WHITE PAPER

ANTI-RACIST CLINICAL CARE:

Improving Health Outcomes For Black Women

BLACK WOMEN'S
LEARNING INSTITUTE

ABOUT THE BLACK WOMEN'S LEARNING INSTITUTE

"The way to right wrongs is to turn the light of truth upon them." – Ida B. Wells.

The Black Women's Learning Institute (BWLI) is a national center focused on the health and wellness needs of Black women across the lifespan. We are committed to improving health outcomes for Black women through culturally responsive and appropriate programming. We especially focus on systematically disadvantaged communities in the southern US who experience significant health and racial disparities and are largely underserved. We provide safe spaces for critical conversations that provide a deeper understanding of the history and current issues that impact the health and lives of Black women. BWLI also creates pathways for Black women to inform their clinical providers about what they need to achieve optimal health. Through translational research, BWLI serves as a vehicle to inform the development of health programs that respect the experience and intersecting identities of Black women. Our vision is to advance health equity for Black women at multiple levels (individual, interpersonal, community, and policy) using a whole of society approach.

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LETTER FROM LEADERSHIP

It is an honor for us to lead and serve the Black Women's Learning Institute (BWLI). BWLI recognizes the greatness of Black women. Through translational research, BWLI serves as a vehicle to inform the development of health programs that respect the experiences and intersecting identities of Black women. Our vision is to advance health equity for Black women at multiple levels (individual, interpersonal, community, and policy) using a whole of society approach. We seek to serve and protect Black women, while helping them to get the support and care they deserve from our healthcare system. Black women exist and attempt to thrive with intersecting identities, while navigating a healthcare system that is structurally and systematically designed to be racist, sexist, and transphobic. We are not seen, heard or treated in a way that recognizes the complexity of our lived experiences. Historically in the US, we have seen the unethical treatment of Black people through clinical trials and research. These historical traumas lead to diminished trust in the US healthcare system today. It is imperative that Black patients and Black physicians are involved in creating solutions that work to advance health and racial equity in order to improve health outcomes for Black women.

The rising US maternal mortality is by far the worst among high income countries, and according to the CDC, in 2020, the US maternal mortality rate surged by 20% in the wake of the COVID-19 pandemic. Black women are three times more likely to die from a pregnancy-related cause than their White counterparts. This disparity persists regardless of education level or accumulation of wealth. Implicit bias is a key driver of these disparities that go beyond access to healthcare. According to the CDC, more than 80% of pregnancy-related deaths were preventable. The primary cause of death varied among different racial and ethnic groups with cardiac and coronary conditions as the most common underlying cause of pregnancy-related deaths for non-Hispanic Black people. The bottom line is that the system is inherently flawed and Black women are experiencing poor outcomes in almost every area of health, including maternal health, heart disease, cancer, HIV/AIDS, COVID-19 and beyond.

Last fall, we released our Engage Empower Educate report on Black women's health and wellness. The report was based on a survey of approximately one thousand Black women mostly based in the southern US. When asked about the biggest barriers to accessing healthcare, they said finding a doctor I like (40%), and finding a Black doctor (29%). When we asked about their top 3 health concerns, they reported high blood pressure (36%), depression (29%), and breast cancer (28%). We know that Black women are disproportionately living with HIV, yet it did not make the list of top concerns. Black women represent 13.7% of the US population, but make up more than half (59%) of new HIV diagnoses in the US.

When we asked Black women whether they believe their health care providers listen to their concerns, one third (33%) said "no", or that they were unsure. Additionally, nearly half (48%) reported always, usually, or sometimes experiencing discrimination from their health care providers. Doctors take an oath to practice ethical medicine, committing to do no wrong or harm to patients, yet not all patients are treated well, whether due to implicit or explicit bias. This white paper will outline some of the historical context, provide real life examples of the ways history is manifesting in the present day, discuss anti-racist approaches to clinical care, and propose recommendations in the near and long term.

To achieve health and racial equity, we must employ a whole of society approach, including the private and public sectors, academia, clinical providers, public health systems, media and technology outlets, community based organizations, and all key stakeholders to instill trust in our communities and provide the highest quality of care for everyone. It is our commitment to work toward improved health outcomes for Black women and **we welcome the opportunity to work with you toward that end.**

BWLI invited the Denver Prevention Training Center (PTC) as a contributor to this white paper and we are partners in the implementation of an anti-racist approach to clinical care described in the document. BWLI and the Denver PTC believe this approach is critical for advancing anti-racist practices and policies.

We are in this together,

LISA FREDERICK, BA
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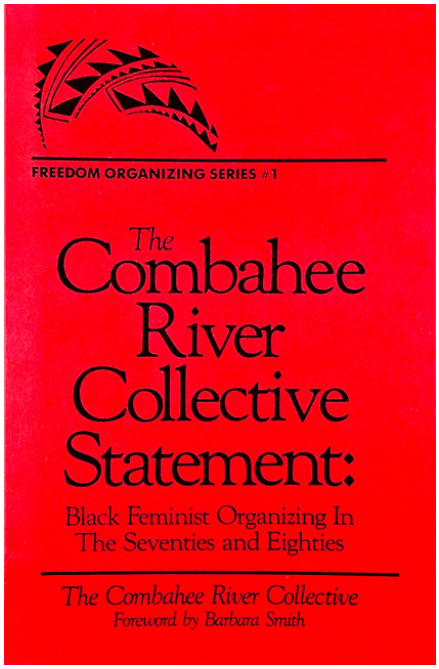
I. HISTORICAL CONTEXT

"Black Women are inherently valuable" – The Combahee River Collective



The Combahee River Collective was a Black feminist lesbian organization who began meeting in 1974 in Boston, MA. They named the collective in honor of Harriet Tubman's notable work leading men in battle in the Combahee River Raid, an act that resulted in the freeing of more than 750 slaves. The Combahee River Collective was considered one of the most important organizations to develop out of the antiracist and women's liberation movements of the 1960's and 70's. The collective issued a compelling statement in 1977 reflecting on their experiences with oppression, highlighting the nuanced interplay of multiple identities (what later became known as intersectionality) and what it was like navigating through a racist system from the lens of Black feminism. They recognized Black women as being on the fringes of society and stated "If Black women were free, it would mean that everyone else would have to be free since our freedom would necessitate the destruction of all the systems of oppression." In 1983, author and social activist, Alice Walker coined the term "Womanist" as an articulation of Black women's liberation. Walker contends that a Womanist is aware of her own value and unlike the White feminist movement, Womanists are committed to the survival and wholeness of the entire Black family; women, men and their children.

It is important for clinical providers to understand the historically documented medical exploitation and abuse of Black women dating back to the 1840's with Dr. J. Marion Sims, a White doctor in Alabama who was deemed "The Father of Gynecology." Sims was the first doctor to conduct a successful surgical repair of a vesicovaginal fistula (tear between the vagina and urinary bladder), a common complication of childbirth for women at the time. For Black enslaved women, these types of fistulas were particularly prevalent as they were often raped by those in positions of power, they were also expected to repeatedly breed more children to be enslaved and during pregnancy did not have appropriate nutrition which sometimes resulted in prolonged deliveries leading to fistulas.

