Interpersonal Racism in the Healthcare Workplace: Examining Insidious Collegial Interactions Reinforcing Structural Racism

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Abstract: The traumatic stress experienced by our black healthcare colleagues is often overlooked. This work contextualizes workplace racism, identifies some interpersonal barriers limiting anti-racist growth, and calls for solidarity.

Medicine as an institution within the United States is unarguably racist — from its origins to its current structures and policies.[1] Much of medicine today still remains a very white-value, white-centric space with much of the leadership, stakeholders, and decision-making power and influence being centralized and relegated to white and white-conforming individuals.[2] These types of environments and sociopolitical conditions serve as a substrate for racism to grow and for racist policies and encounters to permeate.[3] As recently as this article was being written (February 2021), a podcast of the *Journal of the American Medical Association* — one of the most influential and premier journals in medicine debuted an episode during Black History Month on structural racism (since redacted with a formal apology from the journal's editor-in-chief), where the two white discussants (highly powerful and influential in medicine in their own right) questioned and ultimately denied the existence of racism in medicine — despite it ironically being well-documented by the journal itself.[4] This tone-deaf podcast episode masquerading as a nuanced thought-piece serves as a great example of the thoughtless nonchalance by which race is discussed by white healthcare providers in the everyday, unscripted moments of daily workplace life. These types of misleadingly innocuous interactions are part of the very structure of racism that actively harms black individuals.

In a parallel vein, despite many white providers priding themselves on being advocates for patients of color and committed to equitable care, these providers exist in a system that is designed to privilege white individuals at the cost of disenfranchising other groups. These well-intentioned providers contribute to reinforcing a racist norm at baseline — whether in patient or collegial encounters.[5] With black physicians among the lowest percentage of the physician workforce, and even fewer in positions of higher leadership[6] — there are many healthcare settings in the country where no black or brown providers exist in upper-level positions (or entirely) in the hierarchy of medical care (i.e., attendings, fellows, residents). This observation also reflects the extreme hierarchical, white-privileging structure of healthcare institutions. A healthcare-setting with no black employees, for instance, can still perpetuate groupthink and promote white-privileging policies and culture. In acknowledging the power imbalances and abuses toward lower-ranking colleagues, a compounded discrimination can exist when you consider the experiences of lower-ranking female employees who are black into a hierarchy with the design or effect of advancing white

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About This Column

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(generally male) positions of power, compensation, prestige, and wellness. Unfortunately, black and/or female individuals in a white male privileging structure, no matter how high in the hierarchy one exists, are still subject to abuse. As unchecked white leadership and structures continue to dominate, racist practices will continue to be reinforced and remain uncorrected.[7]

Whether a combination of historically prejudicial policies, exclusionary practices, denial of access to quality mentorship, lack of career-development, or inadequate medical education resources/opportunities — it is more common to find black providers and staff in greater numbers in diminishing levels of power in the healthcare hierarchy: from junior medical faculty, nursing, to medical assistants/tech, and staff.[8] Black providers working at lower-level positions are more vulnerable and susceptible to workplace racial abuse and are in positions with very little opportunity to feel empowered to report such abuse or trust that their voices will be heard.[9] The daily traumatic stress and suffering experienced by our black colleagues by simply existing and operating within a racist environment are often overlooked.

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Reflecting on my own context as an example, Kentucky is home to a white population of 88% who are represented by elected and re-elected officials, many of whom continue to uphold racist rhetoric and policies that predominately benefit its white population. Black providers at all levels of the healthcare hierarchy living in Kentucky (and Louisville more specifically) were acutely aware of the racial overtones of the 2020 intrusion and murder of emergency room technician Breonna Taylor by Louisville police. As the aftermath unfolded alongside the backdrop of multiple national protests against the wanton killing of innocent black civilians at the hands of law enforcement and white vigilantes, many black healthcare providers continued to come into work carrying this trauma in addition to the stress of witnessing a fatal pandemic disproportionately affecting the black and brown patients they were caring for. Our colleagues continue to bear the emotional stress of working in such environments that do not afford them the trust, confidence, or freedom to voice their indignation without fear of judgement or retribution.

