

# WHY CONVERSATIONS ABOUT RACE MATTER

## EFFECTS OF CONVERSATION ON PATIENT CARE

The health and well-being of infants, children, adolescents, young adults, and their families are negatively impacted by racism embedded within structures, institutions, relationships, and environments. Relatedly, bias and discrimination, as contributors to racism, perpetuate disparities in health care access, use, and outcomes among marginalized populations. In the overall health and well-being of children and their families, pediatric health care professionals play an important role and therefore must consider the various influences on patients' health. **Addressing the needs and concerns of patients and families is the first priority for all health supervision visits.**

The following information can help pediatric health care professionals **effectively address and begin to mitigate** the negative impact of racism, bias, and discrimination on the physical and mental health and well-being of their patients and families within the context of a health supervision visit in any health care setting. Please note that a group of thought leaders, guiding efforts to address racial and ethnic disparities in health and health care, curated these suggestions.

Interactions with patients and families around race and racism are complex and are part of a continuous relationship-building process. The greater the time invested in building the relationship and in focusing on the **child's and family's strengths**, the better positioned pediatric health care professionals will be to gain the trust needed to provide effective care and guidance.

This resource is part of a series of resources, including a **Frequently Asked Questions (FAQ) Guide** and **Resource Repository** found here: <https://www.aap.org/en/practice-management/bright-futures/bright-futures-in-clinical-practice/bright-futures-health-equity-resources-for-health-care-professionals>.



This resource is recommended for pediatric health care professionals who want to obtain and understand introductory information about the impact of racism, bias, and discrimination on health and on why conversations about race matter for patient and family health and wellness.

### TERMINOLOGY

**Structural racism** (as defined in the 2019 American Academy of Pediatrics policy statement, [The Impact of Racism on Child and Adolescent Health](#)) is a “system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call ‘race’) that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.”<sup>1,2</sup>

These disadvantages cut across multiple systems (eg, educational, prison, housing, health care, other systems) and work together to reinforce each other. Structural racism also works to disenfranchise peoples via history (eg, unfair home lending practices, segregation), power (eg, voter suppression, hate crimes), and representation (eg, stereotyping, lack of diversity in media).

**Bias**, within the racial context, refers to the preference or dislike for one racial group over another. Bias may stem from attitudes, beliefs, or stereotypes that affect understanding, actions, and decisions in an unconscious manner. It can be directed toward racial out-groups or be held toward one's own group.<sup>3</sup>

**Discrimination** is the unequal treatment of members of various groups, based on race, gender, social class, sexual orientation, physical ability, religion and other categories.<sup>4,5</sup>



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**Microaggression** is the brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward marginalized people.<sup>6</sup>

**Intersectionality** refers to the multiple identities one may hold and how they might intersect (eg, race, gender, sexual orientation). For example, the experiences that a Black trans woman has may differ from a White trans woman, despite their both being women.<sup>7</sup>

**Racial equity** is the principle that race should not be a deterministic factor for health, livelihood, opportunity, educational or occupational success, or other parts of life or livelihood.<sup>4</sup>

**Health equity** is the principle that optimal health and wellness should be achievable and accessible to every single person.<sup>8</sup>

## HOW DID WE GET HERE?



Discriminatory practices, health inequities, medical abuse, and mistreatment date back to the early colonization of North America by European colonizers and the initiation of the Transatlantic Slave Trade. In 1493, the Catholic church established the [Doctrine of Discovery](#) which provided a framework for European Christian explorers to legitimize the colonization of Indigenous People. The doctrine was used to establish the [legal basis](#) by which Indigenous people had the right only to occupancy, but limited rights to sell the land, which had devastating effects to the culture, lifestyle, and health of Indigenous People in North America. The [Removal Act of 1830](#) paved the way for the United States' westward expansion for European settlers, further devastating the culture and community structure of Indigenous People in North America.

Advances in modern medicine were made through experimentation on the bodies of enslaved Africans and Indigenous People during the 1600s before the colonies became the United States (US). From that time within medicine and research, eugenic explanations for health inequities were continually promoted, further stigmatizing health conditions and racial stereotypes negatively impacting the way these groups and marginalized populations received health care. The widespread practice of forceful medical processes and procedures on those enslaved and oppressed was utilized to further medical knowledge. Within the history of health care and medicine, there are glaring incidents of violence, injustice, and exclusion that were foundational to the development of the modern US health care system. As such, these health inequities, medical maltreatment, and patient medical mistrust we see today is rooted in centuries of abuse of marginalized populations in this country.