In order to perfect this procedure, between 1845-1849, Dr. Sims performed numerous surgeries on enslaved Black women without anesthesia. These unconsenting women endured excruciating pain while their dignity was ripped from them by assuming a physical position on their hands and knees while many White male doctors observed. In his autobiography, Dr. Sims references the story of the last enslaved woman he operated on, Lucy. He described her case as particularly challenging, and notes "the poor girl, on her knees, bore the operation with great heroism and bravery. I had a dozen doctors there to witness the series of experiments that I expected to perform…the operations were tedious and difficult." He adds "I put a little piece of sponge in the neck of the bladder and ran a silk string through it, it was a very stupid thing for me to do" because five days later, Lucy was very ill with a fever, frequent pulse and blood poisoning. Dr. Sims, like many doctors at the time, believed that Black people were capable of enduring higher levels of pain than their White counterparts. Once Dr. Sims' experimentation was proven successful, the surgery was then performed on White women under anesthesia.

Illustration of Dr. Sims performing experiments on enslaved Black women without anesthesia

J. Marion Sims
The New York Public Library

There are many key historical considerations and documented abuses of Black women that have spanned nearly 400 years. On May 29, 1851, Sojourner Truth, evangelist, abolitionist, and women's rights activist, delivered her renowned "Ain't I a Woman" speech at the Ohio Women's Rights Convention. She spoke with indignation over the way her worth as a Black woman was unceasingly disregarded. She said, *"That man over there says that women need to be helped into carriages, and lifted over ditches, and to have the best place everywhere. Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a woman?"* During the Black Codes/Jim Crow era, laws against rape in many states only protected White women, leaving Black women vulnerable to gang rape and genital mutilation. Abuse and discriminatory medical practices continued into the civil rights era with forced and coerced sterilizations. In 1961, Fannie Lou Hamer, a civil rights activist, checked into a Sunflower County, Mississippi hospital for a routine procedure to have a small benign tumor removed. Without her consent or knowledge doctors performed a hysterectomy, removing her entire uterus. Many Black scholars documented this common practice of dehumanization of Black women's bodies. Fannie Lou Hammer coined the term "Mississippi Appendectomy", a phenomenon and common medical practice of involuntary sterilization of poor Black women in the 1920s-1980s who were thought to be unfit to have children.

In her book, Killing the Black Body, author Dorothy Roberts highlights mistreatment of poor Black women: "During the 1970s, sterilization became the most rapidly growing form of birth control, rising from 200,000 cases in 1970 to over 700,000 in 1980…teaching hospitals performed unnecessary hysterectomies on poor Black women as practice for their medical residents." The eugenics movement began in the late 1800s; it was the practice of selectively mating and breeding out "undesirable" characteristics from the population. Those considered undesirable were typically people of color and those with mental disabilities. Eugenics was particularly widely supported by upper class White Americans who were worried about the changing demographics of the US population due to immigration as well as migration of Black people from the south to the northern parts of the country. Eugenics was also widely supported by scientists who saw it as a progressive way to improve the population.

54 Popular Science Monthly

Registering Human Pedigrees

How Kansas Developes Fitter Families; A Remarkable Experiment in Eugenics

By Arthur Capper, *U. S. Senator from Kansas*

Mrs. Mary T. Watts, Audubon, Iowa

Dr. Florence B. Sherbon, University of Kansas

The Eugenics Building at the Kansas Free Fair, where families are judged and registered. Seated in the center is a "fitter family" surrounded by examiners

THE average American family of today is the result of haphazard mating. Men and women marry with little scientific thought as to their physical and mental fitness for bearing and rearing children. When the children come they too often are brought up in the same haphazard fashion in which their parents chose each other. Is it any wonder that the number of mentally and physically unfit increases?

For years, American farmers and breeders

member of a family. Another sheet of the record shows the results of the intelligence test, and an examination by a psychiatric specialist of the nerve reflexes, emotional and intellectual responses. A thorough structural examination is made, including strength tests and measurements. The medical record gives the results of a complete physical and organic examination, with blood pressure, hemaglobin blood test and the Wasserman blood test. Every member of the family is examined

Article "Registering Human Pedigrees. How Kansas Developes Fitter Families; A Remarkable Experiment in Eugenics" By Arthur Capper, U.S. Senator from Kansas, published at the Popular Science Monthly, August 1923.

During this time, many sterilizations were performed on Black people, and 33 states in the US allowed involuntary sterilization based on race, feeble mindedness, disability, IQ scores, and other criteria government led eugenics boards felt were appropriate.

The case of twelve year old Minnie Lee Relf and her fourteen year old sister Mary Alice Relf amassed much media attention in Montgomery, AL in the 1970's. In 1973, Alabama permitted parental approval of sterilization for the mentally incompetent. The sisters were considered mentally disabled. Their mother, Minnie Relf, was presented with paperwork by two nurses from the local family planning clinic to approve birth control shots for her daughters. Minnie was illiterate. She trusted her clinical providers and unknowingly signed paperwork (with an "X") authorizing their sterilization.

The Southern Poverty Law Center filed a lawsuit on behalf of the Relf sisters which exposed just how widespread sterilization abuses funded by the US government were. The district court found that 100,000-150,000 poor people were sterilized each year through government funded programs. As a result of the court case, the Department of Health, Education, and Welfare (now known as HHS or the US Department of Health and Human Services) was required to amend its policies as they were "arbitrary and unreasonable". Intentional abuse, disregard, and violation of Black women's bodies has been woven into this country's medical and social systems and practices.

Mary Alice and Minnie Lee Relf, 1973
Courtesy of Ebony

Mary Alice and Minnie Lee Relf,
Hannah Price for the New York Times

Minnie Lee and Mary Alice Relf are two African-American sisters, who at age 12 and 14 respectively, were involuntarily sterilized in the name of public health by a federally funded family planning clinic in Montgomery, Alabama in 1973.

The timeline below illustrates the personal experiences of Black women over time in the US that have contributed to disparities in sexual and reproductive health:

Table 1. Historical and Contemporary Sexual-and Reproductive-Related Health and Healthcare Experiences of African American Women

Period	Time Span	No. of years	Personal experiences of AAW that contribute to disparities in sexual and reproductive health	Healthcare experiences that contribute to disparities
Slavery	1619-1865	246	Public, nude physical auction examinations to determine reproductive ability, raped for sexual pleasure and economic purpose, purposely aborting pregnancies where rape occurred; Jezebel stereotype emerged of Black women being hypersexual, generational poverty	Nonconsensual gynecological and reproductive surgeries performed at times repeatedly on female slaves without anesthesia, including cesarean sections and ovariotomy to perfect medical procedures
Black Codes/ Jim Crow	1865-1965	100	Rape, lynching (genitalia/reproductive mutilation) uncertain/unequal civil rights, stereotypes and negative media portrayals continued, generational poverty	Noncensensual medical experiments continued, poor or no healthcare for impoverished Blacks, compulsory sterilization; Jim Crow laws enforced lack of access to quality healthcare services and opportunities; Effects of Tuskegee Untreated Syphilis Study on women
Civil Rights	1955-1975	20	Lynching, uncertain/unequal civil rights and violence against women to show superiority and Control, stereotypes and negative Hypersexual media portrayals Continued; generational poverty	Nonconsensual medical experiments continued compulsory sterilization; effects of Tuskegee Untreated Syphilis Study on women, unequal healthcare services
Post-Civil Rights	1975-2018	43	Black exploitation movies, media's hypersexual images continued, Generational poverty	Unequal healthcare continued, targeted sterilizations, hysterectomies, abortions, Birth control
Total No. of years	1619-2018	399		