In the past two decades, there has been a slow growing openness and recognition of systemic and institutional racism that perpetuate and amplify health disparities primarily impacting people of color — specifically black Americans.[10] Much of the literature thus far has tended to focus on the numerous ways black and brown patients interface with the healthcare system in terms of limited access (e.g., screening, diagnosis, resources, and treatment), poorer outcomes (secondary to delays in diagnosis, care, medical errors), and experiences of general mismanagement or mischaracterization of their illnesses within the healthcare system.[11] A subset of disparities literature has highlighted the need for culturally competent care, curricula/teaching reforms, diversity and inclusion in leadership roles, and the detrimental impact of implicit bias or insensitive care on patient trust, comfort, and physician-provider relationships.[12] An adjacent body of literature has focused on racism experienced by providers from patients.[13] It is important to recognize that policies, curricula, and hiring and promotion practices are aspects that reinforce structural and institutional racism. However, it is the casual and cavalier racist individual views and attitudes by healthcare providers that are in part fueling and reinforcing a system, way of thinking, and action that prioritizes a "white-as-superior" way of operating — further marginalizing providers of color.

While there has been some discussion on the existence of interpersonal racism in the workplace,[14] very little has been published on the mechanics of the racism that black healthcare providers and staff experience on a

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regular basis.[15] With some suggesting that black providers are more likely to experience racism from their colleagues than from patients,[16] an examination of these issues is important as we try to move toward a more equitable anti-racist society, foster a healthy, inclusive, and safe work environment, dismantle structures unfairly benefitting whites, and ultimately reduce workplace traumatic stress, burnout, job dissatisfaction, and workforce turnover.[17] To this end, this article: contextualizes workplace racism, identifies some interpersonal barriers limiting anti-racist growth, and calls for solidarity. Although recognizing that racism and racist behaviors are also perpetuated by non-whites, this work specifically places the focus on white colleagues — those benefitting the most from structural racism in medicine.

Discriminatory and prejudicial abuses are not only experienced by our black colleagues. It is a reality and burden experienced regularly by women, people of color, and people of various faiths,[18] but it is our black colleagues who arguably continue to suffer the most within the healthcare enterprise. In borrowing from the solidarity justice literature, it is through addressing and alleviating injustices experienced by those worst-off that we will improve conditions for all. This work will also focus primarily on the more subtle, yet weighty ways in which particular racist or biased attitudes of blackness reinforce a structure of racism within healthcare.

Contextualizing Workplace Racism

Defining and naming the problem is an essential first step in clarifying the scope and context of this discussion.[19] "Racism" in America should be understood in terms of a socially constructed belief in the superiority of white people over others and the integration of this belief into a system that empowers whites and disenfranchises non-whites from equal social, political, and economic rights and gains.[20] "Racist" is a descriptor — irrespective of intention — for actions, ideas, and policies that sustains or produces inequity for non-white racial groups.[21] "Racism" and "racist" imply an access to power that allows them to act on prejudice. Good intentions, without more, cannot prevent devastatingly racist actions. By the very nature of being acculturated in the United States it is common for individuals to hold racist and prejudicial views of non-white groups. Therefore, it should not be surprising to state that many of our healthcare colleagues are "racist" to varying degrees.[22] Racial microaggressions, or more appropriately characterized as racial abuse,[23] are ubiquitous, implicit, and deeply engrained — making the process of identifying and denouncing implicit interpersonal racism challenging. Understanding what accounts for racism can be a challenging mental undertaking for all acculturated in a white-privileging system. For progress and improvement to emerge, understanding one's racial privilege is part of the structural dismantling that must occur before a rewiring/relearning is to take place.

