Healthcare Workplace Conversations on Race and the Perspectives of Physicians of African Descent

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BACKGROUND: Although experts recommend that healthcare organizations create forums for honest dialogue about race, there is little insight into the physician perspectives that may influence these conversations across the healthcare workforce.

OBJECTIVE: To identify the range of perspectives that might contribute to workplace silence on race and affect participation in race-related conversations within healthcare settings.

DESIGN: In-person, in-depth, racially concordant qualitative interviews.

PARTICIPANTS: Twenty-five physicians of African descent practicing in the 6 New England states.

APPROACH: Line-by-line independent coding and group negotiated consensus to develop codes structure using constant comparative method.

MAIN RESULTS: Five themes characterize perspectives of participating physicians of African descent that potentially influence race-related conversations at work: 1) Perceived race-related healthcare experiences shape how participating physicians view healthcare organizations and their professional identities prior to any formal medical training; 2) Protecting racial/ethnic minority patients from healthcare discrimination is a top priority for participating physicians; 3) Participating physicians often rely on external support systems for race-related issues, rather than support systems inside the organization; 4) Participating physicians perceive differences between their interpretations of potentially offensive race-related work experiences and their non-minority colleagues' interpretations of the same experiences; and 5) Participating physicians are uncomfortable voicing race-related concerns at work.

CONCLUSIONS: Creating a healthcare work environment that successfully supports diversity is as important as recruiting diversity across the workforce. Developing constructive ways to discuss race and race relations among colleagues in the workplace is a key step towards creating a supportive environment for employees and patients from all backgrounds.

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Prior research indicates that race has a substantial impact on the professional lives of physicians from racial/ethnic minority groups.[1–6] Physicians of African descent report discrimination at work,[1,2,4,7,8] and experiencing perceived race-related discrimination in the workplace can negatively affect job satisfaction and career trajectories.[4] Furthermore, research with physicians of African descent has suggested that negative race-related experiences are often ignored or normalized,[4,8] limiting potentially beneficial discussions about improving the quality of work life for physicians in the healthcare workplace.

Experts recommend that healthcare organizations should openly acknowledge issues of race and create safe forums for honest discourse about race-related work experiences.[9–11] Similar strategies have improved the job satisfaction and career trajectories of minority business professionals.[12–14] The similarities between the described experiences of minority physicians[4,8,15,16] and the experiences of minority business professionals[12–14] suggest that these interventions may also promote similar outcomes for physicians. However, there is little guidance available for healthcare organizations in this area. Less than one-third of physicians report having opportunities for such discussions at work,[8] and the diverse perspectives that might influence this dialogue are poorly understood.

Promoting constructive dialogue about race in the workplace requires insight into physicians' views on the role that racial identity plays in their professional lives. While our previous paper demonstrated that race permeates the experiences of physicians of African descent in the workplace;[4] we did not explore how such experiences may influence the content and character of race-related dialogue at work. A better understanding of these influences on conversations about race is needed as organizations strive to respond to the urgent call for institutional dialogue on race. Although race-related viewpoints held by both white and minority physicians are important, we focus on views of physicians of African descent in this study. We examined the data from qualitative, in-depth interviews with a diverse sample of physicians of African descent to identify the range of perspectives that might contribute to workplace silence on race and affect participation in race-related conversations within healthcare settings.

METHODS

Study Design and Sample

We conducted in-depth interviews with a purposeful sample of practicing physicians of African descent designed to ensure representation across work settings and gender. We located potential participants using the membership roster of the New England Medical Society (an organization of minority physicians), the Web-based African-American physician locator (membership data from the National Medical Association), referrals from community-based organizations, and we identified faculty at all nine academic medical institutions in New England. We sent personalized invitations to more than 50 potential participants; every invited physician agreed to participate. We used a random number generator to select participants from among those physicians responding within 2 weeks of the invitation, allowing skips to ensure diversity across gender and work setting. Using the snowball sampling technique[17,18], we asked study participants to provide the names of other potential participants in the region. Our final sample size of 25 physicians was determined by thematic saturation, the point at which no new themes emerged from successive interviews.[17,18] The research protocol was approved by the Human Investigation Committee of the Yale School of Medicine.

Data Collection and Analysis

Racially concordant interviews were conducted in-person by one of the researchers (MNS). Interviews lasted an average of 40 minutes, were audio-taped, and professionally transcribed and reviewed by the interviewer for accuracy prior to analysis. Interviews began with a broad question: "How do you think race influences your experiences at work?" Specific questions and probes addressed interpersonal and institutional work experiences attributed to race and the influence of race on the physician's career.