AAW, African American Women
https://www.liebertpub.com/doi/10.1089/heq.2017.0045

The 1954 Brown v. Board of Education decision declaring that the separating of children in public schools based on race was unconstitutional served as an impetus to the dismantling of other institutionalized systems of racial segregation, including healthcare in the US. However, it wasn't until the mid 1960s that US hospitals were forced to desegregate. In the case of Black Americans, separate was not equal, as many received low quality health care as a result of segregated hospitals. Many hospitals remained segregated in secret until President Lyndon B. Johnson signed the Medicare and Medicaid Act into law in 1965. In order to receive federal funding from Medicare and Medicaid, hospitals were required to desegregate. For context, our first Black US president, Barack Obama, one of our youngest US presidents, was born in 1961. Older Black Americans still remember when some areas of the country had segregated hospitals and clinics, not to mention profoundly unethical medical failures and abuses, such as the 40-year-long Tuskegee syphilis study.

Nurses serve patient meals in segregated gynecological ward at the Johns Hopkins Hospital Women Clinic, 1939.

On May 22, 1962, Malcolm X delivered a speech in Los Angeles, California, where he spoke about his observations of what it meant to be a Black woman living in America. It is there that he said "the most disrespected person in America is the Black woman. The most unprotected person in America is the Black woman. The most neglected person in America is the Black woman." Those words and sentiments still persist today. Unfortunately, Black women have bore the heaviest burden, and the history of discrimination and oppressive healthcare practices and policies have caused significant harm.

II. HIDDEN BIASES & HEALTH DISPARITIES

a. Hidden Biases

The historical context of racism in clinical care is harrowing, but unfortunately these historical occurrences lead to present day manifestations. Institutionalized racism has traveled through time and much of it is embedded in our healthcare institutions and among our medical professionals who have sworn to do no harm. Many of these contemporary occurrences of racism exist by way of implicit, or hidden biases that operate outside of a person's conscious awareness. It can manifest in implicit ways and it is ingrained in structural and systemic ways through individual and interpersonal level behaviors, and through macro level policies. In our experience working closely with Black women throughout the US, particularly in the south, they report having experienced racism in their encounters with the health care system, resulting in inequitable outcomes. Implicit bias is a form of bias that occurs unintentionally. It affects judgments, decisions, and behaviors and these sorts of biases are deeply embedded in our health care system. Ultimately, these biases affect the quality of care for Black women. Sometimes these implicit biases play out in ways that directly oppose a person's conscious beliefs and values. This is why it is important to establish clear mechanisms for identifying these biases and dismantling them.

The aforementioned historical factors have contributed to deep seated medical mistrust, a lack of trust or suspicion of medical providers, institutions, and the government. Medical mistrust is a protective response against the racism Black women experience daily in multiple contexts, including health care. It is particularly pronounced when we take into account intersectionality, the social categorizations like sex, gender identity, race, ethnicity, class, religion, disability, weight, physical appearance, and other groups in which Black women exist. Black women have endured gender discrimination and racial oppression for centuries, creating overlapping and interdependent systems of disadvantage. In 1941 civil rights attorney Pauli Murray introduced the term "Jane Crow" to bring attention to the intersectional oppression Black women experience that limits their engagement in society. It is the complex and cumulative ways the effects of discrimination based on these social categorizations manifest for Black women. Medical mistrust, implicit bias and the intersecting identities of Black women can create overlapping and interdependent systems of discrimination and disadvantage in all aspects of their life including healthcare. Medical mistrust can result in lower utilization of health care and poor management of health issues overall.

b. Weathering & Allostatic Load

The continued stress of living under racial discrimination, marginalization, and social adversity can lead to "biological weathering" for Black people. In 1992, Dr. Arline Geronimus, researcher and current professor in the Health Behavior and Health Education department at the University of Michigan in Ann Arbor coined the term "weathering" to describe how the constant stress of racism leads to poor health outcomes and premature biological aging for Black people. Dr Geronimus concludes that Black people have to participate in daily "high-effort coping" with racism and discrimination which inevitably causes weathering.

Clinically speaking, this means that Black adults experience higher allostatic loads than their White counterparts. Allostatic load refers to "the wear and tear on the body" due to chronic stress and the burden of adverse life events. Allostatic load has been used as a biomarker to measure the concept of weathering. Black people experience disproportionately higher death rates and low survival rates related to stroke, and other chronic conditions like heart disease, diabetes and cancer as a result of weathering and high allostatic loads. Despite what some may suspect, poverty does not explain differences in allostatic load resulting from weathering. CDC considers maternal mortality a public health crisis based on the statistics showing that Black women are three to four times more likely to die from pregnancy complications than White women. This is a devastating reality for Black families. It is important to note that weathering is a driver of Black maternal mortality. In a 2019 interview with online publication SELF magazine, Dr. Joia Creer -Perry, founder and president of the National Birth Equity Collaborative notes, "Mental anguish and stress from "fighting against larger structures and systems can have an impact on your health."

c. Microaggressions

"Microaggressions are the everyday slights, indignities, insults, put-downs, and invalidations that people of color experience in their day-to-day interactions with well-intentioned individuals who are unaware that they are engaging in an offensive or demeaning form of behavior."
– Dr. Derald Wing Su

Alongside the microaggressions Black women face in the workplace, at school, and within the healthcare system, they must also manage the defensiveness that some White people exhibit when they are confronted with their personal role in perpetuating White supremacy. This is known as white fragility.

Black women have been subjected to racial-gender microaggressions

"You're so articulate."

"My best friend is Black."

"As a woman, I know what you go through as a person of color."

"When I see you, I don't see color."

d. Medical Trainees

In a 2016 study of 222 medical students and residents, historically racist ideologies about differences in pain tolerance between Blacks and Whites persisted. Trainees who believed that Black people are not as sensitive to pain as White people were less likely to treat Black people's pain appropriately. In this study, 40% of first and second year medical students endorsed the belief that Black people's skin is thicker than White people's. Additionally, the study asked respondents about their beliefs on statements like:

- "Black people's nerve endings are less sensitive than White people's."
- "Black people's skin is thicker than White people's."
- "Black people's blood coagulates more quickly than White people's."

