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HeartBeat

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Healthcare and Race: Confronting Our Past and Finding an Empathetic Path Forward

By Jim Kinsey, VP Engagement Strategies and Continuum of Care Services, Planetree International

While racism is not new in healthcare, the COVID-19 pandemic has lifted the veil in what feels like an earthshaking way. The Centers for Disease Control and Prevention (CDC) provided evidence that, for the period ending June 12, 2020, persons of color, including Black, Hispanic, Asian, and Native Americans, are experiencing more negative outcomes from COVID-19 than are their white counterparts. Specifically:

- Non-Hispanic American Indian or Alaska Native persons have an infection rate approximately 5 times that of non-Hispanic white persons.
- Non-Hispanic Black persons have an infection rate approximately 5 times that of non-Hispanic white persons.
- Hispanic or Latino persons have an infection rate approximately 4 times that of non-Hispanic white persons.

Why this disparity?

CDC data shows that persons of color are at risk of negative outcomes related to social determinants of health at a higher rate than white individuals. According to the Kaiser Family Foundation, social determinants of health include economic stability, neighborhood and physical environment, education, food, community and social context, and access to healthcare. These determinants combined with our history of systemic racism go a long way to explain differential outcomes in COVID-19 and health care in general.

Many people believe that, on the surface, the US healthcare system treats people equally. In interviews with healthcare professionals, most say “I don’t see color” or “I deal with the person, not their color.” On the other hand, when discussing with patients the impact of race, many people of color discuss feeling trivialized, having their symptoms overlooked or judged, and their pain

neither evaluated nor addressed. In a focus group conducted in New York City in 2019 by Planetree International, a Black American Male shared a story of two healthcare encounters related to his chest pain. He talked about the stark contrast between the two encounters that he attributed to differences in how he dressed for each encounter. In the first, he went to the hospital from the basketball court; he was dressed in sweats, tank top, and sneakers. He said, "I was not at my best; I was in pain and looked sloppy." After experiencing chest pain again a week later during church, he returned to the hospital, now in his "Sunday best", and received more extensive and attentive care. For example, on his second visit, he was offered pain meds immediately, while, on his first visit, he was not offered pain meds until staff subjected him to a full evaluation of his (non-existent) history of drug use. In my experience and according to the research conducted on ***implicit bias***, most people don't recognize their bias, and, feeling uncomfortable, prefer to end conversations about it.

"Most people don't recognize their bias, and feeling uncomfortable, prefer to end conversations about it."

When examining the differential impact of the pandemic on persons of color, implicit bias and differential treatment by healthcare personnel is one significant factor. Another powerful factor relates to people's roles and experience in the community. Many people of color work in roles that are deemed "essential" and cause increased exposure. Also, many people work two or more jobs, further exposing them to the virus, its transmission, and negative outcomes.

Why, in a country that presents itself as a world leader, do these differences exist in neighborhoods that are adjacent to each other? The history of "Othering" in the United States sheds light on this question.

"Othering" is a social process defined as,

> *"a set of dynamics, processes, and structures that engender marginality and persistent inequality across any of the full range of human differences based on group identities. Dimensions of othering include, but are not limited to, religion, sex, race, ethnicity, socioeconomic status (class), disability, sexual orientation, and skin tone."*
>
> **(Powell & Menendian, 2016)**

While the term "othering" may be contemporary, the process has historical roots that have contributed to healthcare disparities and negative health outcomes for Native, Asian, Hispanic, and Black Americans. See my perspective on ***The Dynamics of "Othering" That Contribute to Healthcare Disparities***.

We must start somewhere!

Dismantling systemic racism and race-based othering is a complex challenge with no easy answer. While it will take a multi-tiered approach, we must start somewhere and the time is now.

"It's time to change the equation. We need to become allies for positive action."

In *Dissecting systemic racism in health care*, ***RHEA RAJ*** proposes a powerful equation that shows the many factors inherent in systemic racism (*KEVIN MD*; JUNE 18, 2020):

Systemic Racism: The Equation

Lack of access to quality health care + social inequities + higher mortality rates + underrepresentation in health care jobs + genetic explanations for biological inferiority + unimportance of acknowledging racial biases in healthcare professional training + using race as a risk-factor	=	**Systemic Racism in Health Care**

It's time to change the equation. We need to raise awareness about systemic racism in health care and confront racist behaviors, words, policies and practices. We need to take a good hard look at our biases and the impact they can have on patient care. We need to examine and understand the intersections of racism with sexism, ageism, ableism, gender identification, and LGBTQA discrimination. We need to have courageous conversations about actions we can take to ensure health equity. We need to become allies for positive action.

By vigorously applying principles of person-centered care, we can greatly build and strengthen the foundation for equity in healthcare. When we structure our processes to see the whole person, when we care for them in the space that they are in, when we strive to understand their experience, and when we commit to doing everything possible to provide compassionate, top quality care and service to every person without bias, we can be forces for a much better tomorrow. Seeing the whole person challenges us to build relationships with one another and with our coworkers. We in healthcare have a great opportunity to build a new system post-COVID, if and only if we seek to understand the whole person and communicate empathy with everyone.