We created code definitions as concepts emerged inductively from the data. Each member of the coding team independently coded individual transcripts line-by-line, meeting regularly to resolve discrepancies and review the code structure. We used the constant comparative method of qualitative analysis[19,20] to compare coded segments of text to expand existing themes and identify new themes. Codes were refined until we reached a final coding structure, including a total of 31 codes capturing the major concepts in the data, which was then applied to all of the transcripts. The themes presented in the current analysis emerged from specific codes focused on participant self-view, participant sociohistorical context, career success determinants, and participant perceptions of organizational climate. As recommended by some experts in qualitative research, we contacted participants and asked them to review the summary of the primary themes and supportive illustrative quotations; we asked participants to endorse or amend the findings and none negated or revised any of the findings.[20–22]. Our coding (MNS, LAC, EHB) and broader research teams were diverse across gender, racial/ethnic self-identification, academic discipline, age, and religious affiliation. We used qualitative analysis software to facilitate data management and retrieval.[23]

RESULTS

Our study sample was diverse across a range of characteristics including practice settings, gender, specialty, age, and nativity. The median age of the sample was 45 years (range 35–79 years) and 14 of the participants were women. Six physicians were born outside of the Unites States. Primary work settings included academic medical centers, community health centers, hospital-based practices, private practices, and public health departments. A total of eleven specialties and subspecialties were represented in our sample. More than 70% of participants described the racial/ethnic composition of colleagues and staff in their primary work setting as predominantly white.

Five relevant, novel, and common themes characterize key perspectives of participating physicians of African descent that potentially influence the content and character of race-related conversations in the workplace. First, perceived race-related healthcare experiences shape how physician participants view healthcare organizations and their professional identity prior to any formal medical training. Second, protecting racial/ethnic minority patients from healthcare discrimination is a top priority for interviewed physicians of African descent. Third, physician participants often rely on external support systems for race-related issues, rather than support systems inside the organization. Fourth, physician participants perceive differences between their interpretations of potentially offensive race-related work experiences and their non-minority colleagues' interpretations of the same experiences. Fifth, physician participants are uncomfortable voicing race-related concerns at work.

Perceived Race-Related Healthcare Experiences Shape How Physician Participants View Healthcare Organizations and their Professional Identity Prior to any Formal Medical Training

Participants communicated that their decision to become a physician was in some way influenced by race. Participants were motivated by prior childhood interactions with healthcare professionals and organizations that were interpreted within a racial context. In some cases, these interactions were inspirational experiences with positive role models such as healthcare professionals of African descent. As one participant reflected on his decision to enter medicine:

> "I was very ill as a child, and we lived in a rural part of the state. There really weren't healthcare options for me or my family. The black doctor came all the way from town to see me everyday.... And that is when I knew I wanted to be just like him."
>
> *Male, internal medicine subspecialty, private practice*

Other participants described being motivated to become a physician in order to address the poor treatment of people

of African descent by the healthcare system. Illustrating this inspiration for a career in medicine, a participant described:

> "My grandmother died before she should have…because she was a black woman.… She was not poor.… So, I became a physician to stop black people from dying needlessly or at least to do my part. Ever since I was a kid I have always felt that disparate care for black people goes across all socioeconomic strata. So that's why I went into medicine."
>
> *Female, internal medicine subspecialty, academic*

Career choices, such as practice location and specialty, were also linked to race for some participants. One physician described her choice of work setting:

> "Race actually was the determining factor in choosing this location to practice.… I was working in private practice…but I had always wanted to serve communities of color and so for me that meant coming to this particular institution because the patient population here is why I was driven to become a physician in the first place. So, for me, race was a paramount issue in terms of choosing a location to work."
>
> *Female, internal medicine subspecialty, academic*

Although individual physicians identified several other factors that contributed to their career choices, such as an affinity for basic science or clinical care, the conviction that their presence in the physician workforce would result in improved health outcomes of minority patients was an important consideration in their professional choices.

Protecting Racial/Ethnic Minority Patients from Healthcare Discrimination is a Top Priority for Interviewed Physicians of African Descent

Regardless of their specialty or work setting, participants expressed the belief that race often negatively influenced the care that racial/ethnic minority patients received. Participants referred to historical and contemporary examples of racial/ethnic discrimination in healthcare, and they related personal knowledge of discrimination experienced by racial/ethnic minority patients. Participants related stories of poor treatment experienced by their family members and friends who were of African descent as well as situations when they witnessed the differential care of minority patients, which participants attributed to race in their stories. Although participant responses varied in these circumstances, they identified the protection of minority patients from harm as one of their major roles in healthcare settings. For instance, participants noted:

> "I also have a responsibility to the (black) community to represent the (black) community where they can't go and be seen and heard on their own to protect them. After all, that's why I'm here."
>
> *Female, pediatrics, hospital-based practice*
>
> "I had the pleasure of correcting a white resident once who was upset about my not establishing a policy with patients, mostly patients of color, [that patients] who came late (to clinic) would be automatically turned away before anybody even found out what was going on…and there's something empowering about that for my whole community that I can look out for the patients by prohibiting that kind of policy."
>
> *Female, internal medicine, community health center*

Many participants expressed a voluntary commitment to informal protective roles. These informal roles contrasted to more formal roles into which participants felt they were cast by the organization. Participants frequently felt that these formal roles were not explicit or professionally rewarded, and for some participants, being expected to fulfill these formal roles was viewed as offensive and isolating.

Physician Participants Often Rely on External Support Systems for Race-Related Issues, Rather than Support Systems Inside the Organization

Participants often sought support outside of the workplace especially when race was perceived as an important consideration. Particularly in situations where their professional authority and abilities were being challenged, participants sought support from friends, family, and colleagues outside their workplace. Participants used these external support systems to help validate their abilities and to affirm their contributions at work.

> "Finding support… in my work environment has been hard. Other minority physicians at other hospitals have been a tremendous support for me. I knew they existed and I would contact them and essentially ask them to take care of me. Even though our specialties might be different; they were senior and we made a connection."
>
> *Female, internal medicine, academic*

Although participants varied in the level of support they expected from their organizations, they were most likely to rely on these external connections and reassurances when they did not trust their organizations to provide them with an expected level of needed support or when the organization had failed to do so in the past.

> "A [colleague's] patient died. Even though the decision to give this patient so much fluid might have not been the best, there was much more of a sense of rallying around and a kind of discussing and trying to understand why you would make that decision in that situation. Whereas

[when I was] in a similar situation, there was not that same sort of rally and support for me."

Female, family medicine, hospital-based practice

"This may be overly simplistic, but few people reach out to physicians of color. Many of our colleagues aren't comfortable working with people from different backgrounds, be it patients or colleagues.... They don't know what to make of someone who is different and, in the end, you can't rely on them to support you."

Female, obstetrics/gynecology, academic

Physician Participants Perceive Differences Between their Interpretations of Potentially Offensive Race-related Work Experiences and Their Non-Minority Colleagues' Interpretations of the Same Experiences

Participants perceived that race-related interactions that were potentially offensive to them were dismissed by non-minority colleagues. Participants described the fragility of work relationships, even with well-known colleagues, when confronted with issues of race. In the following example, a surgeon of African descent and a nurse who was white interacted around a race-related issue. The nurse viewed her comments as harmless; the surgeon viewed the comments as racist. They argued and the result was that the colleagues, although they shared clinical responsibilities, had not spoken to each other since the event.

"I have been at my institution for several years and know all of the nurses very well and thought we all worked well. The other day, I was just walking by and heard one of the nurses [who was white] explaining that her daughter was very disappointed that her track and field team had lost.

Another nurse [who was white] said 'The reason why the African American team won is because everyone knows that African Americans have extra muscles in their legs'. She then said to me 'I do not mean to be racist because I'm not. But I want to know if it is true that African Americans have extra muscles in their legs.'

I said 'In fact you are racist because you know with your 20 years of experience as a nurse that you have never seen an African-American with extra leg muscles.'

See this is what I mean. This place where I work is not a level playing field because there is institutional and personal racism.... That nurse and I haven't spoken since."

Male, surgical subspecialty, academic medicine

Several participants described specific situations when comments made by non-minority clinicians were not recognized as offensive by the non-minority individual but were extremely offensive to minority patients, families, and physicians. For instance, a pediatrician related this experience:

"This young white female surgical resident came in and commented on how cute her patient's 'bee stung' lips were. This stuff goes on. The parents looked at me; I looked at them. I went to talk to [the resident].

I said 'That comment about the bee stung lips is offensive.... I told her that those are not comments that she can make to minorities.' That is language used by plastic surgeons for goodness sake.

But, when all the black people are ancillary staff and you think you're a god, you think you can say whatever you want in the workplace.... I don't know if I want her to take care of any of my patients now. You would not believe the stuff that happens."

Female, pediatrician, hospital-based practice

In these examples of differences in the perceptions of shared events, participants believed that race played a major role and perceived that their non-minority colleagues considered race irrelevant. In many cases, long-standing work relationships were damaged or terminated due to unspoken and unaddressed racial tension.