Half of the participants in the study agreed with one or more of these false statements.

e. The Legacy of Segregation

Despite the desegregation of US hospitals in 1965, the legacy of segregation continues to be a driver of the health disparities we see among Black communities. The Lown Institute, a nonpartisan think tank, issued an index for social responsibility ranking US hospitals on racial inclusivity to determine their success at serving communities of color in their respective regions. The hospital rankings identified the US cities with the most racially segregated hospitals, though the level of segregation was markedly reduced in the case of COVID-19 care. Additionally, patients receiving elective procedures were disproportionately White in 70% of hospitals. This likely contributes to lower access to healthcare for Black communities.

The cities in the table 2 have the most segregated hospitals in the US (except regarding COVID-19 related care).

It is also noteworthy that many of the elite hospitals named in the U.S. News & World Report's America's Best Hospitals Honor Roll ranked very poorly on racial inclusivity. Of the 20 hospitals on the honor roll, more than half of them were in the bottom third for racial inclusivity and only five ranked in the top third. The contemporary manifestation of segregation in our hospital systems and the flourishing of implicit bias among clinical providers and trainees begs several questions, including how do we fix this, and who's job is it to fix things? How can we fix a problem that many don't acknowledge or understand? Will the US be able to overcome its addiction to racism? We have a responsibility to overcome and dismantle racism within our healthcare systems at an individual and systemic level to improve health outcomes for Black women. The Combahee River Collective reminds us that if Black women were free, it would mean that everyone else would have to be free since our freedom would necessitate the destruction of all the systems of oppression.

f. Race Correction: Clinical Algorithms

Clinical algorithms are used widely to make decisions regarding patient care. Some of these algorithms incorporate race correction, or making

Table 2. Most Segregated Hospitals in the US

Rank	City	% Hospital segregation, all patients	% Hospital segregation, patients only
1	Detroit	90%	0%
2	St. Louis	77%	40%
3	Kansas City, MO	75%	25%
4	Atlanta	68%	18%
5	Philadelphia	68%	32%
6	Washington, DC	63%	19%
7	East Long Island	61%	26%
8	Houston	58%	27%
9	Baltimore	56%	39%
10	Manhattan	55%	35%

decisions using a patient's race to influence how they should be treated. It is worth noting that a patient's racial classification may not even be accurately captured in medical records. These types of clinical algorithms are biased and inherently flawed which can drive health disparities. They are problematic because race is not a biological construct, it is a social one. In the 1950s and 1960s, x-ray technologists were told to give Black patients higher doses of radiation to penetrate their skin and bones. This was due to a false belief that Black people have thicker skin, harder flesh, more muscle, and denser bones than White people. It was believed that Black bodies would offer resistance to cathode rays which required sometimes up to a 25% increase in level of radiation given. This was eventually brought to the attention of professional societies like the American College of Radiology (ACR) and the American Dental Association (ADA). Significant political advocacy from clinicians and politicians led to the stop of this racist practice. The history of radiology shows how systemic racism can impact Black lives in very important ways, perpetuating health disparities. While things may have changed in radiology, we still have a long way to go as race correction still exists in many other areas of health care.

In a New England Journal of Medicine article entitled "Hidden in Plain Sight: Reconsidering the Use of Race Correction in Clinical Algorithms, some of the most problematic race corrections impacting Black patients are highlighted. This is not an exhaustive list.

Pulmonary Function Tests
Spirometers use correction factors for Black patients due to inaccurate assumptions that Black people have lower lung capacity. This leads to misclassification of disease severity assuming that low lung volume is normal in Black patients, delaying appropriate treatment.

eGFR Nephrology
Black people are assumed to have higher eGFR due to a presumed higher muscle mass than non-Blacks. A multiplier is used to assign higher values to Black patients. Higher values correlate with better kidney function. This is misleading and can result in inequitable and delayed care.

Vaginal Birth After C-section (VBAC) Risk Calculator
The VBAC score predicts a lower chance of success of vaginal birth among Black patients. Non-White women in the US have higher rates of c-sections than their White counterparts, and this type of risk calculator can further exacerbate this issue. Implicit bias from providers can lead to Black patients being discouraged from trying for a vaginal birth if they've previously had a c-section - despite a chance of success.

Get With the Guidelines (GWTG) Heart Failure Risk Score
This is a predictor of mortality among patients in the hospital with acute heart failure. This calculator adds 3 points for non-Black patients, regarding Black patients as lower risk, leading to delayed treatment.

Cardiac Surgeons Risk of Death Calculators
Cardiac surgeons use elaborate risk of death calculators produced by the Society of Thoracic Surgeons. These calculators take race and ethnicity into account based on observed differences in outcomes after surgery though the underlying reason for these differences is unknown to the creators of the calculators. Changing the race of a patient in the calculators can increase estimated risk of death by nearly 20% which could deter patients of color from life changing or life saving surgery.

Many of these race corrections force clinical providers to take a reductionist approach to a patient's race, ethnicity and lived experience when categorizing them, applying an algorithm, and determining a care plan. This opposes the principles of collaborative and coordinated patient centered care which centers the individual's health needs and goals when developing individualized and comprehensive care plans. It is through thoughtful and collaborative care that we can take an anti-racist approach to clinical care.

Providing patient centered care does not mean we should ignore race. It should be considered in providing culturally appropriate patient centered care, however, it should not be included in clinical algorithms and calculators to determine treatment options and plans. Removing racial bias in clinical care plans is an important part of achieving better health outcomes for Black women.

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Debra Malina, Ph.D., Editor

Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms

Darshali A. Vyas, M.D., Leo G. Eisenstein, M.D., and David S. Jones, M.D., Ph.D.

Physicians still lack consensus on the meaning of race. When the *Journal* took up the topic in 2003 with a debate about the role of race in medicine, one side argued that racial and ethnic categories reflected underlying population genetics and could be clinically useful.[1] Others held that any small benefit was outweighed by potential harms that arose from the long, rotten history of racism in medicine.[2] Weighing the two sides, the accompanying Perspective article concluded that though the concept of race was "fraught with sensitivities and fueled by past abuses and the potential for future abuses," race-based medicine still had potential: "it seems unwise to abandon the practice of recording race when we have barely begun to understand the architecture of the human genome."[3]

The next year, a randomized trial showed that a combination of hydralazine and isosorbide dinitrate reduced mortality due to heart failure among patients who identified themselves as black. The Food and Drug Administration granted a race-specific indication for that product, BiDil, in 2005.[4] Even though BiDil's ultimate commercial failure cast doubt on race-based medicine, it did not lay the approach to rest. Prominent geneticists have repeatedly called on physicians to take race seriously,[5,6] while distinguished social scientists vehemently contest these calls.[7,8]

Our understanding of race and human genetics has advanced considerably since 2003, yet these insights have not led to clear guidelines on the use of race in medicine. The result is ongoing conflict between the latest insights from population genetics and the clinical implementation of race. For example, despite mounting evidence that race is not a reliable proxy for genetic difference, the belief that it is has become embedded, sometimes insidiously, within medical practice. One subtle insertion of race into medicine involves diagnostic algorithms and practice guidelines that adjust or "correct" their outputs on the basis of a patient's race or ethnicity. Physicians use these algorithms to individualize risk assessment and guide clinical decisions. By embedding race into the basic data and decisions of health care, these algorithms propagate race-based medicine. Many of these race-adjusted algorithms guide decisions in ways that may direct more attention or resources to white patients than to members of racial and ethnic minorities.

