding systemic and cultural realities of the person and develop attitudes of allyship or advocacy
- Cultural safety is an actively created context co-construction including:
    - Attentive listening, language skills, dignity, taking time
- Cultural humility is crucial to person-centred care

- Be comfortable with “not knowing” - trauma is shared slowly

Cultural Formulation Outlines: DSM

- Cultural identity
- Cultural explanations of the illness
- Cultural factors related to psychosocial environment and levels of functioning
- Cultural elements of the clinician-patient relationship
- Overall cultural assessment for diagnosis and treatment

Delusion of Neutrality

- We must look for awareness of the cultural diversity of the patient (ancestral and present contextual), we are a nation of complex diversities and hybridities
- Awareness that none of us are “neutral”: be comfortable with “not knowing” as a position
- Awareness of patient’s explanation of their health and illness, e.g. spirits, to be able to share those experiences is important.

How are you heard…

- Must let patient set the agenda at their own pace
- Use emotional signals of patients and your internal discomfort to slow down and explore
- Micro and macro aggressions accumulate as a traumatic impact in health

Self-Care is part of patient-centred health care

- Preparing to meet a patient, gathering your attention and presence for each person’s story, e.g. family doctor taking a moment
- Awareness of power and privilege in hierarchies involves awareness of stigma, othering, silencing, addressing anti-racism spaces to discuss our moral distress and vicarious trauma, towards coworkers and in training, supervision, policies, and patient care

Question & Answers

Q: I find those who attend sessions such as this one is those that are already interested in the problem? Those who need the training the most, the larger part of the problem, don’t often join. How can we increase physician training?

A: Confront the power dynamics that exist. Public Health, early childhood education, education system and embedded in our medical learning is important. The way that our children are informed now is different. We must go across our own organizations to confront change in our own experiences.

We must make our organizations feel that this is everyone’s work.

Doctors of BC is working on policy papers to attempt to create a gold standard.

The lack of data is still a problem, there continues to be resistance in BC that by collecting this data you’re embarrassing and making people uncomfortable. That’s part of the issue.

COVID has inspired us that uncomfortable is normal, and we must embrace the work that has to be done. It takes a lot of courage to resist.

We must look at it as a core competency, and make sure it is an expectation. On an individual level we can continue to influence our spheres. We must understand our history and how the implicit discrimination and how bias has been embedded into our specialties.

Q: Reflecting on the Florida data, on survivorship of black children, how do you think this translates to care provided to patients of other cultures and or care by care providers of the same gender?

A: We don't have study here today but we can extrapolate. We know that the in surgical specialities, that evidence does exist that female surgeons may have improved metrics than male surgeons in certain aspects of women's health care. Probably is a lot of invisible dynamics at play.

Things are missed when space isn't created where a patient feels safe to disclose. Patients don't feel they have permission at times.

Not a proportionality of representation in our medical spaces that reflect communities.

We must gather our own local disaggregated data to identify systemic biases both positive and harmful.

Psychiatry has an important history of racism. Through the work on the truth and reconciliation commission, the mental health groups have made a lot of decision and colluded with a lot of decisions that made things worse. It was based on an idea of a universal theory that is though culture was not influx or that colonialism did not exist. This kind of delusions continues to haunt us.

We must open our eyes through a different lens than what we inherited and making ourselves available to learning and to open mindedness.

Q: How can we better equip our patients to feel comfortable or safe in disclosing racist incidents in our own office?

A: We must acknowledge and ask how people identify and I think the environment should be welcoming and reflect the diversity of identities in BC. As an institution, it is important to have reporting mechanism, but involving people that understand nuances. Are our advocacy committees, consulting groups, truly reflecting the community they are serving? We must think of community representation as much as individual patient representation. We will all get it wrong, but we want to know when we are getting it wrong.

Q: What can we do to educate our staff to examine their own biases. Are there any courses available?

A: Lived experience counts for a lot. Being in a team that is reflective of the community you serve is important. Ethnic match is not the solution, it is about our internal reflective capacity and to learn from our patients. When a patient says they feel hurt, do not dismiss it. "Thank you for telling me that". Keeping teams healthy, promoting critical thinking without punitive response is important. Denial is a big disease.

Q: The burden of dealing with racism by changing behaviours seems often to be directed to people of a white European background, what do you think of this perception?

