

Q: Will we be hosting more of these?

A: Yes; updates will be posted on the [website](https://www.utsouthwestern.edu/equity). (<https://www.utsouthwestern.edu/equity>)

Questions addressed by Dr. Dale Okorodudu

Q: Do you think it is possible for someone who is not from a particular culture to truly be free of implicit biases of that culture? As a person who is not black, I completed the Race IAT and was in the 2% of people who have a more favorable association of African Americans compared to European Americans. Yet, I feel there is a lot more that I can do. Thoughts?

A: I believe everybody has positive and negative biases of every race (their own included). These biases serve as a survival mechanism in a sense. People live and act on patterns. These patterns build biases. It is important to note that on the Race IAT it pertains to more favorable biases. That is not the same as having no bias.

Q: How do you process getting 'the look' from your faculty colleagues, nurses, other staff and medical students at every interaction? Institutionally, this is compounded by being foreign born AND religious, yet fully competent/demonstrably accomplished as a physician, but cast off invisible and questioned at every move. I strive to be a human racist and follow my calling in spite of this reality.

A: Unfortunately, sometimes the easiest way to stop the questioning is to simply become excellent at your craft so they know not to question you in a negative way. There is nothing inherently wrong with questioning someone, especially in the field of medicine. The problem comes when the questioning is based on biases. In such situations, challenge that bias by being the best doctor you can be. People can say whatever they want about someone based on the way they look, but your work will ultimately speak for itself. The challenge is getting over the imposter syndrome and realizing that your MD/DO degree is worth the same as everyone else's.

Q: Can Dr. Okorodudu also share links to his books, including the kids' series?

A: I do not promote my books via the UT Southwestern system so the individual asking would need to search on their own, or someone else would need to share that with them.

Q: Educate me- African American or Black? How offensive is it? I did not grow up here and I feel very conflicted about how I'm perceived when I say Black. I feel that since George Floyd its become more open to say "black". I feel African American indicates the cultural and racial upbringing vs someone Black who was not born or raised here therefore does not necessarily carry the experiences of segregation and inequalities that an American may have

A: No great answer for this. Different people feel different when called one or the other. In general, I believe black is the safer term. Black technically should pertain more to race, whereas African American should pertain more to a culture.

Q: I'm a white physician. I've read voraciously on these subjects - from slavery to reconstruction to Jim Crow to war on drugs to southern strategy to mass incarceration. Most consider me a severe liberal, but I feel a sense of guilt and disgust that I'm racially from the group that imposed this ugly (and ongoing history). I'm fearful of even broaching this topic with African American colleagues, because I fear they'll view me as someone seeking their approval while never remotely understanding the world they've lived. Any advice?

A:-Preface your conversations by letting them know you are trying to learn and have a deep interest in the topic. You want to be part of the solution. Do not feel guilty.

Q: How do you deal with your accomplishments being discredited and not being given the opportunity to learn in the workplace, when you know that you are not doing anything wrong? in fact, you are doing everything right?

A: This is very difficult. Step 1, keep excelling and being excellent in your craft. Step 2, get a mentor who can give you honest feedback and advice from an outside perspective. We can't see our blind spots so it's important to have a trusted individual there to tell you. Step 3, get a sponsor. This person will speak up for you, make sure others know and see your good works, and be your biggest advocate. They'll fight the fights that sometimes you may not be able to. With the right team around you, people will take note of "step 1".

Responses provided by Dr. Elizabeth Paulk

Q. Do you feel that electronic records are perpetuating these types of predetermined opinions? "Drug seeking" "refused HD" seems to be easy to copy and paste and then follows them around.