To illustrate the potential dangers of such practices, we have compiled a partial list of race-adjusted algorithms (Table 1). We explore several of them in detail here. Given their potential to perpetuate or even amplify race-based health inequities, they merit thorough scrutiny.

CARDIOLOGY

The American Heart Association (AHA) Get with the Guidelines–Heart Failure Risk Score predicts the risk of death in patients admitted to the hospital.[9] It assigns three additional points to any patient identified as "nonblack," thereby categorizing all black patients as being at lower risk. The AHA does not provide a rationale for this adjustment. Clinicians are advised to use this risk score to guide decisions about referral to cardiology and allocation of health care resources. Since "black" is equated with lower risk, following the guidelines could direct care away from black patients. A 2019 study found that race may influence decisions in heart-failure management, with measurable consequences: black and Latinx patients who presented to a Boston emergency department with heart failure were less likely than white patients to be admitted to the cardiology service.[10]

874 N ENGL J MED 383;9 NEJM.ORG AUGUST 27, 2020

Article "Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms" By Darshali A. Vyas, M.D., Leo G. Eisenstein, M.D., and David S. Jones, M.D., Ph.D., published at the New England Journal of Medicine, August 27, 2020

III. CURRENT MANIFESTATIONS OF RACISM IN HEALTHCARE

a. Engage. Empower. Educate. (EEE) Survey Findings

In our 2021 Engage. Empower. Educate. report, based on a survey of approximately one thousand Black women mostly based in the southern US, many Black women reported having negative experiences with their healthcare provider, largely driven by what is perceived to be racial prejudice.

WHEN WE ASKED ABOUT THEIR EXPERIENCES, THEY SAID:

"I've seen providers build more rapport with White patients"

"I would love for our doctors to know that we are fully human, just like the other women that they treat"

WHEN WE ASKED ABOUT HOW THEIR EXPERIENCES COULD BE IMPROVED, THEY SAID:

"Listen to us when we voice concerns"

"..Doctors need to listen to Black women"

"Re-evaluating standards to check for racial bias in healthcare"

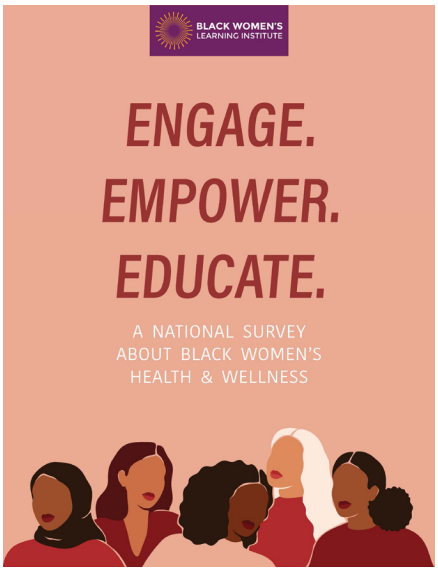
"If healthcare providers took Black women's health concerns more seriously and weren't dismissive about it"

"That we are treated more fairly and not like a junkie when we are in pain"

"Doctors that actually listen to Black people"

"Terminate racial discrimination in hospitals"

Empirical evidence shows that Black patients tend to have better health outcomes when their medical care is provided by Black doctors. But this is not always an option, especially in the southern US and in rural places across the country. There are many pieces to the puzzle - we need more Black doctors, but we cannot rely solely on Black doctors to provide high quality care to Black patients. Instead, we must revamp the entire system, including all health care providers, clinic staff, case managers and others to build trust among our communities and intentionally implement anti-racist approaches in clinical care.



Engage. Empower. Educate. A Survey released in 2022 by the BWLI

"I had a bad experience with a doctor which is why I won't go unless it's a Black woman. They never really have your best health interests at heart."

– SURVEY RESPONDENT

b. Amplifying the Stories of Black Women

The following stories from Black women are highlighted to show the real life manifestations of history in today's health care system. Poor health outcomes like the ones shared here happen too often, and are often preventable with an anti-racist approach to clinical care. In order to protect Black women, provide equitable care, and improve health outcomes for all in the US, we must shine a spotlight on these experiences and elevate the voices of Black women.

"I see inequity wherever it exists, call it by name, and work to eliminate it." – DR. SHALON IRVING

Dr. Shalon Irving

Dr. Shalon Irving was an epidemiologist with the Centers for Disease Control and Prevention (CDC) and lieutenant commander in the US Public Health Service Commissioned Corps. She had a B.A. in sociology, two masters degrees and a Ph.D. in sociology and gerontology. She was a champion for social justice and health equity; her twitter bio read: "I see inequity wherever it exists, call it by name, and work to eliminate it." She was committed to understanding the effects of structural racism and other drivers of health disparities in the US.

Dr. Irving gave birth to her daughter Soleil in January 2017. A few days after returning home from the hospital, she began experiencing pain at the site of her c-section incision. Additionally, she had alarmingly high blood pressure of 174 over 118, chronic pain, constant severe headaches, dramatic swelling in her legs, and she gained 9 pounds in 10 days. Despite reporting these issues, doctors sent her home multiple times and her concerns were dismissed. Her health history and her experience after giving birth necessitated close monitoring, but unfortunately after being sent home one day, she collapsed in her home due to cardiac arrest. She died a week later in the hospital due to complications from high blood pressure.

Education and a successful career did not act as protective factors for Dr. Shalon Irving. The very challenges she was working to fix were unfortunately central to her death. Kira Johnson, a healthy and active 39-year-old woman, underwent a scheduled c-section in April 2016. She experienced severe abdominal pain but was not given a CT scan for over 10 hours, despite pleas from her family. "Sir, your wife is not a priority right now" hospital staff told her husband few hours before she required emergency surgery and was found to have 3 liters of blood in her abdomen. She died on the operating table, leaving behind her husband and two sons. In her memory, her husband Charles Johnson founded 4Kira4Moms, an organization aimed at improving maternal health outcomes. Wealthy Black women celebrities Beyonce and Serena Williams also shared their harrowing and nearly fatal birthing stories in 2017. Wealth and fame did not prevent their experiences of being dismissed by their health care providers.

Charles Johnson IV with wife, Kira Johnson, and son Charles Johnson V

Beyonce. Source: beyonce.com

Serena Williams. Source: IG @serenawilliams

"This is how Black people get killed. When you send them home and they don't know how to fight for themselves."

- DR. SUSAN MOORE

Dr. Susan Moore

Dr. Susan Moore was a general family and geriatric medicine doctor born in Jamaica and raised in Michigan. She had a degree in engineering from Kettering University and later went to the University of Michigan to earn her medical degree. On November 29th, 2020, she tested positive for COVID-19 with a fever and a racing pulse. She was admitted to the Indiana University Health North Hospital in Carmel, Indiana. After a few days in the hospital, Dr. Moore was experiencing pain and having trouble breathing. Her doctor did not believe that she was in pain and the staff attempted to discharge her early. Dr. Moore felt her concerns were ignored due to the color of her skin. She had to convince her doctor to give her a CT scan, and that scan revealed pulmonary infiltrates and new lymphadenopathy, so she was given pain medication, but had to wait for hours before receiving a dose.