Overt and subtle forms of workplace discrimination experienced by black colleagues is a known phenomenon,[24] and the healthcare enterprise is not immune from interpersonal workplace racism.[25] At a minimum, it is manifested as white privilege, which affords white providers a disconcertingly disproportionate opportunity to avoid self-examination and ultimately compromise any attempt to effectively upend racism.[26] Among my most well-intentioned white colleagues and superiors, I have heard them opine that "we would all be better off if we did not see color" or that "racism is a thing of the past and the preoccupation with it only stifles progress." A black colleague once summarized the response to these sentiments succinctly, positing: "how often do you think about your skin color and its impact on your day? I think about it *every second of every day.*"

Unfortunately, "colorblindness" or racial sameness is not an option; not "seeing color" ignores and minimizes the realities of how color affects and impacts the lives of our colleagues and patients by cleverly dodging discussion on the everyday pervasiveness of racism.[27] Not confronting the white-privileging power structures underpinning racism by characterizing racism as a "problem of the past" denies and avoids the continued impact of racism on real lives and can facilitate the creation of new barriers to minority flourishing.[28] Not confronting the ways in which white colleagues make interactions and work environments unsafe, traumatic, and stressful for colleagues of color is ultimately antithetical to social justice. Minority providers at all levels (from medical assistants/techs to attending physicians) continue to experience racism in their workplace from both fellow colleagues and patients. Our healthcare systems are replete with anecdotes from providers about racist episodes of indignation and dismissal from colleagues when issues are experienced and reported.[29] This is a problem that requires concerted examination.

At some-level, white silence arguably represents a manifestation of either complacency, avoidance, low activation energy to challenge racist attitudes and privilege, or a "not-my-problem" attitude that denies the interconnectedness of human beings. Silence from our white colleagues can also represent a lack of understanding of the daily trauma our black colleagues experience (let alone our patients). In the wake of the Breonna Taylor grand jury determination, demonstrations were held down the street from our hospital. The palpable tension surrounding whether justice would be realized was clear among our department's black medical assistants, nurses, and scheduling staff. Their ranking in the hierarchy of medicine did not afford them many alternatives for expression outside of an internalization of their stress. Thus, in these sociopolitical environments, white silence can contribute to the continued existence and pervasiveness of racist structures that prioritizes the fragility and discomfort of white staff and leadership who hold immense power over the livelihoods of lower-ranking colleagues.[30]

The absence of formal anti-racist policies and regular denunciations

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of racism can serve as institutional complacence and signal that racist comments or behaviors do not reach a threshold to garner rebuke, and therefore must be acceptable to some degree.[31] The effects of this silence and inexperience in anti-racism are detrimental and inhibit workplace cohesion and inclusivity. As one white physician recently reflected, "health care is not safe for people of color as long as the overwhelming majority of U.S. physicians are white and we avoid examining where racism lives within us and how it lives through us."[32]

An unequivocal response is required, even if it results in white discomfort.[33] However, the burden must be on those in power; there should be no expectation on those victimized to have the responsibility to defend themselves or explain why something is racist — especially when the power imbalance is such that drawing attention to racial abuse could lead to censure, retribution, resentment, or criticism.[34] Moreover, the foundational ethical tenets of the healthcare profession are based on beneficence. Thus, those privileged to practice medicine have a greater moral responsibility to be models of empathy and champions of human dignity — especially in addressing and alleviating suffering. The moral responsibilities of healthcare professionals to be actively anti-racist are categorically different from hourly employees in the industrial or service industry, for example.

Thus, our white colleagues are in a unique position to disrupt existing systems and bear an ethical burden to act.[35] For example, something as obvious as white senior faculty standing up for their colleagues and trainees when workplace discrimination is observed is less commonplace than one should expect.[36] The absence of such actions — or worse — the participation in mistreatment of junior faculty or residents results in a tacit acceptance of mistreatment of nurses toward nursing technicians or assistants, who then in turn mistreat those below them in the healthcare hierarchy (e.g., custodial staff, scheduling, and transport). Mistreatment of lower-ranking individuals does not have to assume the form of abuse. Mistreatment can also result from preferential treatment for white colleagues, silence in the face of racist behaviors, ignoring the role of race on experience, and tasking non-white colleagues with the job of explaining race-related issues. The work of dismantling structural racism in part requires disrupting and altering the everyday manifestations of bias, racism, and prejudice to create a more inclusive and equitable environment.[37]

Interpersonal Barriers and Anti-Progress

In the current political climate, illogical and polemical statements defending the racial status quo have been elevated in legitimacy and many people have been led to believe that such ideas represent credible and valid counterarguments — creating a false equivalence to valid and sound reasoning. The political normalization of racist ideas, language, actions, and policies make discerning and refuting discriminatory ideas, or non-sequitur and strawman arguments difficult.[38] This can lead to a serious confusion, which further dampens the activation energy or even the practical knowledge necessary to publicly and confidently denounce hate.