A: The short answer is yes, and for two different reasons. The first is that subjective input (e.g., "drug seeking") can easily be a function of either conscious or unconscious bias and is all too easily cut and pasted forward. This is unhappily not restricted to racial bias – other factual errors are easily propagated in the EMR because it is so easy to just keep pushing something on down the road. Note bloat brings in a lot of unnecessary data and rather than a carefully considered document clarifying medical decision-making we are often left with a list of random findings and marginally related bullet points. Ways to reduce this bias on an individual level would be to remember that the "Subjective" part of a SOAP note IS subjective, taking the words of previous authors with a grain of salt, and then resisting the temptation to cut and paste and thoughtfully composing a document that states the facts in a way that promotes the health of the patient. The second is that many apparently "objective" elements are also biased. Nature (Nature 574, 608-609 (2019)) contains a commentary about a biased risk-assessment algorithm designed to help identify patients with multiple medical conditions who would benefit from referrals for additional care. The author states, "...black people had to be sicker than white people before being referred for additional help. Only 17.7% of patients that the algorithm assigned to receive extra care were black. The researchers calculate that the proportion would be 46.5% if the algorithm were unbiased." The problem is that the algorithms also represent biases that are present in society. This could be reduced by ensuring diversity among those designing the algorithms, and ensuring that designers are aware of the social and historical context of their work, according to Ruha Benjamin, author of Race After Technology (2019) and a sociologist at Princeton University in New Jersey.

Q: This is a time when I would have preferred to hear from a panel of all minority voices instead of being lectured at by two different white women. Again, this is not to be disrespectful of these women, but I don't feel they gave any information that even someone with a passing interest in this subject would not have been aware of.

A: Thank you for being willing to share your thoughts about this. To be perfectly frank, I was deeply honored but surprised to have been asked to participate in the panel, and more than a little uncomfortable speaking on a subject about which I do not have a lived experience. I am not an expert, and would also agree that the information I shared barely scraped the surface on the topic of cultural humility. While I have had a life-long passion for social justice, I am relatively new on my formal journey to becoming an anti-racist. After lengthy reflection, and speculation about the reason I might have been asked to participate, I will share these thoughts, for what it is worth. This was a very broad audience. There are a number of very sophisticated participants, including many people of color, whose lived experience and study of structural racism and implicit bias is beyond what I will ever be able to achieve, and for whom having to listen to my rudimentary remarks was not enlightening. I imagine that it felt as though the time would have been better spent listening to someone (likely present in the audience) who could address the issue first hand, and

provide more sophisticated analysis of how clinicians can provide more culturally appropriate care. However, there were also people in the audience who have not even realized yet that they are part of the problem. A shockingly large percentage of white physicians, particularly white male physicians, DO NOT BELIEVE that patients are treated differently on the basis of race. According to the Kaiser Family Foundation, 77% of black physicians endorse the view that the health care system is very or somewhat often biased against people based on race but only 25% of white physicians agreed (<http://www.kff.org/minorityhealth/20020321a-index.cfm>). If they do not even believe that there is a difference in how patients are treated, I worry that they are not going to be able to internalize sophisticated messages about how to reduce implicit bias. My hope was that by participating in the panel, I might be able to get the attention, not of people who were already aware of the issues, but of those who look like me and are NOT. If white people are not willing to step up and convince other white people to be part of the solution, the problem is going to take much longer to get better. I recognize that there will be some on both sides who do not want to hear what I have to say, but that is a very small burden for me to bear if it helps move the conversation forward.

Q: As role models, how should we deal with explicit racism/bias in the exam room?

A: There are multiple contexts in which this can occur, the most harmful of which is when it results in discrimination against a trainee. A 2016 article in Academic Medicine outlines a four-step approach for faculty as well suggested faculty development activities. In an emergency, generally patient care has to move forward, and issues of bias or discrimination can be addressed later. Otherwise, however, there are several possible approaches to take with the patient/family as outlined in the table on the right. There are three points that I think should be particularly emphasized. The first is that silence on the part of those who are not targets of the discrimination is not an acceptable response. It is not deemed appropriate to address the behavior with the patient directly for whatever reason (the patient is psychotic, for example), providing support and reassurance to the trainee is essential. It is better to say something well-intentioned (even if sub-optimal) that ignore the problem. Discriminatory comments are uncomfortable to address, but it is incumbent upon the person with the most power to call it out. Second, issues of racism and discrimination should be handled in the same way we address problems with safety – total transparency, and an attitude of openness to learning more. Just as anyone on the team needs to be able to “stop the line” for safety, the same should be true about discrimination. It is often the most junior members of the team who can see it the most clearly, and we need to them to be free to call it out. Finally, there has to be a strong institutional response to back up an individual faculty position. Each institution needs to have policies in place that prevent patients, no matter how wealthy or connected they may be, to discriminate against providers based on features that have nothing to do with their qualifications.

