



AMA Journal of Ethics®

February 2021, Volume 23, Number 2: E140-145

STATE OF THE ART AND SCIENCE: PEER-REVIEWED ARTICLE

How to Measure Racism in Academic Health Centers

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Abstract

Institutional racism is a set of practices and policies that disadvantage individuals not part of societies' dominant groups. In academic health centers (AHCs), institutional racism mediates structural racism; it is embedded in institutional policies, clinical practice, health professional training, and biomedical research. Measuring institutional racism in AHCs at the individual, intra-organizational, and extra-organizational levels renders visible how AHCs mediate structural racism by implementing policies that unfairly treat minority groups.

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Institutional and Structural Racism in US Health Care

Racism is the root cause of inequity in health care in the United States.^{1,2,3,4,5} Clark et al define racism as “beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation.”³ The health services literature focuses on racism embedded in attitudes of individuals in health care settings⁵ that express implicit bias, or a “negative association [that] operates unintentionally or unconsciously.”⁵ Bias flourishes in institutional settings that allow racism to fester.

Griffith et al define institutional racism as “a systematic set of patterns, procedures, practices, and policies that operate within institutions so as to consistently penalize, disadvantage, and exploit individuals who are members of non-White groups.”⁶ Calling out institutional racism shifts the focus from implicit bias and clinician intent to how health care institutions nourish racism through tolerance “of institutional policies that unfairly restrict the opportunities of particular groups.”² It is these institutional policies within a health care institution that feed individual, intra-organizational, and extra-organizational policies and practices that contribute to structural racism.^{6,7} This article discusses how institutional racism can be measured in academic health centers (AHCs)

at the individual, intra-organizational, and extra-organizational levels in order to render visible how AHCs mediate structural racism through policies that unfairly treat minority groups.

Roles of Academic Health Centers in Structural Racism

As noted by Bailey et al, structural racism “refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice.”⁴ These systems are saturated with White supremacy,¹ which promotes White superiority and inferiority of people of color and guides policies that confer benefits and burdens according to membership in racialized categories. Interactions among housing, education, and health care systems disadvantage people of color in the United States⁸ through their influence on access to and quality of services and health professions training and biomedical research.⁵ As institutions that provide health services, academic training, and human subject research, AHCs are uniquely positioned to exacerbate or alleviate the health consequences of structural racism.

Institutional racism in AHCs is not new.⁹ Makeshift operating rooms, such as depicted in an illustration of gynecologist James Marion Sims examining an enslaved woman of African descent as others observe, are some of the earliest sites of health professional training, human subjects research, and restricted clinical care.¹⁰ Appreciating the **historical traumatic impact** of such sites and what they have done to people of color is key not only to understanding the mistrust, pain, and death caused by the US health infrastructure but also to motivating health equity.¹¹ One starting place is holding US health care accountable for its legacy of racism.

AHCs have long behaved and continue to behave as White supremacist institutions. This article moves beyond a call to recognize the historical origins and persistence of White supremacy in AHCs that has been so widely documented.^{12,13,14} We propose a measure of institutional racism in AHCs and suggest why the Joint Commission and Centers for Medicaid and Medicare Services should require and assess its implementation.

Measuring Institutional Racism

Measuring institutional racism allows health care organizations to right historical wrongs by adopting antiracist agendas and action plans for providing equitable care (eg, resources according to need) that can mitigate health inequity.¹¹ Early strategies aimed at understanding health consequences of institutional racism focused on self-report scales that capture individuals’ perceptions of racism on the assumption that racism must be encountered by an individual in order for institutional policies to have racist implications,^{15,16} which is not how institutional racism actually works.¹⁷

Scholars have subsequently used institutional racism to describe structural influences on health, as is the case with early literature on the connection between residential segregation and the health outcomes of individuals.¹⁸ Such work speaks to **health consequences of structural racism** on groups but does not identify the unique roles of specific institutions (eg, housing authorities, insurance companies, and banks) that implement or endorse discriminatory practices. As can be gleaned by publication dates of literature on institutional racism, scholarly output on institutional racism has declined in the 2000s¹⁹ as scholarly output on structural racism has increased. Based on these 2 lineages, this article argues that there is still need to identify institutional racism—but by evaluating roles of specific institutions, such as AHCs, in structural racism. To our

knowledge, no measure of institutional racism in AHCs has yet been developed or deployed.