Although slavery was abolished after the Civil War ended in 1865, many states enacted numerous laws around the US to control the movement, health, employment, housing, freedom, education, and citizenship rights of Indigenous people, formerly enslaved Blacks, Asian immigrants, and Latinos. These laws include the [Black Codes of 1865 and 1866](#), [Dawes Act of 1887](#), and [Chinese Exclusion Act of 1882](#) and expanded upon addition of the [Scott Act of 1888](#) and [Jim Crow Laws](#) (from 1887 through the mid-1960s). All of these racist and discriminatory laws systematically excluded people of color from access to health care, education, employment, housing, and citizenship rights—including voting rights.

Although the [Civil Rights Act of 1964](#), [Immigration and Naturalization Act of 1965](#), and [Fair Housing Act of 1968](#) abolished all of these laws (except the Dawes Act), having more than a century of government-sanctioned racist policies and laws led to the significant health, educational, and financial inequities that are evident today. Inequities, discrimination and structural racism continue to have impact on the health of marginalized groups.

## WHY SHOULD WE HAVE THESE CONVERSATIONS?

To achieve racial and health equity, it is important not only to understand the historical context, but the role conversations can have in improving patient care and outcomes. Racism is an endemic, ubiquitous, and dynamic system of differential racial oppression. Racism is all around us, especially if we take the time to learn and listen. Not to acknowledge its pervasiveness is akin to ignoring the larger context in which pediatric patients and families live when delivering care. Racism, bias, and discrimination have a significant impact on the health and well-being of children and their families. We cannot comprehensively care for our patients without acknowledging the impact these factors have on the health care system and their detrimental effects on patients.

Racial biases as contributors to racism impact the quality of care delivered within the health care system. Many patients may enter the health care system with prior experiences of racism not only within other social institutions, but also within health care. By discussing racial biases and racism with our patients, we begin to recognize and acknowledge our complicity in structural racism, as well as our role in being a part of the solution.



## WHAT IS MY ROLE AS A PEDIATRIC HEALTH CARE PROFESSIONAL?

Health care professionals are in a unique position to address the needs of our patients and families over the long period of care they provide. With the understanding that health is more than medicine and clinical care, we are able to build relationships with our patients, while considering the identities they hold. The intersectionality of identities brings forth varied experiences in our patients' lives. By increasing awareness of our identities and their immediate and long-term impact on the lives and health of pediatric patients and families, we move toward acknowledgment and grounding of the differences among us rather than ignoring them. As health care professionals, it is vital to:

- “Practice what we preach” to children as they enter a busy intersection: Stop. Look. Listen.
- Explore our own racial identities and the impact on our lives, along with considerations to make prior to engaging in this conversation (eg, as described in the [FAQ Guide](#))
- Be willing to continue learning and unlearning
- Create psychological safety within an encounter, allowing space for these conversations if a discussion is desired by the patient or their family
- Practice humility within encounters
- Outwardly acknowledge the journey toward antiracism and continued learning with your patients and their families
- Provide support and resources in patient visits, when necessary

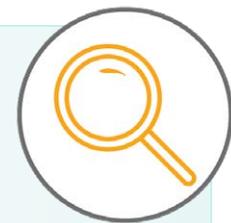
## CASE EXAMPLES

In the following three cases, racial and ethnic identities are prominent themes in the conversations. For each of the cases, ask yourself the following questions as you reflect: What is important to consider in each situation? How would I have responded in this situation?

These cases are based on real-life experiences; the names and ages are fictional. They are shared purely for teaching purposes and to use the reflection points to begin a dialogue with your colleagues.



### CASE 1. Pediatric Health Care Professional Perspective



**Case:** Today, a child's parents refused to receive care from me. They made this decision after they saw me. I do look different, as I wear a headscarf or cover (hijab) as an expression of my religion. Although the hijab is part of my freedom of religious expression, it also signals to others that I am most likely Muslim.

**Reflection:** At the time, I was taken aback, as I have taken care of so many different children and their families and had never had anyone refuse care from me. As I reflected, I realized that I assumed it was my cover that triggered their request. Talking with my peers, while many agreed with me, others shared that it might have been that I am a person of color, a woman, or perhaps it was none of these. I do not know, because I did not ask nor did anyone else. The child and family was simply assigned to another health care professional. We all realized that without clarification, no real learning was accomplished.