Our white and white-conforming colleagues must recognize the insidious forms of racial abuse which include, but are not limited to:[39] mischaracterizing or essentializing racially-laden political issues; minimizing black experiences with racism; not believing or trusting black colleagues; reacting with silence when witnessing black discomfort or racial abuse; displaying favoritism/partiality for white colleagues or unequal expectations between similar ranking colleagues; restricting black success and achievement through competition, while restricting their access to information; failing to listen or take direction from black colleagues; interrupting, discrediting, or usurping credit from black colleagues; playing "Devil's advocate" without consent and approaching racial trauma as "open for debate;"[40] exhibiting condescension, passive aggression, or unconstructive behaviors directed toward black colleagues; hoarding power, opportunity, promotion, or resources; gaslighting; and not celebrating, commending, or recognizing the work of black colleagues.

Equivocation or using one phrase with interchangeable meanings is another type of argumentative fallacy sometimes used. A common example is using the phrase "All Lives Matter," which *prima facie* seems to evoke the idea that the lives of all human beings have equal intrinsic worth, and any other position is by default discriminatory. However, the phrase is often used as a misleading rebuttal device to obfuscate the inherent restorative justice message of "Black Lives Matter," wherein an equitable and just society cannot exist until the inequities facing those worst-off in society are alleviated (i.e., "all lives cannot matter until black lives matter").[41] Similarly, we must be weary of common accusations of "reverse racism" or "race-baiting" tropes waged against victims of racism as it manipulates the definition of racism to silence black narratives of racial abuse or discrimination. "Reverse racism" and "race-baiting" are non-concepts that cannot exist in a system where actionable and enforceable power to act on prejudice is wielded entirely by one racial group.

Other forms of argumentation common in casual workplace conversations include slippery slope arguments, imperfect analogies, essentialism, ad hominem, etc. Certain anti-progress attitudes can also reinforce racist thinking, namely indifference, apathy, or defeatism. These reflect sentiments that see the problem of racism as so insurmountable and outstanding in magnitude that any single anti-racist contribution or denunciation of witnessed racial abuse ultimately has no impact. These attitudes are a form of empathy-fatigue, a disinterest in empathizing or understanding the suffering of fellow black colleagues. It represents the self-absolving of any responsibility or moral burden/culpability in addressing racism and changing the status quo. It is the failure to see all

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human beings as inherently interconnected in their humanness. It is the choosing to not be bothered by the suffering of others.

Equally concerning is the real phenomenon of the banality of racism that often emerges in white-only circles or with white-passing colleagues.[42] In white-only spaces, the phenomenon of group-think can pervade wherein racist ideas can be reinforced and remain unchallenged. As noted, many race-related topics can be initially challenging to grasp and require self-driven investigation and reflection that requires significant mental energy. Group-think makes one's preconceived notions a more acceptable and less mentally demanding option when that idea is shared and unchallenged within an in-group. Additionally, discussions of race and what constitutes racism in white-dominant spaces are often conclusion-driven, generalized opinions. They are not in the same epistemic category as the lived and real experiences faced by black individuals. The more devastating end is when these reinforced opinions enter the workplace at-large. The main takeaway in drawing attention to forms of conversation or debate that is perpetuated and reinforced in white-dominated spaces is to raise awareness of how seemingly innocuous comments,[43] ideas, questions, or arguments operate to discredit, devalue, and invalidate real black suffering and contribute to racial abuse.

We need to be additionally weary of the false woes of "political correctness" or "hypersensitivity" that are designed to limit meaningful discourse by stifling any conversation entirely so long as they do not occur on the terms set forth by those in a position of power. One can also argue that such comments represent coded language that signals a specific meaning to those belonging to an in-group where "hypersensitive" could be seen as code for "those who challenge white supremacy." Such evasive sentiments reflect a lack of desire to be empathetic or emotionally in-tuned to the stressful lived experiences and suffering experienced by our black colleagues on a daily basis. So long as white colleagues evade vulnerable, uncomfortable conversations and not see anti-black racism as their problem, dismantling the racial hierarchy and unlearning strongly held biases will be impossible.