When her doctor didn't believe she was short of breath and experiencing pain, Dr. Moore made a video which went viral and was seen by millions. She said "I was crushed. He made me feel like a drug addict. And he knew I was a physician. I don't take narcotics," She said, "I put forward and I maintain if I was White, I wouldn't have to go through that."

At the age of 52, after being transferred to the intensive care unit on a ventilator, she died. Her last words were "I had to talk to somebody…maybe the media to let people know how I'm being treated..." IU's health system has since committed to implementing new anti-racism, anti-bias and civility training. Her story contributes to what we know - that even with education, wealth, and health insurance, Black women still experience worse outcomes than their White counterparts.

Naomi Louissaint

Naomi Louissaint

"As a Black woman with cancer, my sister deserved far better treatment than she received"

– BEATRICE LOUISSAINT

Naomi was diagnosed with stage IV breast cancer and she was given only six months to live. Her family recognized her prognosis, and expected high quality care, but that is not what Naomi received. Her sister Beatrice had this to say: "We needed more empathy, compassion, hope and humanity from Naomi's caregivers. Despite her condition and prognosis, we expected better." Beatrice reported that her sister Naomi, an overweight Black woman, was mistreated as she awaited an experimental drug. Naomi was a highly regarded manager at a hospice care company for ten years. She missed family events and took on extra shifts at work, and despite this, as she was in the hospital, her employment was terminated leading to a loss in medical insurance. Naomi was hospitalized for a month and during that time she suffered both physical and emotional pain. Her providers did not provide adequate pain medication and they did not treat her with dignity. She died on May 30, 2022.

Anonymous 60 year old Black woman with Breast cancer

A 60-year old uninsured Black woman who chose to remain anonymous reported visiting an emergency room due to her concerns about finding a lump in her breast. The doctor discharged her with antibiotics and did not recommend any follow-up testing or referrals to a specialist. The lump persisted and she pursued further testing on her own which found breast cancer. The surgeon removed the lump and recommended a mastectomy. She was not told the stage of cancer, and again she was not referred to an oncologist.

Dr. Angela Anderson

"I couldn't help but think, if this could happen to me and my husband [who is a M.D.] this could happen to anyone. I thought about the numerous people of color whose symptoms have been ignored or minimized. Healthcare disparities are real and far more common than we think. We have to talk about this because lives are at stake." – DR. ANGELA ANDERSON

Dr. Anderson thoroughly explained her concerns about experiencing chest pain and shortness of breath to her doctor and he misdiagnosed her with post nasal drip and suggested she blow her nose. When they checked her oxygen level with the pulse oximeter, she was told that sometimes the machines don't work on 'colored fingers'. She advocated herself with the support of her husband and went to another care facility that sent her to the ER. She then had a CT scan, blood panel and echocardiogram done which revealed a pulmonary embolism, pneumonia, and an infarction in the right lung. She then spent four days in the hospital on intravenous antibiotics and blood thinner.

"I have to be the angry loud Black woman making a scene for you to do something. ...I used to want to avoid that, but when it comes down to my health, I'd rather you be uncomfortable and me not be dead."

– JAYLA

Jayla

In the summer of 2020, amid a US national reckoning on race, a young Black woman named Jayla shared this on a CBS special on racial bias in healthcare regarding her experience requesting an STI test from her doctor. Despite having requested a specific test, her doctor instead ordered a test for a yeast infection, and didn't inform Jayla. She incorrectly told Jayla that the STI test was negative, and as a result of the STI going untreated, Jayla developed Pelvic Inflammatory Disease. To add insult to injury, the doctor who misdiagnosed Jayla told her she "should have had safe sex."

"Primary health care providers may make judgments about candidates for PrEP based on conscious and unconscious stereotypes – such as hypersexuality – and prejudices that disadvantage Black women. Identifying how intersectional stigma in clinical encounters disadvantages Black women is crucial to increasing their access to the medication." – Dr. Shawnika Hull

Dr. Shawnika Hull, assistant professor of communications at Rutgers University notes that primary care providers are a key gatekeeper for information about PrEP for Black women, but evidence is showing despite knowing about the benefits of PrEP, they are not prescribing it to Black women who need it.

HIV is one of the leading causes of death for Black women aged 20-44. According to the EEE study, less than half (43%) of Black women in the south were aware of Pre-Exposure Prophylaxis (PrEP) as an HIV prevention option. Cisgender women were left out of the development of Descovy, a PrEP option for cisgender men and transgender women. This is particularly problematic because when Black women do seroconvert, they have lower CD4+ cell counts and achieve lower rates of viral suppression when compared to women of other racial or ethnic backgrounds.

IV. TAKING AN ANTI-RACIST APPROACH

What does it mean to take an anti-racist approach? The first step is to recognize and wrestle with the history and impact of institutional and structural racism within health systems and its present day manifestations. It is only then that clinical providers can work to build trust and combat medical mistrust and dismantle racist clinical care practices. Anti-racism is rooted in action. It is about taking steps to eliminate racism at the individual, institutional, and structural levels.

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An antiracist approach cannot erase the centuries of oppression and injustice Black women have endured but can set the stage and lay the foundation for protecting the health and well-being of Black women. Most recently the COVID-19 pandemic and the Black Lives Matter movements have helped increase the focus and importance of anti-racist frameworks. The goal of anti-racism is to dismantle structural and institutional racism and actively change the policies, practices, behaviors, and beliefs that perpetuate racist ideas and actions. Providers must approach anti-racist clinical care with intention.

In his book *How to Be an Antiracist*, Ibram X. Kendi, a leading scholar on race and racial discrimination, examines many of the individual attitudes held by both White and non-White people that play a role in sustaining racism. Kendi states, *"It is impossible to be "not racist" if you hold negative attitudes about entire groups of people based on their race, ethnicity, or cultural heritage."* Some people are quick to say they are "not racist" but unwilling to take actionable steps to participate in the work of anti-racism. *"To be anti racist is a radical choice in the face of history, requiring a radical reorientation of our consciousness."* –Ibram X. Kendi

According to the Association of American Medical Colleges (AAMC), as of 2018, 56.2% of physicians identified as White, and only 5% identified as Black or African American. In order to take an anti-racist approach to clinical care, White providers must be willing to be open and vulnerable enough to sit with the discomfort of talking and learning about issues of medical mistrust, racism, implicit bias, intersectionality and other driving factors that negatively impact health outcomes for Black women. A founding member of the Coalition to Advance Antiracism in Medicine (CAAM), Robin Collins, DO says, *"biases are cemented early on in a doctor's career."* Terrie Mendelsen, MD, director of graduate medical education at Dignity Health, St. Mary's Medical Center and associate professor of medicine at the University of California San Francisco, says, *"people often come to the table with their own set of biases and beliefs based on how they were raised. It's necessary to recognize your own unconscious biases and consciously practice anti-racism, which is different than just wishing that you don't have racist thoughts."*

We have seen first hand the benefit of clinicians participating in a course titled "The Introduction to Anti Racist Clinical Care." BWLI co-founder Lisa Frederick serves as a subject matter expert on intersectionality and trainer for the Denver Prevention Training Center (PTC) housed at The Public Health Institute at Denver Health.