In the future, we agreed that we needed to be prepared for this situation. So we proactively began the discussion with office personnel, starting with how to handle a parental request for another health care professional. However, we also began reflecting on how each of us may not be well equipped to care for some patient populations or to encounter some conditions and need to hand off these patients to a colleague. In the end, we had a plan to which we all agreed. Equally important, we learned that each of us has our own preferences because we took the time to discuss them. Going forward, we agreed that while a child and family had the right to refuse care, the team needed to learn what informed their request. Then we can examine what institutional policies we have in place so we could try either to find an alternative or to refuse change in care. Acknowledging that request based solely on bias and discrimination toward the health care professional cannot be tolerated.

## CASE 2. Pediatric Health Care Professional Perspective



**Case:** A 2-year-old Black male came in for a health supervision visit with his father. This is the first time the resident I was precepting was seeing the child. When the resident came to precept the child with me, she reported minimal detail regarding the patient's feeding habits and daily routine. When probed further, the resident noted that the child was with his father, who probably was not aware of details about the child; I encouraged the resident to not assume and to ask the same questions to the father as she would any other parent. Upon further discussion with the father, she learned that the father was the primary caretaker of the child. As she was leaving the room, she exclaimed to him how pleasantly surprised she was to see a father so involved, "something we do not see often." The patient's father asked to speak to a supervisor to describe his frustration.

**Reflection:** This resident made an assumption about the patient and his father, based on her biases, which manifested in both her inactions and actions: inaction in proper history taking and action in offending the father with her comment regarding her surprise. There are times when we will be the source of bias and times when we will be a bystander. In these scenarios, it is important to avoid becoming defensive. Defensiveness can be an overattachment to being right rather than a genuine seeking of the truth. We should acknowledge our bias; focus on the impact of our words, not the intent (ie, ensuring to focus not on what we "meant" but on how we made someone feel); and apologize. In instances where our biased behavior is brought to our attention by a patient or colleague, it is important to thank them for this, as well as to thank our patients and families for their understanding and grace.

## CASE 3. Parent/Caregiver Perspective



**Case:** My pediatrician has seen my 9-year-old son and our entire family since he was born. We have a very close relationship. She displays great empathy and provides sound medical advice, and I trust her very much. Though she is White and we are Black, I feel like she welcomes us and makes us feel at ease. However, my son had a check scheduled last week, which took place a few days after the murder of another unarmed Black child by the police. My son was upset, and we talked about it at home, but my pediatrician never brought it up. I was wondering if she didn't hear about it, think it affected me or my son, or think it was her job to ask about the event. I really wanted her to ask so I could tell her what we have been going through as a family, but now I am not sure if she's comfortable having these conversations.

**Reflection:** Patients and their families are likely to be most comfortable and trusting of pediatric health care professionals when they can be their full, authentic selves and bring those experiences and identities into our offices. By not acknowledging the repeated killings of Black youth and adults, the pediatric health care professional created doubt in this mother's eyes about what topics are safe and ok to bring up with her and what topics are not. This missed opportunity or future events could cause an unintentional rift or mistrust in the relationship.

Making an effort to understand the social environment and what is happening in the local, national, and global community is important for pediatric health care professionals to be able to support their patients and families. Please consider using the questions in the [FAQ Guide](#) to bring up these topics. You can open generally by saying, "How are you doing during this/these challenging time(s)?" or, more specifically, by saying, "How are you feeling about what's going on in the world/our country as it relates to race/racism?" Then, invite the conversation by saying, "Like me, many of my patients and their families are struggling with the racism we are seeing or experiencing. Are there any experiences that you would like to share with me?"

## TIPS

- Know your bias and acknowledge immediate gut responses. We all have biases that may find their way into our conversations. It's important to counter potential bias by working to understand the role and impact of structural racism both on our own biases and on our patients' health.
- Know the evidence – Examine evidence on bias affecting the type of care we deliver and on structural racism's impact on health and racial identity development milestones. It is equally important, whether talking about pacifiers, concussions, or racism, to know the evidence and what other pediatric health care professionals are saying and to ground our responses in science.
- Know your patients and their family – Ultimately, you want to empower your patients and families to be front and center in decisions affecting their health care and related behaviors. To do so, you need to know their stressors, coping mechanisms, support systems, influential voices, etc. This is core to the strength-based approach and to providing patient- and family-centered care.
- Know to practice humility – Be prepared to listen and to convey willingness in learning about your patient and their family. Ask permission to share your lived experience, and build a relationship that incorporates their experiences into the care received.

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