# Health Equity Column: Cultural Humility and Equity

*Ariane Marie-Mitchell, MD*

I remember learning in medical school about differences in disease rates by race, gender, and age. These were presented as facts, such as the fact that African-Americans have higher rates of diabetes than Whites or that women have higher rates of depression than men. I remember assuming, or maybe even being told, that differences by race and gender were part of biological differences in genetics, hormones, and biochemistry. These differences were unfortunate, but like other facts, just part of the way things are.

Several years have passed since I graduated, and in that time, there has been a rising consciousness that much of what we learned as inevitable is, in fact, preventable. This shift in awareness starts with realizing the widespread impact of stress and trauma on our biological and institutional systems.(1) This leads to recognizing the effects of stress and trauma, including societal oppressions, on our systems, and therefore propels a desire for transformation. Cultural humility is a cornerstone of this transformation. Cultural humility is an individual-level shift in perspective, a willingness to recognize that my experience of the world is influenced by my race, gender, sexuality, age and so on and that my experience may be very different from that of my colleague or my patient. Differences in experience may lead us to have different beliefs, expectations, or behaviors. I can respond to these differences by being judgmental and wondering why that person doesn't think and act as I do, or I can respond from a place of humility, one in which I am willing to reflect on variations in lived experience, listen to stories about different realities, and find ways to promote understanding.

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There are a variety of types of societal oppressions, such as racism, sexism, homophobia, xenophobia, ableism, and ageism. These can be thought of like coin tosses because they all represent aspects of who we are that are out of our control. Depending on how your coin toss landed for your birth, family circumstances, or current age, you may enjoy a greater sense of belonging and freedom in society, or you may feel excluded and discriminated against. The result for those on the oppressed side is a chronic sense of threat and vulnerability. While all of these oppressions can show up in the workplace as different degrees of stress and bias, I am going to focus on racism because race is one of the most difficult oppressions to talk about and yet strongly associated with many differences in health care outcomes

You might wonder about the need to talk about race and racism in 2021. After all, the Civil Rights Act was passed over fifty years ago and included provisions to end discrimination based upon race, color, and national origin. And we elected Barack Obama, which suggests that we have made great progress toward being a "color blind" society. Some, mostly White, people might even add that anyone in this country can go to school, work hard, get jobs and be successful, and mostly White people sincerely believe this because that is their lived experience.

I understand the White experience because I grew up White, but my understanding of race began to shift when I went on a cross-country trip with a friend who later became my husband. We had just graduated college and thought it would be fun to spend a few weeks driving from the west coast to the east coast. As we plotted our route, I was surprised to find out that there were places we had to avoid because my friend didn't feel safe. When we chose restaurants, my friend preferred restaurant chains near the highway rather than quaint "mom and pop" diners. When I talked him into eating at a small diner in Kentucky, we left without eating. This is because the waitress brought him lemonade that tasted like soap, and when she brought out his pancakes, there was a dead fly on top. The only thing that my friend had done differently than me was to walk into that diner while being Black. We were living in the same country, and we had graduated from the same college, but we were living in different realities. I would like to say that so much has changed since then, but in fact we recently decided against taking our own bi-racial children on a cross-country trip because, after four years of hate-filled political rhetoric, it doesn't feel safe.

The problem with not talking about racism and pretending that we are a "color blind" society where everyone has equal opportunity is that it allows us to ignore and fail to address the persistence of disparities by race. One reason why disparities still exist in 2021 is that historical racism continues to affect communities today.(2) For example, after the Great Depression, the government wanted to help homeowners refinance their mortgages. They sent surveyors out to assess neighborhoods to decide how "risky" it would be to give mortgage loans to the residents. But they made these decisions very explicitly based on race - neighborhoods with black and brown people were considered risky and marked with red lines on their maps. This was just the beginning of similar practices that continued for decades, resulting in long-term financial disinvestment and increasing racial segregation in these neighborhoods. Redlining was done all over the country, and we continue to see the effects today. Communities with lower homeownership also have lower property taxes. Lower property taxes means lower

funding for schools. Poorer schools mean higher crime rates and the perpetuation of disinvestment in the community, including reduced access to banking, insurance, supermarkets, and health care. This leads to differences in health and psychosocial outcomes, which we tend to blame on communities of color, thereby perpetuating an ongoing cycle of bias and racism.

The majority of Americans want to realize the dream of living in a nation where all people- regardless of race, gender, class, sexual orientation, ability, or any other difference- can realize their full potential. So how do we get from where we are today, where differences like our zip code or what we look like still matter, to the dream of freedom and liberty for everyone?

On an individual level, it starts with a willingness to reflect on our own experience and engage in conversations with other people about their experiences. From a perspective of cultural humility, it becomes possible to recognize how implicit biases influence all of us. Implicit biases are negative associations that people unknowingly or unconsciously hold. These negative associations become hard-wired in our brains based on numerous messages in our social environment about race, gender, and other characteristics. We receive these messages in various ways, such as through conversations, what we read and see in the media, or who plays a leadership role in our personal or political lives. These messages become part of our brain wiring and can bias us for or against a group of people. The biology of implicit bias is the result of years of evolution designed to help us quickly process information about people and situations. While this ability was needed for quick decisions related to survival, the same cognitive processing can unknowingly influence our perception of other people and our decisions.

