"Racial Bias…I'm Not Sure if It Has Affected My Practice": a Qualitative Exploration of Racial Bias in Team-Based Primary Care

J Gen Intern Med 35(11):3395–7
DOI: 10.1007/s11606-020-06219-w

INTRODUCTION

In summer 2020, COVID-19 laid bare social determinants contributing to disproportional African-American death rates,[1] and #BlackLivesMatter protests decried police brutality and systematic racism that continue to exert daily pressure on African American lives.[2] These twin forces resulted in renewed commitment to health equity and criminal justice reform within the medical community.[3]

Microaggressions including "microinvalidation"—the denial of racialized experiences of people of color—may more profoundly impact racial anger, frustration, and self-confidence than overt forms of racism.[4] Furthermore, denial of racism prevents team members from realizing and confronting their role in causing traumatic reactions or perpetuating disparities.[5]

METHODS

As part of a 3-year mixed-methods evaluation of a novel team-based care (TBC) primary care model, Primary Care 2.0,[6] we added questions on rotating topics to standard quarterly implementation-focused interviews (standard interview guide and rotating topic questions available upon request). Our implementation science-informed evaluation actively sought to explore the impact of context, in this case national conversations about racial bias, since context is a known factor in successful implementation.

Items of interest explored the potential role of racism and bias in TBC, effectively establishing a local baseline of reported #BlackLivesMatter impact, with this prompt: "How has #BlackLivesMatter and the national conversation about racial bias changed the way you interact with patients or people at work, if at all?"

For this analysis we examined interview transcripts ($n = 26$, Table 1). A qualitative expert (CBJ) and two physicians (MS, NKT) collaboratively coded responses for themes; co-authors reached interpretive consensus with iterative discussions.

Received June 13, 2020
Accepted September 3, 2020
Published online September 15, 2020

RESULTS

We identified 7 major themes around two divergent foci: lack of acknowledgement of the role of racial bias in healthcare, and strategies to address racism (Table 2). Nullifying themes included *no impact* ($n = 13$), *denial* ($n = 7$), and *no awareness* ($n = 5$). Strategies revolved around *communication* ($n = 6$), *patient care adaptations* ($n = 3$), and *diversity in TBC* ($n = 2$). Specifically, participants discussed the following: acknowledging previous negative healthcare experiences by asking new patients "How has healthcare been for you? Any barriers in the past?"; creating safe TBC cultures that encourage honest communication and support team discussions about racism; becoming aware of providers' own assumptions and leveraging that information to intentionally resist dismissing complaints from patients of color.

DISCUSSION

Our interviews demonstrated a pre-2020 baseline of poor acknowledgment of the role of racism in interactions among our care team members and with patients. It is unknown whether these findings are unique to our time/setting, but they reflect previous research documenting a state of widespread

Table 1 Participants from Interviews Within Five Academic Primary Care Clinics—Three Community-Embedded Clinics and Two Hospital-Adjacent Clinics—in Santa Clara County, CA (census population estimates as of July 1, 2019: total 1,927,852; Non-Latinx White 31.0%; African American 2.8%; Native American or Alaska Native 1.2%; Asian 38.3%; Native Hawaiian and Pacific Islander 0.5%; Latinx 25.3%; Multiple Races 4.1%)

Total	**25**
Role	
Management	4
Clinician (MD and advance practice provider nurse practitioner or physician assistant)	11
Medical assistant	10
Gender	
Female	22
Male	3
Race/ethnicity	
Non-White	14
White	11

Table 2 Themes/Strategies and Exemplar Quotes from Participant Responses to the Question: "How Has #BlackLivesMatters and the National Conversation About Racial Bias Changed the Way You Interact with Patients or People at Work if at All?" (Excerpted from Primary Care 2.0 Evaluation*)

