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BRIEF REPORT
Training Providers on Issues of Race and Racism Improve Health Care Equity

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Race is an independent factor in health disparity. We developed a training module to address race, racism, and health care. A group of 19 physicians participated in our training module. Anonymous survey results before and after the training were compared using a two-sample *t*-test. The awareness of racism and its impact on care increased in all participants. White participants showed a decrease in self-efficacy in caring for patients of color when compared to white patients. This training was successful in deconstructing white providers' previously held beliefs about race and racism. Pediatr Blood Cancer 2015;62:915–917. © 2015 Wiley Periodicals, Inc.

Key words: health care disparity; race; unconscious bias

INTRODUCTION

Disparities that impact communities of color are reported in the management of many diseases. Blacks receive a lower standard of care than whites when being treated for breast cancer, orthopedic problems, cardiovascular disease, pain, and end of life care among others [1–8]. In 2002, the Institute of Medicine (IOM) released their report Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care, showing that racial disparities exist in health care and that provider bias, stereotyping, and prejudice are contributing factors [9]. Little progress has been made in decreasing racial health inequity over the past decade. A Medline search of "healthcare disparities and race" yields over 1,200 articles since 2003. In many reports, discrepancies held when correcting for insurance and socioeconomic status. The 2013 National Health Healthcare Disparities Report (NHDR) shows that disparities for Americans are not improving and some are becoming worse [10]. For example, blacks and Hispanics received worse care than whites for 40% of the quality measures used in the NHDR. Blacks had worse access to care than whites for 32% of access measures, while Native Americans and Hispanics had worse access to care than whites for 40 and 60% of measures, respectively.

Providers may attempt to reconcile these disparities by citing differences in genetics and socioeconomic status. The sequencing of the human genome, completed in 2003, has proven that there is no scientific basis for race [11]. However, lower socioeconomic status does affect access to care, as being uninsured was the strongest predictor of quality of care in the NHDR [10]. But, when correcting for uninsurance and socioeconomic status, blacks still receive worse care than whites. A 2010 study in our community reported similar results. Blacks and Native Americans in Minneapolis and St. Paul have a significantly shorter life expectancy than whites, even after correcting for socioeconomic status [12]. The leading causes of death were cancer and heart disease. Racial health care inequity is most certainly a multifactorial problem. Barriers to health care equity include the health care system (insurance, funding, white-majority providers), the patient (poor health literacy, fear, mistrust), the community (awareness, advocacy), and health care providers (unconscious bias, attitudes, racism, stereotyping). For example, at our institution the perception of race and racism affecting care was significant [13]. This was seen not only in our sickle cell patients and families of color, but also in our white staff members.

Unconscious biases are normal. They are rooted in stereotyping, a cognitive process where we use social categories to acquire, process, and recall information about people. This process helps us organize complex information. Humans tend to rely on stereotyping when we are busy and under heavy cognitive load [14]. Health care providers often work under conditions that are ripe for stereotyping. Consciously reducing this can be difficult.

The IOM made a series of recommendations for eliminating racial/ethnic health care disparities [9]. These include increasing awareness of racial disparities among providers, implementing cross-cultural education for professionals to include avoiding stereotyping, and pursuing research to identify sources of racial disparities and assess promising intervention strategies. Physicians receive little to no training on the topic of race and racism [15]. The goal of this pilot study was to assess the effectiveness of a training module in improving providers' awareness of race and racism and in affecting providers' comfort in caring for people of color.

METHODS

We developed a training module for health care providers to address issues of race, racism, and whiteness (the overwhelming presence of white centrality and normativity in our society). We incorporated issues germane to health care into previously reported foundational approaches to addressing these issues in training and educational settings [16,17]. Specific information about the training module and assessment tool can be found in Supplemental Appendix I.

Additional Supporting Information may be found in the online version of this article.

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TABLE I. Demographics of Training Participants

	Male	Female
Total (n)	5	14
Mean age (yrs)	32.8	31.6
White (n)	2	8
Asian (n)	3	4
Black (n)	0	2

The training consisted of three 2-hr sessions over a 3-month period. The first addressed race, the second addressed racism, and the third addressed whiteness. Participants completed a five-point Likert scale survey before and after the training. Responses were scored as very low to very high (1–5), or strongly disagree to strongly agree (1–5). The anonymous survey consisted of five statements. Results were compared using a two-sample correlated Student's *t*-test. This study was granted exemption from formal review by our Institutional Review Board.