The Denver PTC has over 40 years of experience providing training and technical assistance to healthcare organizations and health departments in the US for HIV and STI prevention and care. In late 2020, the Denver PTC developed a six-hour training for clinical prescribers after witnessing the continued racial health disparities throughout the COVID-19 pandemic and in the HIV epidemic. The course was developed through the Denver PTC's HIV prevention capacity building assistance program. The goal of the Introduction to Anti-Racist Clinical

Care is to increase clinical prescribers' awareness of the impact of medical mistrust and how implicit bias can negatively impact provider-patient interactions in HIV care. Additionally, clinical prescribers learn how to incorporate intersectionality into their patient care and treatment models. This course is for clinical prescribers who have a basic understanding of systemic racism and how it relates to health inequities. This training's primary goal is to inform culturally responsive, high-quality care for patients with HIV, improve the quality of care, and increase engagement of patients from diverse backgrounds.

The training objectives include:

- Describing the history of medical mistrust in the context of HIV research, treatment, and care in the US.
- Defining and describing structural intersectionality as it applies to HIV medical treatment and clinical outcomes.
- Defining and discussing examples of implicit bias and the impact on health outcomes for historically oppressed populations.
- Reviewing tools and implementation strategies to provide equitable HIV clinical services.

Since course development through the end of 2022, the Denver PTC has conducted 17 trainings to over 151 participants. Post-course evaluations indicate participants are highly satisfied with all aspects of the course and had statistically significant pre- to post-training changes in knowledge (+1.06 Likert scale increase from pre- to post-training). In addition, participants showed a statistically significant increase in self-efficacy or confidence in performing skills learned as a result of the training (+1.05 Likert scale increase from pre- to post-training), and 94% of participants indicated they would make a practice change. Evaluation findings from 98 participants who completed the evaluation are summarized in the table 3.

The Introduction to Anti-Racist Clinical Care is an example of an anti-racist approach that clinical organizations can use to promote trustworthiness and enhance provider-patient interactions. The course can be delivered in two three-hour sessions, three two-hour sessions or six one-hour sessions to enable providers to absorb the content without large disruptions to clinic schedules or patient care. This course serves as a proof of concept of how organizations can promote anti-racist practices and it shows that training designed to build knowledge, skills, and intention to make practice changes is a necessary step in building anti-racist clinical care.

Table 3. Introduction to Anti-Racist Clinical Care Training - Findings

Post-Course Evaluation (Likert Scale: 1 = very unsatisfied to 5 = very satisfied)	**98 Participants**
Satisfaction with Overall Learning Experience	4.76
Satisfaction with Quality of Content	4.85
Satisfaction with Trainers	5
Satisfaction with Teaching Methods	4.69
Satisfaction with Quality of Materials	4.68
Knowledge and Skill Change (pre- to post-training)	+1.06
Self-efficacy Change (pre- to post-training)	+1.05
Intent to Make a Practice Change Based on Training	92%

V. RECOMMENDATIONS

The US has a long and indefensible history of systemic, structural and institutional racism which has been sanctioned and embedded in our culture. Addressing and dismantling racism and discrimination in healthcare is a long term and ongoing process. Healthcare organizations must be brave, intentional, and committed to looking internally to disrupt the status quo in their organizational culture, clinical practice, and policies.

"The only way to undo racism is to consistently identify and describe it — and then dismantle it" –IBRAM X. KENDI

"The first obstacle we find is that organizations don't have a shared definition of racism, so it is hard to even talk about it. If you think that racism is merely people saying mean things to each other and I think it is a system of advantage based on race it will be impossible to co-design any solutions together." –ABIGAIL ORTIZ, M.S.W., M.P.H., DIRECTOR OF COMMUNITY HEALTH PROGRAMS, SOUTHERN JAMAICA PLAIN HEALTH CENTER

Once you define what racist practice looks like, the first step is to examine if racism is impacting patients and how Black and Brown staff can also be supported. There are "quick wins" and long-term objectives when implementing an anti-racist approach to care in clinical settings. Quick wins are essentially low hanging fruit. Ideally, quick wins can be achieved in less than 90 days, are relatively easy to implement, economical, and small and narrowly focused. Long term objectives are the expected outcome from implementing targeted, consistent strategies generally from 2 to 5 years. Long term objectives are usually guided by the organization's vision.

QUICK WINS

Individual Level

- Acknowledge that racism in healthcare and clinical practice exists.
- Take the Implicit Association Test, a self reflection tool that measures attitudes and beliefs people may be unwilling or unable to report. Its purpose is to increase awareness of cognitive biases that affect day-to-day decision making.
- Learn what it means to be anti-racist and be intentional about practicing an anti-racist approach in clinical settings.
- Attend trainings on diversity, cultural humility and anti-racist practices.

Interpersonal Level

- Apply clear and effective communication techniques using OARS:
  - Ask open-ended questions about patients' beliefs and experiences in the clinical setting
  - Use affirmations - both gestures and statements to acknowledge and be respectful of patients' beliefs and experiences
  - Practice reflective listening. This includes repeating, rephrasing, and reflecting on what patients have willingly shared. Reflective listening allows you to express empathy, honor patient experiences, and confirm accurate understanding with patients which then helps build trust and understanding.
  - Apply reflective listening through concise summary statements. Summaries can be just a few sentences to ensure everyone is on the same page and to begin thinking through appropriate next steps.

- Educate self & others within your sphere of influence around medical mistrust, the historical context of racism and its current manifestations in the US.
- Mitigate racist practices by addressing and holding yourself and your colleagues accountable for racist comments and harmful discriminatory behavior.
- Connect with your patient's story. Actively listen and become familiar with the consequences of chronic stress that many Black people experience in the US.

Community Level

- Develop meaningful partnerships with Black-led community organizations, key stakeholders, and community vetted organizations that value racial equity and provide services through an intersectional lens.
- Create a Community Advisory Board to elicit feedback on community needs and program/service implementation.

Organizational Level

- Form a racial equity caucus to ensure staff is working toward creating a safe and welcoming work environment free of discriminatory practices and microaggressions.
- Begin to build institutional trustworthiness
  - Recognize that trust building can take time, but it is important to begin this process now.
  - Hire staff that reflect the patient population, especially in leadership; representation matters.
  - Provide ongoing trainings in diversity, cultural humility and anti-racist practices for staff and leadership.
  - Examine institutional policies and procedures.

LONG-TERM OBJECTIVES

Individual Level

- Continue to use evidence informed clinical practices that promote racial and health equity principles.
- Continue increasing your knowledge by attending trainings and provider workshops that promote social justice principles in healthcare delivery.