Themes and responses	*n**	Example quotes
No impact	13	• "No." • "You know, I really, it doesn't affect me at all." • "Racial bias. Um, I don't—I'm not sure if it has affected my practice"
Denial	7	• Denial of personal impact: "I treat everybody the same. We're all human, we're all the same." • Denial of professional impact: "I'm very professional" • Denial of ability to change system (learned helplessness): "We have these tech company executives or engineers [who] are very equipped and health literate. You feel a little bad because I don't think the quality of care you provide is different [for lower socio-economic status patients or patients of color], but I think what you can offer the patient is different... Quality of care is not different, but the type of care you can offer can be different... It's a little hard to reconcile…that's the problem with healthcare here." • Denial of patient experience by actively shutting down conversations with patients: "Try to keep the conversation on like what the main concern is. We'll be like, 'oh really?' and then I just like try to distract them and be like, 'Oh Al, your blood pressure was this. Oh you're due for this.' And then try to guide them away from that. That way we don't get too involved, 'cause then if you get involved you're talking more about something you're not supposed to be talking about. But try not to engage too much, that's what I try to do. Distract them."
Positive communication strategies	6	• Conducting conversations with new patients about previous healthcare experiences: "I keep that [the impact of racism on healthcare access] in the back of my mind so asking questions like, 'How was previous healthcare for you. Any barriers in the past?' Just to make sure that they feel like they can come here and have the access to the care that they need." • Using open-ended questions to gather whole-person patient information: "It also reminds me to be more open-ended with my questions instead of making [assumptions] ... being aware if I'm starting to ask a question that might be leading in terms of what they do or what they might think about something to try and step back and be more open ended." • Setting expectations with patients to avoid potential triggers: "With patients especially, even those that we've befriended and we have long relationships with, just still being very careful with what you say… Just so it's not awkward, I always [say], 'In this sheet, there are a few questions that they [always] ask'…" • Conducting staff discussions about racism: "…And it's funny cause it's not a conversation I've had with my staff at all, but maybe it would be a good conversation to have... Just in general about all these topics." • Creating a culture of psychological safety for honest communication: "I believe that people, the team, staff, patients, and providers, have the courage and feel the right to voice their perceptions and views of what's going on, so I would have to believe that there has to be some aspect of [#BlackLivesMatter] that has brought that to the highline and has encouraged people… I know that it had a very positive affect, so… But that was two years ago, wasn't it?"
No awareness	5	• "I don't even turn [the news] on. I don't look at it. I don't read a feed. I couldn't tell you about what's going on in the world today... Maybe that's my coping mechanism." • "I actually don't even watch the news at all, cause I think it's just not even beneficial to my life."
Already aware and so no change in practice	4	• "I think we're trying, and I don't think that there's anything different that we're doing." • "Yeah so for me personally I think I've always tried to practice keeping that in mind. I know a lot personally being a person of color, just how that can affect healthcare and access."
Changes to patient care	3	• Assisting patients with insurance navigation: "We've had a lot of difficulties with Medi-Cal, insurance-wise, and our staff is so committed to helping those patients… We still don't quite understand it. Medi-Cal's rules are changing, but we have a lot of Medi-Cal patients who have insurance questions that they're not getting answers for. But our staff is really committed to helping them and understanding what they have." • Providers becoming aware of their own assumptions about patients: "I really try to check my assumptions about who people are and what they do. Yeah. I'm not sure it's changed the conversation amongst staff members, but I'm more cognizant if I make an assumption about someone. Do I really have any facts for that? Where did that assumption come from?... it's an internal reflection." • Resist dismissing patient complaints: "I don't know if this is #BlackLivesMatter necessarily or race-related necessarily, but [I try to be] less likely to dismiss complaints. Like being aware that if this [patient] was someone of a different gender or a different race, would I respond differently to this particular complaint?... even providers of color [can] make those same assumptions."
Diversity as need and asset	2	• Diversity of staff for team based care as an asset and a way to connect with patients: "... We see the huge variety of patients…[and] because we have a pretty multicultural staff, we are [able to connect] …speaking their language, understanding them, some of the customs." • Diversity needs in recruitment for faculty, but success with recruiting diverse staff: "We've tried to stay abreast about recruiting and representing minorities, but …we need to be a lot better. I think from the standpoint of recruiting we need to do a lot better in order to enhance our [faculty] diversity. Our staff is incredibly diverse."