Before introducing our proposed measure of institutional racism in AHCs, it is important to identify and assess racism operating at 3 levels: the individual level, or sites of clinical encounters where discriminatory attitudes are expressed and discriminatory actions are implemented; the intra-organizational level, where policies and practices that are enacted or implemented lead to discriminatory practices; and the extra-organizational level, where AHCs and other institutions with which they are connected are overarched by larger structures that wield regulatory power or government authority (eg, the Department of Health and Human Services, the Department of Housing and Urban Development, the Department of Education).⁷ Measuring institutional racism at these 3 levels can help clarify how AHCs embody and practice racism.

Individual level. In some cases, pressure on clinicians to see large numbers of patients encourages clinicians to rely on stereotypes and tropes from historically flawed texts, teachings, or cultural narratives. But extant literature has documented specifically how implicit racial bias tends to be expressed during clinical encounters: limited time given by clinicians to patients of color, inequity in how that time is spent, inequity in conversational pace and tone, dismissive clinician body language, inequity in information sharing, inequity in resource use, and inequity in decision sharing.^{1,5} We propose that these variables—in addition to whether and to what extent patients trust and feel heard by clinicians—be used to measure institutional racism in AHCs at the individual level. Data from application of existing scales for assessing patient communication and trust, for example, can be compared across racial groups.

Intra-organizational level. One reason implicit bias is a clinical and ethical problem in health care is that it can cause inequitable treatment of members of different racial groups in AHCs. From diagnostics to interventions, one reason biases can generate inequitable health care service delivery is that they can influence clinicians' conceptions of what patients deserve from them. Although implicit bias might appear to occur only at the individual level, it informs how **clinicians are trained** in AHCs²⁰ as well as organizational policies and practices. The lack of consequences for clinician bias, the lack of efficient reporting mechanisms, and the lack of culturally responsive training in health professions schools exacerbate health inequity. Consequently, to capture intra-organizational institutional racism, we recommend using an average score on the Implicit Association Test (IAT)²¹ that has been administered to all personnel within an AHC. An institution-wide assessment can identify which types of personnel (eg, those who process claims) and departments (eg, maternity) harbor bias. The personnel who complete the IAT need not have patient contact to be assessed. As described above, it is organizational policies and practices developed and implemented by other personnel that are embedded with bias and representative of an AHC's participation in institutional racism.

Extra-organizational level. AHCs interact with governing institutions (eg, Department of Health and Human Services) and other government agencies (eg, city, county, state) to coordinate, execute, and endorse policies that can result in loss of health care staff; closure of facilities; maldistribution of resources (eg, variations in quality of health insurance coverage); and lack of information technology infrastructure to deliver up-to-date, accurate data of clinical relevance, including data on conditions that disproportionately impact people of color (eg, sickle cell anemia, lupus).^{1,5}

A combination of variables could be included in an index to measure extra-organizational institutional racism: availability of services (eg, number of full-time personnel with appropriate expertise, number of facilities per square mile); distribution of resources (eg, mean difference in prescriptions for an intervention for publicly insured patients vs privately insured patients); and currency of data and health professions schools' teaching (eg, number of learning resources, practices that allege biological differences in races, diversity expressed in biomedical research subjects and data). Such an index might reveal that external policies drive AHCs' internal policies and practices that contribute to structural racism (eg, poor health care access and delivery).^{22,23}

Implementation

Scores on measures of these 3 levels (ie, individual, intra-organizational, extra-organizational) would yield a composite score of institutional racism that could be used to inform **antiracist strategic planning and decision making** over time. We suggest incorporating qualitative components at each level (eg, randomized patient interviews at the individual level; observations and evaluations of AHC operations from preclinical health students and community health workers at the intra-organizational level; and local, state, and federal policy analysis at the extra-organizational level). In combination, this mixed-data formative assessment could ensure that a range of voices is solicited, recorded, and drawn upon to eliminate health inequity. We suggest that this assessment be made annually and, together with quality metrics administered by the Joint Commission and Centers for Medicare and Medicaid Services, be used to evaluate AHC institutional antiracist progress over time.

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Citation

AMA J Ethics. 2021;23(2):E140-145.

DOI

10.1001/amajethics.2021.140.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980