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Studies of physicians show that their biases are no different from the general population and may influence patient-provider interaction, treatment choices, patient compliance, and health outcomes. For example, Black and Hispanic patients are less likely to receive pain medications, even for acute injuries like bone fractures. (3) Black patients are less likely to receive thrombolysis, despite having conditions comparable to White patients. Pro-White bias among primary care physicians influences the patient perception of warmth and friendliness, as well as patient adherence to treatment prescriptions. In addition, studies have reported lower quality of care metrics in hospitals serving a higher percentage of Black infants, fewer early intervention referrals for Black infants, and differential treatment for necrotizing enterocolitis in infants of color.(4) Particularly when we are stressed and time-pressured, unconscious biases are likely to influence our communication and decisions. The good news is that we can become aware of our biases by taking a test for implicit bias (implicit.harvard.edu). We can then use that information to try to stay conscious of our biases so that they do not negatively impact our interactions or decisions.

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The story of Serena Williams illustrates that ending racism is not just about ending poverty. Ms. Williams is a famous and successful tennis athlete. Based on the attributes of being famous and successful, we might predict that she would receive the best medical care, including careful attention to her experience as a patient. However, after giving birth to her daughter via cesarean section, Ms. Williams was having trouble breathing and was concerned that she was having another pulmonary embolism. She asked the nurse for a CT scan and a blood thinner, but the nurse suggested that maybe her pain medication was causing confusion. Ms. Williams spoke to the doctor, but the doctor was doubtful and began with an ultrasound of her legs. Ultimately, she survived what did turn out to be a pulmonary embolism, but not all patients are so lucky. In fairness, I do not know all of the details of this medical scenario and what other factors the medical staff may have been considering. It is hard to know for sure if implicit bias was at work for any one medical story, but when we hear numerous stories from women of color about having their symptoms dismissed or ignored, it seems to me that we should listen. Particularly when we also have data demonstrating disparities in outcomes, as we do for maternal mortality, then as medical professionals, we should take a close look at our decision-making.

On an organizational level, we can use the principle of equity to guide the transformation of our health care system. Key to the principle of equity is the recognition that different groups of people are born into vastly different resources. This is uncomfortable to admit. After all, it is a basic American belief that we are the land of equal opportunity. But in reality, some children are born into very rich families who have accumulated wealth and societal connections over generations, while other children are born into families who don't even have a savings account. Some children are born with a skin color that allows them to feel welcomed in leadership positions throughout society, while other children are born with a skin color that may make them feel unwelcome and unsafe. The examples could go on, but the underlying point is that- depending on how the coin toss worked out-- the current reality is that some groups have advantages and some groups have disadvantages, and these disadvantages show up as differences in health care outcomes.

But the influence of societal oppressions on health care outcomes is not inevitable because society can change, and we as health care professionals can be part of that change. We can transform

our health care system to make sure that we are reducing stress and trauma and promoting safety, compassion, trust, collaboration and resilience. The first step in that transformation is the realization that we are not achieving the best possible outcomes for everyone. For example, African-Americans, Native Americans, and Alaskan Natives have higher infant mortality rates than White infants.(4,5) Mortality from intraventricular hemorrhage is two times higher in Black compared to White infants. Hispanic infants with necrotizing enterocolitis are less likely to survive than non-Hispanic infants. In 2015 the rate of low-birthweight infants for African-American and Hispanic infants increased. These are just a few from the long list of disparities in our medical system, and although many of these problems start outside the health care walls, we can make sure that the inequities are not perpetuated inside the health care walls.

On an individual level, we start with being self-reflective. Similarly, on an organizational level, we start by examining our own system. What outcomes are we producing? Do we need to change our thinking to produce different outcomes? For example, what are the demographics of the employees we are recruiting? Does this fit the needs of the services we are providing? Or how do our employees feel about working here? Do they feel respected? Included? Do they have opportunities to provide input? Do they have choices for religious and cultural holidays? And do we have representation where we need it? To answer this question, we need to know who is affected by the decisions being made by a particular committee or team. Are the voices of the people affected by the decisions represented on the team or committee? These are just a few examples of the kinds of questions that could be asked as part of a reflective organization.

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Next, we need to assess the outcomes that we deliver by demographic groups. If we don't measure disparities, then we won't know about disparities.(6) Are the outcomes for our patients comparable across different demographic groups? If not, are there differences in the timing of medical care? Are there differences in treatments offered or utilized? Are there differences in patient satisfaction with care? If yes, can we re-design our system to impact these differences and improve outcomes? Measurement is the first step toward eliminating disparities. Equally important is stakeholder engagement because the identification of successful interventions will require input from the members of the community being served.

It is uncomfortable talking about racial disparities and other societal inequities. It takes courage to share the truth of your own experience and listen to someone else who has had different experiences. Listening to find the commonalities in our experiences helps with forming the bridges needed to solve problems together. If we are happy with the status quo, then not talking, not listening, refusing to self-reflect, and ignoring the data on disparities works. Personally, I am not happy with the status quo, and I believe that as physicians, as scientists caring for patients, we have an obligation to use our knowledge and our power, to ensure that we are fulfilling the Hippocratic oath for all of our patients.

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*Ariane Marie-Mitchell MD, PhD, MPH*
*Associate Professor Preventative Medicine and Public Health*
*Department of Pediatrics*
*Loma Linda University*
*Loma Linda, CA*
*Email: AMarieMitchell@llu.edu*