Q: How do we even highlight that systematic racism exists for those that deny its existence? Even in healthcare

A: Until we start treating the investigation of structural racism as the medical epidemic that it is, it will be hard to convince skeptics of its existence. Up until now, social determinants of health and structural racism have largely been considered, “soft science” and at many institutions not seen as the province of physicians or scientists. As such it was easy to dismiss it as something imaginary. There is an excellent review article called, Racism and Health: Evidence and Needed Research (Annu Rev Public Health. 2019 Apr 1;40:105-125) that “ provides an overview of the evidence linking the primary domains of racism-structural racism, cultural racism, and individual-level discrimination-to mental and physical health outcomes.” We need to be publicizing this science at grand rounds and journal clubs. More to the point, though, we need to acknowledge that at a research powerhouse like UT Southwestern, we should be studying how structural racism affects outcomes in our own systems and how we can help mitigate those disparities.

Responses provided by Dr. Jaclyn Albin

Q: Clinician Observations about Telehealth and Racial Bias

A: For many health professionals, the pandemic necessitated rapid acclimation to telehealth. The process has been a learning curve, with many bumps along the way. From a patient access standpoint, the true impact remains to be seen and should certainly be studied. However, it appears to introduce both new potential for racial bias (especially in the context of patients with existing socioeconomic barriers) while simultaneously presenting new solutions to barriers to care.

Initially, technology barriers became apparent, including patient access to devices enabling video visits. For patients who do have smartphones that include webcam capability, finding a personal or private space during a pandemic is additionally challenging, especially if a patient may not feel safe in their home environment but cannot privately share this during a virtual visit. Language barriers can further complicate virtual care and don't always include easy modalities for high-quality interpretive services. Additional barriers include challenges building trust, especially if a patient seeks care from a new physician or other provider.

On a positive note, many health professionals have reported improved access for their patients who previously struggled with barriers to care. Removal of transportation and need for large amounts of time to travel to and attend appointments make access easier for many patients. In fact, the Medical Director of the Parkland Center for Internal Medicine recently presented observations and early data at Parkland's Medicine Performance Improvement Committee in May of 2020. Early analysis of pandemic care found that patient care volumes done virtually (notably, these were mostly telephone-only visits) increased above prior clinic volumes, and there was a trend toward reduced hospital and ED visits for the same patient population established in this large primary care clinic. In many instances, patients that struggled to attend appointments over prior years successfully received care for the first time in 1-2 years. Patients also expressed very high levels of gratitude and satisfaction with care, especially regarding the time spent with them on the phone being more than expected. Resident physicians noted the ease of confirming medications when patients could check their pill bottles in real time, and access to relatives and caregivers was easier than ever.

In summary, much remains to be seen and this requires significant further study, but virtual care may be a promising option in the elimination of some barriers while other new barriers will need to be carefully monitored.

Q: Talking to Kids about Racism (How? When? Navigating sensitivity?)

A: What an important question! To truly change the deeply structural systems that uphold racism in the United States, we need the next generation to grow up with awareness, ownership, and a sense of justice about the problem. Instilling this feels daunting and confusing to many parents.

Children often develop racial identity, stereotypes, and perspectives before they even begin school. Exposure to books, toys, and conversation that celebrates diverse races and cultures should begin at birth. The American Academy of Pediatrics provides basic guidance here (in English and Spanish) <https://www.healthychildren.org/English/healthy-living/emotional-wellness/Building-Resilience/Pages/Talking-to-Children-about-Racism.aspx>

As physicians, it's critical to recognize the health effects of racism and thus take action as we would for any public health threat. This article summarizes the impact of racism on child and adolescent health.

<https://pediatrics.aappublications.org/content/144/2/e20191765>

Use of child-friendly media or books can be a great tool to promote conversation. The Office of Faculty Diversity and Development will share pediatric book resources routinely beginning later this summer. Book topics can range from teaching about Black history, highlighting People of Color as lead characters in a story, or teaching key principles that promote racial equity. There are some great suggestions by age here https://booksforlittles.com/racial-diversity/?fbclid=IwAR2cPiKEcJ54QDf6No38ZQHf6BUN27TDZsNUxJ736ksIX8_EZLpfcTXocl

Movies may also promote conversation with elementary-aged (or older) children including ones such as “Akeelah and the Bee,” “Remember the Titans,” and “Hidden Figures.” Each of these reveal historical and present-day themes worth discussing. It’s important to not just watch but to promote open conversation that it’s not only okay to talk about race but that we must.