RESULTS

Nineteen residents completed the training (Table I). Participants reported an average of 76 min of racism training prior to the study. However, when removing one resident with 10 hr of training during college, the average became 47 min. Most (68%) reported no racism training.

The awareness level of issues of racism in the United States increased significantly in all participants, but was most striking in participants of color. The impact of racism on health care in general as well as individuals' ability to deliver care was felt to have increased in all. White participants showed a significant decrease in feeling as effective in caring for patients of color when compared to white patients and they felt less equipped to care for patients of color following the training (Table II).

DISCUSSION

Race affects health care delivery and is an independent factor in health care disparities. At our institution, physicians received an average of 52 min of racism training [15]. This was no better in our younger cohort of residents. Training on issues of race and racism is not consistently occurring at any level of physician training including continuing medical education. As a result, awareness of racism and its impact on healthcare delivery remains low. A national survey found that 29% of physicians (and only 4% of white physicians) felt that patients are treated unfairly based on race, while 47% of the public felt this way [18,19]. Our previous report showed similar results. Half of patients/families saw race as affecting health care, but less than one-third of staff perceived this [13]. After completion of our module 100% of physicians either agreed or strongly agreed that racism affects health care delivery.

Following our training, awareness of racism increased significantly in all participants. Interestingly, this was more striking in the residents of color. Most were recent immigrants. As such, they may have a different awareness of and experience with racism in the United States when compared to multigenerational Americans of color. This training was successful in deconstructing white providers' beliefs about race and racism, as feelings of effectiveness in delivering equitable care went down significantly in this group. This is the first step in working on our own understanding of racism and unconscious biases [14]. This was a small cohort, but this work can be done in all areas of health care and in any institution. Further study is warranted to define and refine the best training methods.

Finally, we would like to underscore that while the presence of more significant training for providers regarding racism may help to lessen the racial disparities in health care, the opposite is also true. The absence of substantial training on issues of race and racism will serve to perpetuate and potentially exacerbate racial health care disparities [20]. Until racial issues are honestly addressed by the health care team, it is unlikely that we will see significant improvements in racial health care disparities for Americans.

TABLE II. Survey Results

Statement	Pre (95% CI)	Post (95% CI)	*P*-value
My awareness level of issues of racism in the United State is			
All	3.42 (3.05–3.79)	3.89 (3.51–4.28)	0.018
White	3.40 (3.04–3.76)	3.40 (2.91–3.89)	0.5
POC	3.44 (2.66–4.22)	4.44 (4.04–4.84)	0.033
The impact of racism on health care delivery is			
All	3.89 (3.62–4.16)	4.52 (4.28–4.76)	0.001
White	4.00 (3.67–4.33)	4.50 (4.13–4.87)	0.018
POC	3.78 (3.21–4.29)	4.55 (4.15–4.95)	0.011
I am as effective at caring for white patients as I am at caring for patients of color			
All	4.10 (3.71–4.48)	3.10 (2.54–3.65)	0.001
White	4.00 (3.41–4.58)	2.50 (1.66–3.34)	0.004
POC	4.22 (3.58–4.86)	3.78 (3.27–4.29)	0.084
I feel well equipped to care for patients of color			
All	3.84 (3.43–4.24)	3.36 (2.99–3.72)	0.012
White	3.70 (3.02–4.38)	3.00 (2.41–3.58)	0.012
POC	4.00 (3.45–4.54)	3.78 (3.44–4.12)	0.223
The impact of racism on my ability to deliver quality care is			
All	2.58 (2.04–3.12)	3.58 (3.03–4.12)	0.005
White	2.70 (1.94–3.45)	3.90 (3.37–4.43)	0.006
POC	2.44 (1.49–3.39)	3.22 (2.14–4.29)	0.121

Responses were scored as very low to very high (1–5), or strongly disagree to strongly agree (1–5). POC, people of color; CI, Confidence Interval.

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