**Complementing qualitative interviews focused on implementation science outcomes and emergent topics such as racial bias, other evaluation activities were framed around the Quadruple Aim, and included tracking patient outcomes and satisfaction through HEDIS metrics and Press Ganey patient satisfaction results, assessing cost/value based on salaries for TBC team members, and biannual wellness Professional Fulfillment Index surveys for all staff and providers*

denial of local impacts of racism in large system settings, which can include healthcare and academia.[4] Denial of racism may be a protective learned mechanism, but it can also perpetuate silence and inaction.[5] Denial, overt racism, and covert microaggression/microinvalidation can threaten high-performing healthcare teams.[4, 5]

Responses to racism that promote racial justice, such as #BlackLivesMatter, may be particularly relevant to team-

based primary care, which brings together interdisciplinary healthcare staff with diverse training and backgrounds. The American Medical Association's code of conduct emphasizes "[care] for the health of the community" and individual patient-provider relationships "based on trust." It additionally requires "patients' welfare above the physician's own self-interest". Our respondents' specific anti-racism strategies align with this code, but may be uncomfortable for some team members. Suggested communication approaches include active listening and checking in with colleagues and patients about their experiences of racism; explicitly acknowledging patients' previous potentially negative interactions with healthcare; and staying informed of current events. Additional anti-racism strategies alluded to, but not overtly highlighted in our data, include promoting national-level change for equitable care regardless of race or other factors.

This study is limited by its single-institution setting; we attempted to increase applicability by sampling multiple individual clinics and various level of staff.

#BlackLivesMatter and COVID-19 disparities dominated US media in early summer 2020, potentially raising awareness around racism impacts in both the national collective awareness and local clinic settings. This awareness may afford team-based care a valuable window of opportunity to engage in individual reflection and group work around the legacy of racism. We hope this manuscript and others provide clues for individual and team behavior change, especially since our data demonstrate specific ways healthcare providers and staff can interact to potentially reduce racism's negative impact on health and healthcare.

Cati Brown-Johnson, PhD[1]
Megha Shankar, MD[2,3]
Nicolas Kenji Taylor, MD MSc[1,4,5]
Nadia Safaeinili, MPH[1]
Jonathan G. Shaw, MD MS[1]
Marcy Winget, PhD[1]
Megan Mahoney, MD[1]

[1]Division of Primary Care and Population Health, Stanford University School of Medicine, Stanford, CA, USA
[2]VA Palo Alto Health Care System Center for Innovation to Implementation (Ci2i), Menlo Park, CA, USA
[3]Stanford University Center for Primary Care and Outcomes Research (PCOR) and Center for Health Policy (CHP), Stanford, CA, USA
[4]Roots Community Health Center, Oakland, CA, USA
[5]Intermountain Health Care, Intermountain Health Delivery Institute, Salt Lake City, UT, USA

Corresponding Author: *Cati Brown-Johnson, PhD; Division of Primary Care and Population Health, Stanford University School of Medicine, Stanford, CA, USA (e-mail: catibj@stanford.edu).*

Compliance with ethical standards:

Conflict of interest: *The authors have no competing interests to declare.*

REFERENCES

1. **Hooper MW, Nápoles AM, Pérez-Stable EJ**. COVID-19 and Racial/Ethnic Disparities. JAMA. Published online May 11, 2020. doi:https://doi.org/10.1001/jama.2020.8598
2. **Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT**. Structural racism and health inequities in the USA: evidence and interventions. Lancet 2017;389(10077):1453-1463. doi:https://doi.org/10.1016/S0140-6736(17)30569-X
3. Police brutality must stop | American Medical Association. Accessed June 8, 2020. https://www.ama-assn.org/about/leadership/police-brutality-must-stop
4. **Solorzano D, Ceja M, Yosso T**. Critical Race Theory, Racial Microaggressions, and Campus Racial Climate: The Experiences of African American College Students. J Negro Educ 2000;69:60-73.
5. **Sue DW, Capodilupo CM, Torino GC, et al.** Racial microaggressions in everyday life: Implications for clinical practice. Am Psychol 2007;62(4):271-286. doi:https://doi.org/10.1037/0003-066X.62.4.271
6. **Brown-Johnson CG, Chan GK, Winget M, et al.** Primary Care 2.0: Design of a Transformational Team-Based Practice Model to Meet the Quadruple Aim. Am J Med Qual 2019;34(4):339-347. doi:https://doi.org/10.1177/1062860618802365