The convergence of empathy and person-centered care is where the foundation of health equity begins. However, this is not enough. We must also dismantle longstanding structures of systemic racism.

Becoming Allies in Seven Steps

According to Minisha Rudhra in *What Is Performative Allyship? Making Sure Anti-Racism Efforts Are Helpful* (Elle Australia; June 3, 2020), "Performative Allyship" is the practice of words, posts and gestures that do more to promote an individual's own virtuous moral compass than actually helping the causes that they're intending to showcase. In some scenarios, performative allyship can also directly hinder actual activists who are on the ground and doing the sustained, continual work." We must become allies for persons of color, avoiding performative allyship.

Take a look at this excellent resource ***A Guide to Allyship***. This guide identifies and provides examples related to seven distinct steps for becoming an ally of positive action:

1. Take on the struggle as your own.
2. Transfer the benefits of your privilege to those that lack it.
3. Amplify voices of the oppressed before your own.
4. Acknowledge that even through you feel pain, the conversation is not about you.
5. Stand-up, even when you feel scared.
6. Own your mistakes and de-center self.
7. Understand that your education is up to you and no one else.

In Closing

I'll close by posing five questions that I hope you will consider personally and with your team to spark personal insight, constructive conversation, and identification of truly helpful actions to combat systemic racism and the health disparities it feeds.

1. We must critically analyze our processes and services. Can those we serve see themselves engaged in and benefitting from our processes and services, or are we perpetuating the othering that has existed for centuries?
2. Do staff understand how to engage, interact, and connect with individuals?
3. Are our forms, environments, reading matter, scheduling, and communications racially and culturally sensitive?
4. Are we willing to look within to identify implicit bias and do the hard personal work of reversing it?
5. Are we willing to have hard conversations with each other?

These questions are the tip of the iceberg. Complexities are no excuse. We need to commit and be part of solutions. And we need to continue to support our patients and staff in coming together with empathy and partnership to improve equity, our patients' everyday experience and outcomes.

For further reading and source material, see ***references***.

Note: Jim provides regular webinars and interactive programs on Healthcare Disparities and Systemic Racism and many other topics for healthcare organizations across the continuum of care. For information, contact Jim at ***jkinsey@planetree.org*** or 203-732-1365.

QUOTEWORTHY

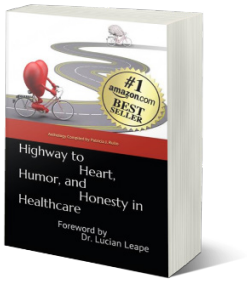
In This Time of COVID

"I am only one, but I am one. I cannot do everything, but I can do something. And I will not let what I cannot do interfere with what I can do."

Edward Everett Hale

I LOVE THIS RESOURCE

Highway to Heart, Humor, and Honesty in Healthcare
by *Patricia Rullo* with Foreward by *Lucian Leape*, MD



Nationally syndicated patient safety radio host, Patricia Rullo, shares interviews with 31 healthcare movers and shakers in this book that was just awarded Amazon's #1 New Release in Hospital Administration, Doctors and Medicine, and Q and A References.

Pat's goal for this book: To add heart, humor and honesty to healthcare, hospital safety and the patient experience with quick-to-read chapters, such as "Chronic Pain—the Invisible Illness", "End of Life Wishes", and "The Person Behind the Patient". The Foreword is written by Dr. Lucian Leape, the physician leader of the patient safety movement in the United States. And, the book opens with "Make Caring Visible," an interview Pat conducted with Language of Caring's very own ***Wendy Leebov***!

Flood Nurses (and all caregivers for that matter) with Appreciation

On the website nurse.org, Angelina Walker shares ***This Compilation of Kind Words Written By Strangers, To Nurses, Will Make You Smile***

Ms. Walker invited friends, family, patients, coworkers, loved ones, and strangers to share words of encouragement for nurses working so hard and selflessly to care for patients with COVID. She received hundreds of responses. Not only can you encourage caregivers to read these love notes. You can also include bits and pieces in newsletters, emails, Twitter feeds, and more….all with the purpose of helping our beloved caregivers feel the gratitude they engender.

STAFF MEETING IDEAS

In light of the pandemic, help your team reflect on and share how their lives have changed and how they are coping. You can engage them in person or virtually! Choose a few questions that spark your curiosity and that you think will spark theirs.

1. What are you grateful for today?
2. Who am I checking in on or connecting within my network today?
3. What expectations of normal am I letting go of?
4. Where and what is a small blessing in this very frustrating situation?
5. What is one thing you are secretly pleased that you don't have to do during these times?

For more great ideas and tips, go to ***Virtual Meeting Check-Ins & Icebreakers During A Pandemic***; Beth's Blog; March 24, 2020

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