A: Unfortunate that this is the perception. Many of us who have witnessed the colonization of this land, the truth of indigenous people and the genocide and we think of it from a settler lens, this perception exists because that is what history has taught us. The literature shows that those who have done the training, the bias is of a white European male with blue eye is who we feel safest with in this world. The antithesis of this is a black male. This is a conditioned social construct. That is where this comes from. When we commit to anti-racist structures, we must confront that perception to acknowledge the allyship and work that is being done. We are active participants until we lead every day with an anti-racist framework.

Q: How can white physicians best learn about the multicultural population they serve? Who can they ask questions about specific cultures from their experiences?

A: As physicians we strive to go to a reputable source and to look for tools where they exist. We can look at large body of literature on micro and macroaggressions in medical education settings. These things are all available in peer-reviewed articles. Must be careful not to put additional burdens on one individual person or entity. In Plain Sight report is a seminal document should be a go-to for turning to when it comes to anti-Indigenous racism. Advocating on a system level for these policies or documentation to be readily available if it's through organizations through Doctors of BC or CPSBC.

If you were studying Heart Failure, you wouldn't ask one patient about it, you may review several patients and compliment it with best practice guidelines. We must hold our organizations accountable to be publishing guidelines that are inclusive of this metric.

Q: How do we give agency to those who are on the receiving end of racism in the health care setting? Healthcare providers wield a lot of power. Should we look at a redoing health care services to a more equitable relationship?

A: Issue is of access and safety. Cultural formulation, we are constructed through our systems, relationships, attachments and through our ancestry and what grounds us. I am in a clinic of visible minority children, and I have no one on my staff that reflects that, and that makes a powerful statement. Dispersing that into our training as a normal part of our understanding. If we don't' do it now, we are losing our children. We must start it as early as possible and work on changing our teachers/educators' attitudes. Collaborative upstream prevention.

Q: Would you be willing to share any personal stories on how you have been impacted by systemic racism?

A: Dr. Guzder – Parents did not have an opportunity to get educated. Grandmother was psychotic by the time she settled on the island and was very distressed. Endured ECT without anesthetic and never left the island again. Felt privileged to go to school. Teacher dissuaded her from being a doctor or artist, as

"people like you don't become doctors or artists". Cruelty in offhand remarks without reflection continues to exist today.

Dr. Dosanjh – Father was an immigrant from New Delhi, came here at age of 24 and worked at 75 cents on the dollar/hour vs 1.50 for non-racialized person doing same job. He was Masters educated in Economics, and went to one of the most prestigious universities in India. None of his training was recognized. Was rooted in her upbringing. There were racial slurs, oppression, and injustice. Has been witnessed so often that it has become a daily battle. Creating a culture of intolerability of racial oppression. Racism is a social construct. Take a deeper look at the patient in front of you.

Dr. Sotindjo – The first place is to start from a systems issue is to hear and address our own colleagues. Power imbalances continue, so must address these issues from our colleagues, and be open to hearing it. If we can't do it within our own profession, it doesn't bode well to addressing with our patient and client. Seeing patients during the racial upheavals that followed the death of George Floyd. Had experience sitting with mothers, who asked her "how are you doing"? Patients want to know that we are thinking about it. A mother shared with her, "I don't want you think for a minute that when I see George Floyd dying that I see him, I don't see him, I see his uncle, my father, and my son."

There isn't adequate curriculum, or training to deliver care that helped with this, must develop the anticipatory guidelines. Need something in place.

Colleagues may experience micro-aggressions; this must be a part of physician health and wellness.

Q: I sense that you don't feel that we can be unbiased when it comes to how we view patients of different races. Can you expand on that?

A: There was not one time in Dr. Guzder's training where she was asked about what it felt like to be the only brown resident in that experience and what that means for the patients? So how comfortable are we in supervision? Power and privilege are alive in our profession. Hierarchal way of thinking is being challenged by the youth today. Must offer young people space to talk about this.

Thanks to the Speakers:

- **Dr. Ramneek Dosanjh**, Family Physician; President, Doctors' of BC
- **Dr. Jaswant Guzder**, Professor, Department of Psychiatry, McGill University (currently on leave); Indigenous Child and Youth Mental Health (CYMH) Services, South Vancouver Island
- **Dr. Tatiana Sotindjo**, Pediatrician; Clinical Instructor, Division of Adolescent Medicine & Division of Pediatric Infectious Diseases, UBC
- **Dr. Shirley Sze (Moderating)**, Family Physician; Co-Chair of Child and Youth Mental Health and Substance Use Community of Practice