There are many resources widely available on the internet, as well. This brief video from a kindergarten teacher demonstrates an excellent approach using language and a book that makes sense to young children.

<https://www.youtube.com/watch?v=1vHymutysWU&feature=youtu.be>

Another great resource is this PBS podcast supporting adult-led conversations.

https://www.pbslearningmedia.org/resource/talking-to-children-authentically-about-race/virtual-professional-learning-series/?fbclid=IwAR1NxfkQFeoq1Bfs281bnjVHem6jJ75Pqn_6T_wR3HXdQPR-zNRz2Y4wqTg#.XvX_YmpKjEY

For sensitive children, it’s important to be attentive and present in conversation. Minimizing their exposure to the filter of the news and instead having a discussion is a good approach. Sensitive children may need to have smaller doses over time to process and apply action (instead of potentially becoming too overwhelmed by emotion to have a productive response), but it’s helpful to keep in mind that feeling pain for others may be the very thing that empowers them to become leaders and change agents.

Here’s the punchline – start early and remember that young children don’t initially have the messy, complicated feelings that adults do when talking about race.

Q: Panel Diversity – should white people be there?

A: Many important things in academic medicine - such as education and mentorship of the next generation of health professionals - take enormous amounts of time, energy, conversation, and passion. But these same important things often don’t align with what pays the bills or gets the promotion, so many focus on the things that typically generate more support and “value” in academic medicine (successful grant writing, impactful research, and clinical care, to highlight a few).

Dedicating time to some of the most critical things (like mentorship of trainees), therefore, often falls to the few. Diversity work very similarly exists in this realm, but there are even fewer faculty aware of and willing to champion these efforts than there are tireless medical educators, leaving enormously time-consuming work to a small, often exhausted cohort of dedicated diversity leaders. Increasingly, many academic minority voices across the US reflect frustration that diversity work within academic medicine is routinely expected of minorities. The very ones suffering the inequities of the system are the ones called upon to devote their time and energy to work that is hard, slow in progress, and rarely valued (or, at best, not valued commiserate to the level of investment). Minority faculty sometimes share frustration that their career vision to pursue a particular area of research is redirected to diversity, and they often feel their opportunities to pursue other passions become limited. Assuming support will be most likely found with faculty that look like them, medical students and other trainees also seek mentoring from minority faculty – the same ones often asked to repeatedly devote time to other diversity efforts.

Thus, the time has been long overdue for more people – especially White people - to channel their passion to advancing the equity efforts, even when they are not the ones that directly benefit (although everyone eventually benefits when diverse voices and perspectives design equitable systems, it may not initially seem that way to many). Instead of expecting minority faculty to generate all the energy and momentum, their uncomfortable but needed colleagues must own their role in this work. The more diverse and collaborative the teams driving these efforts, the more impactful the results.

Sadly, there are still many within academic medicine (and certainly, the community), who struggle to hear and receive the voices and stories of bias experienced by Black people and other People of Color. In fact, recent racial tension has shed disturbing light on the reality that some White individuals find it easier – and more comfortable – to listen to the voices of other White people on the issue of race. While this leads to a very incomplete narrative, it should not be the responsibility of those who are marginalized to prepare and deliver all the education that is needed to increase awareness and engagement to the level that is desperately needed for widespread change. As such, including the voices of passionate White health professionals willing to dedicate time and resources remains vital to promote both bridge-building (especially for the White people struggling to embrace realities previously not recognized by them) and to re-energize the tireless effort of minority colleagues.

Q: Race as a patient identifier

A: This is an incredibly important and thoughtful question – these are the kinds of questions that will allow us to uncover and work to change sources of unconscious bias permeating education and clinical practice. While race is one of many important sociodemographic identities, it should be carefully integrated into the overall understanding of a patient’s life and background in such a way that minimizes introduction of bias.