Interpersonal Level

- Assess patient experiences by checking in with patients regularly about their experience
- Conduct focus groups and/or interviews to gather in-depth information from patients about their clinical care experiences. Be sure there is racial concordance between the facilitator and the participant(s).
- Create a detailed action plan to address challenges expressed by patients related to racism they have experienced in their clinical care. Inform patients about the plan and welcome their input/feedback.
- Co-create treatment plans through shared decision making with patients to build trust and respect patient autonomy.

Community Level

- Invest in thoughtful, inclusive, and intentional community engagement.
- Consider implementing community-based participatory research projects to improve services and to become a trusted community resource. This includes being collaborative by working closely with key community leaders, and being transparent by sharing findings with community members widely.

Organizational Level

- Develop, seek out and implement racial equity tools
  - Racial Equity Impact Assessment (REIA) to help prevent organizational racism by systematically examining proposed organizational policies, practices, and budgetary decisions
  - Equitable Hiring Practice to ensure the recruitment, interview process and onboarding is free of bias to increase the hiring of staff including clinicians and leadership that reflect the patient population
  - Racial Equity Scorecard to assess and evaluate policies and programs
- Review clinical algorithms to ensure clinical decisions are not race-based
- Implement patient reported outcome measures (PROMs) surveys. This is a standardized mechanism for understanding a patient's health status, including symptoms, level of function, and overall quality of life. These are particularly valuable because the feedback comes directly from patients. This standardized tool provides clinicians with a better understanding of whether the patient's treatment protocol was influenced by racism or bias. Review institutional barriers to implementing PROMs and create an implementation plan. Mass General Brigham in Boston, MA. shared their success story.
- Review patient satisfaction surveys on a regular basis as appropriate to your organization. Create a detailed action plan to address issues raised by patients in the survey and implement the plan within a timely manner. Share the plan with patients and have accountability measures in place to ensure proper implementation.
- Establish diversity, equity, and inclusion (DEI) advisors for each department in your organization to sustain an inclusive work culture

VI. CONCLUSION STATEMENT

Black women have endured centuries of institutional racism, oppression, indifference, and abuse of power from systems that were designed to protect and serve all members of our communities in the US.

Consequently, Black women continue to shoulder a disproportionate burden of disease. This white paper contextualizes the historical and systemic discrimination Black women experience in healthcare, and proposes anti-racist clinical care as a means of achieving health equity for all, including Black women. We aspire to see healthcare providers across the country adopt the proof of concept and recommendations presented to improve health outcomes.

VII. RESOURCES

The Racial Healing Handbook
https://www.anneliesesingh.com/downloads

In Focus: Reducing Racial Disparities in Health Care by Confronting Racism
https://www.commonwealthfund.org/publications/2018/sep/focus-reducing-racial-disparities-health-care-confronting-racism

"Not Racist" Is Not Enough: Putting in The Work To Be Anti-Racist.
https://www.npr.org/2020/08/24/905515398/not-racist-is-not-enough-putting-in-the-work-to-be-anti-racist

Confronting Racism in Healthcare
https://www.commonwealthfund.org/publications/2021/oct/confronting-racism-health-care

Medical Apartheid by Harriet A. Washington
https://www.mahoganybooks.com/9780767915472

Killing the Black Body by Dorothy Roberts
https://www.mahoganybooks.com/9780679758693

Healthcare Triage: Racial Disparities in Healthcare are Pervasive
https://theincidentaleconomist.com/wordpress/healthcare-triage-racial-disparities-in-healthcare-are-pervasive/

Under The Skin: The Hidden Toll of Racism on American Lives and on Our Nation
https://www.mahoganybooks.com/9780385544887

Using Patient-Reported Outcomes to Improve Health Care Quality
https://www.commonwealthfund.org/publications/newsletter-article/using-patient-reported-outcomes-improve-health-care-quality

BU Center for Anti Racist research
https://www.bu.edu/antiracism-center/the-center/

How to be Antiracist
https://www.mahoganybooks.com/9780593395707

Understanding Microaggressions
https://www.youtube.com/watch?v=e4N50b76cZc

Professionalism: microaggression in the healthcare setting
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7984763/

TEDx Talk: Combating Racism and Place-ism in Medicine
https://www.youtube.com/watch?v=0bnm__UPTRM

Racial Disparities in Healthcare are Pervasive
https://www.youtube.com/watch?v=T2mirYemCmo

Why Race Matters: Women & HIV
https://www.thewellproject.org/hiv-information/why-race-matters-women-and-hiv

VIII. GLOSSARY

Anti-racism
Consciously and actively identifying and opposing racism by changing systems, policies, practices and attitudes, so power is re-distributed and shared equitably. Anti-racism is rooted in action.

BIPOC
An acronym that stands for “Black, Indigenous, and People of Color,” this term was coined in 2013 and highlights the unique experience in America which includes discrimination, oppression, and culture erasure

Health equity
Grounded in social justice, health equity is realized when all people have fair access and opportunity to resources that allow them to achieve their highest level of health regardless of race, sex, sexual orientation, socio-economic status, geographical location, or other societal barriers.

Implicit bias
Unconscious and unintentional bias or stereotype toward a particular individual or group of people. According to the Perception Institute, a fairly commonplace example of this is seen in studies that show that White people will frequently associate criminality with Black people without even realizing they’re doing it.

Institutional racism
A form of racism deeply embedded in systems of power and institutions which uses political, economic, or legal means to perpetuates discrimination and oppression on the basis of race or ethnicity

Intersectionality
The term was coined in 1989 by civil rights activist and scholar Kimberle Crenshaw. It is a concept that explores a person’s multiple identities, ie; race, gender, sexual orientation, class, etc. and how they overlap to create systems of privilege for some while creating systems of discrimination and oppression for others.

Medical mistrust
Lack of trust, suspicion and confidence in the medical system including fear of ill-intent by medical providers and health organizations

Microaggressions
A form of frequent and everyday discrimination that can be intentional or unintentional; specific stereotypical remarks, comments, or questions directed mostly at Black and other people of color.

Power
The ability to control and influence people, circumstances, and outcomes.

Racial equity
A state that is achieved when all people of color (particularly Black people) are treated with humanity, respect, and fairness free of racism and unconscious bias and are able to thrive and achieve success.

Structural Intersectionality
Looks at how political, and economic systems and structures compound creating opportunities for some individuals or groups while creating discrimination and barriers for others

Structural racism
The ways in which societies foster racial discrimination, impacting different reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care and criminal justice that is entrenched in our daily life

Systemic racism
Patterns of behavior, policies or practices within a system and society that was founded on racist principles and practices, and so embedded it is often accepted as normal

White fragility
When white people become angry, uncomfortable, defensive, and even dismissive or unwilling to engage when presented with information and/or conversations of race, racism, and injustice. This is a term coined by Social Justice Educator and author Robin DiAngelo

White privilege
The unearned privilege that only people with White skin possess in our society that affords them advantages, benefits and power

White supremacy
The ideology that White people are inherently superior to all other racial and ethnic groups and should therefore dominate society

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