Calls to Action

While the task at hand may seem daunting, it is helpful to remember that implicit racism and bias can be unlearned as one becomes more aware of the subtle and innocuous ways in which they manifest.[44] However, this unlearning is a life-long, constant and iterative process that requires an ever-renewing commitment to anti-racism and justice. To reiterate, white providers must learn to recognize that they are part of a system that benefits them while causing others to suffer.[45] This awareness should translate into an unlearning of racism, and a mental re-wiring toward anti-racist action and vigilance in combating racist moments that make workplaces toxic for our black colleagues. Even in the absence of a harmful intent, an action could still yield a harmful effect. Thus, it is important to hold oneself accountable for harmful actions irrespective of intent, speak up when abuse is witnessed, alleviate suffering, and ensure collective dignity. Allyship is a dynamic process that must be chosen every day. Especially as healthcare professionals, there is no absolving oneself of this responsibility to perpetually do good to those worst-off and most vulnerable.

Oftentimes, it is our colleagues of color who are in a better position to detect behaviors and attitudes with racist overtones, frequently due to having been personally impacted.[46] Racism and bias towards particular groups are products of not having direct or meaningful interactions with individuals. Limited exposures can lead to typecast ideas about other cultures. If much of what is discussed herein is foreign, shocking, or not readily apparent — as some black physicians have pointed out — this potentially signals a lack of awareness of the racist structures in place (both at the level of the self and of the system in which one participates) and/or a disconnect between fellow black colleagues that may not feel comfortable or trusting to raise these issues.[47] We must create opportunities for our colleagues to feel empowered to log, report, or address racial abuse without retribution. We must listen humbly and remain grateful for the vulnerabilities associated with trauma sharing without placing the burden of responsibility on those affected to also alleviate white ignorance.[48]

The goal in our interactions with our offending colleagues is to inspire a moment of humble contemplation of how structural injustice affects us all, and to consider the long-lasting impact of casual racism.[49] Anti-racism and racial literacy resources are widely available and easily accessible, with step-by-step details for both individuals, departments, and institutions.[50] However, the motivation to interrupt and disrupt everyday racism must be self-originating. White colleagues need to *choose* to see black suffering as their suffering. White healthcare colleagues have the privilege of choice in deciding whether or when to care about anti-black racism, something not afforded to our black colleagues. Moreover, the idea that the onus of responsibility to dismantle racism befalls everyone needs to be challenged. The onus of responsibility must first befall those who *have* the power to dismantle racism, especially those standing to gain the most from the continuation of racist structures (i.e., white and white-passing individuals). As we should not expect our black colleagues to bear the burden of improving our collective racial illiteracy, it too is inappropriate and unreasonable to expect our black colleagues in positions of diminishing power on the healthcare provider hierarchy to be responsible for dismantling a system that has rendered them powerless.

Thus, beyond listening, situational mindfulness, and anti-racist action is a state of solidarity with black colleagues and an active effort to confront structural injustice.[51] To be in true solidarity with black colleagues frequently experiencing the lived realities of racism and racial trauma requires a recognition of the com-

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monality of human dignity and the interconnectedness of our humanism; expanding our moral horizon to include the injustices experienced by others; mutual concern for others and barriers to their flourishing; understanding human agency in relationship to structures that limit one's agency; respect for others born out of empathy; standing up for and advocating for colleagues who are not in similar positions of power.[52] Solidarity requires action to appraise structures that restrict human flourishing or infringe upon the dignity of those disadvantaged.[53] Finally, solidarity with our colleagues is participating in a process that ultimately dismantles structures of injustice contributing to the harm and suffering of others.[54]

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38. The strawman fallacy can take shape as a misconstruing or deliberate misassignment of beliefs to a person, and rebutting those beliefs in a misleading defeat of the original position. Raising such tangential or non-sequitur counterarguments can be interpreted as devious means of distracting from the original point — further distancing one from meaningful discourse. *See also* C. Slatin, "Calling Out White Supremacy," *New Solutions* 29, no. 1 (2019): 5-9.
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