The AMA Journal of Ethics provides a brief case and enlightening commentary here: <https://journalofethics.ama-assn.org/article/mention-patients-race-clinical-presentations/2014-06>

Academic Medicine published an incredibly helpful article entitled “Addressing Race, Culture, and Structural Inequality in Medical Education: A Guide for Revising Teaching Cases” which can be found here:

https://journals.lww.com/academicmedicine/fulltext/2019/04000/addressing_race_culture_and_structural.36.aspx

The article above includes a tool to use as a guide in case presentation and teaching case modification. There are clear examples and suggestions for case modification which can be applied to existing cases and can guide approach to case presentations. The supplemental guide affiliated with the above article is here: https://cdn-links.lww.com/permalink/acadmed/a/acadmed_2019_02_27_chretien_acadmed-d-18-00624_sdc1.pdf

Responses provided by Dr. Shawna Nesbitt

Q: How can I address cultural bias professionally and respectfully within the work environment?

A: Addressing cultural bias in the workplace can be done in a few ways: First, it is important to help the team to see that everyone has bias and importantly to point out that having implicit bias does not mean you are a racist. This can be done with group workshop/ discussions. Second is to look at the processes/practices in the work environment that may perpetuate cultural/racial bias and address them. Opening the conversation with the group is a worthwhile task that can be eye opening and move the group forward.

Q: 2 unrelated questions: Do medical education and training have elements of built in structural unfairness with respect to race? If so, how can we dismantle them?

A: Yes, I believe there are some built in structural elements of racial bias. This begins with the lack of discussion of the effects of race as a social determinant of health and the effects of race on medical care. This is an important discussion which fuels an equitable delivery of healthcare in the future but also helps minority students to feel “seen and heard” on the topics that they are often very interested in. The inclusion of these topics in education for everyone will remove the task for minority students to bear the duty to educate everyone else on culture and healthcare disparities.

Q: Is it really implicit bias or just cultural ignorance as every race and ethnicity has their own culture? America has become more diverse now where immigrants brought their own values, culture and heritage. To others who don't understand, the immigrant's culture and heritage seem "weird." But immigrants and younger generation have a hard time adapting to this changing world. Children of immigrants and other people of color are torn between their own individualities and their own race. They see themselves as Americans but some Americans see them as "outsiders." Some Americans are probably not prejudicial or not biased but they rather want to hang out in an "exclusive society" - their own kind - in educational level, social status, their own race. Other Americans are "Inclusive- they welcome everybody from all walks of life. I guess, this is just the reality of life. I see America now as more exclusive than inclusive- and I wonder if politics has something to do with this - dividing the people as conservatives against liberals, Republicans vs. Democrats, Pro-life vs Pro-choice; and one tends to avoid people who don't agree with his/her ideology and politics. America needs to be more understanding of one another- now more than ever. 'Just my opinion as I see America now-

A: Thanks for your comments. While it is definitely true that immigrants have unique and challenging tasks to integrate into American culture, and the US has become more diverse which is a healthy transition for the culture. However, the history of African Americans is unlike any other group in this country. The tragic history of enslavement on American soil with exclusion of recognition of their contribution to building the foundation and wealth of this country creates a different divide compared to other races. It is more important than ever that we work together to eliminate the institutionalized racism across all aspects of our society. This will benefit all of its members.

Q: What will UTSW do to also be inclusive of other minorities such as people with disabilities (PWD)? For example, accessible education/teaching for PWD in healthcare or increasing accessibility on campus.

A: This is a great question. We have made accommodations for students with physical disabilities in the past and we do not discriminate on admission for students with disabilities. This is done on a case by case basis.

Q: On the video some instances such as the elevator door closing why assume that was done on purpose because the person was black? A lot of times I find myself in a situation that I'm afraid will be taken wrong but I don't mean anything racist or implicitly biased. How do we act in a way that attitudes that could occur towards a white person but just happened to be a black person are not perceived as a micro aggression?

A: It is true that there are situations occur that are not intended to be racist but are perceived to exemplify bias. The best step is to examine oneself with IAT or other exercises to understand your own influences in decision making. This is an important step to help you to see which of your behaviors reflect bias. The second point to remember is that the long term effects of societal racism has led to limited expectations and guardedness on the part of people of color. So, it may not be your intention, but the cumulative effects of multiple experiences leads to differing perspectives on events.