Physician Participants are Uncomfortable Voicing Race-Related Concerns at Work

In addition to the inter-personal consequences of race-related interactions at work, participants were concerned that their professional challenges and successes might reflect differential treatment due to race. Being a racial minority was seen as a characteristic that was used by others as the primary criterion for inclusion or exclusion at work. Whether doors were ultimately opened or closed, participants were guarded in part because they anticipated that race would factor into career-related decisions made by others.

"I have been asked to do a lot of things.... I chair this big thing for the government...and I wonder did they kind of put somebody out there to say 'hey, we got minorities, put the black guy out there.' But, then I say, 'well I have done a lot of good stuff and earned this!' That's the question, that is always you never know, you just never know".

Male, surgical subspecialty, academic

"It is very subtle. Race is a factor in terms of movement, by that I mean when you try to change job responsibilities, change course in an organization, or move up. I joined faculty as a clinician educator. I was supposed to be the cultural competency person but became very interested in health administration and the business side of healthcare. I made it clear to everyone but that interest wasn't nurtured or given an opportunity to grow while I watched others [who were clinician educators] get mentored in administrative medicine. So, I wasn't told

that I wasn't welcome or invited to leave, but I knew I had to move on after that experience. So I left that institution"

Male, family medicine, community health center

Participants discussed their organizations' race-related expectations of physicians of African descent. Although several participants expressed concern that patients from minority backgrounds were vulnerable within their own organizations, few ever voiced these concerns at work. Participants commonly expressed fears that, unless they fulfilled unspoken race-based expectations or roles into which they were cast, they would not be perceived as being of value to the organization.

"At work, people all saddle you with the problem of the resident who is having trouble who happens to be black and you always have to be involved in those conversations to have to speak or have to be on that committee or serve as that representative…I can't stay and not do this. This is part of my job. Right?"

Male, general surgeon, academic

Physicians also anticipated that they would be labeled or stereotyped by colleagues at work if they voiced race-related concerns and, therefore, participants often censored their speech and behavior in work settings.

"I will probably be wrestling with all these issues for the next twenty years. You know, when something [race-related] happens at work, I can feel myself getting annoyed or irritated. When they [non-minority colleagues] say racially insensitive things, I need to know that I can have a voice and say 'did you really mean to say it like that?' But, I don't know that so…I have to keep my cool. My (non-minority) colleagues can show their temper. I dare not do that, act out in any way, because then I'll be dismissed as another 'angry black woman'."

Female, pediatrics, academic

"Professionally, there is no doubt that most medical schools in the US are dying to hire black faculty. But, of course, they want it to be within certain parameters. They don't want you to be too outspoken on racial issues."

Male, family medicine, academic

DISCUSSION

The views and experiences described by our physician participants shed light on the tensions and challenges that healthcare organizations may face as they attempt to promote healthy dialogues about race in the workplace. We found that physicians of African descent in our study often had early and powerful healthcare experiences that were influenced by race. Participants described healthcare organizations as settings in which racial/ethnic discrimination still occur. In addition, participants primarily relied on support networks external to their workplace and were hesitant to discuss race-related experiences within their work environment. This apprehension was reinforced by the perception that their non-minority colleagues would not want to discuss race. Furthermore, participants were concerned that their non-minority colleagues would dismiss the potential contribution of race if the participant found an interaction racially offensive. Participants also expressed fears of damaging their work relationships, being labeled as hypersensitive, and hurting their chances for advancement if they openly discussed race in their work settings.

Our findings build upon an existing literature documenting reports of racial/ethnic discrimination experienced by physicians and physicians-in-training. Prior qualitative studies of racial/ethnic minority high school students, medical students, residents, and practicing physicians described their perceptions and experiences of discrimination within healthcare organizations[4,15,24,25]. Surveys of practicing physicians found that racial/ethnic discriminatory experiences extend post-medical training for significant numbers of racial/ethnic minority physicians[1,2,6,7]. We extended the previous work with practicing physicians of African descent[4] by characterizing the challenges and potential consequences that may arise as healthcare organizations respond to recommendations for open dialogue about race.[9–11]

The perspectives offered by the physicians of African descent in this study highlight both the importance of workplace conversations about race and the challenges organizations may face when trying to promote a healthy dialogue in the workplace. Our findings have several important implications for healthcare organizations focused on the recruitment and retention of a diverse workforce. Given that our findings and management literature identify challenges when engaging racial/ethnic minority and non-minority individuals in such dialogue,[26–28] healthcare organizational leadership must proactively raise awareness and foster organizational climates that support dialogue about race relations and diversity. Our findings are similarly consistent with the literature that notes minority business professionals are less likely to network within their workplace.[12–14] Although seeking support outside of the organization may be effective for the immediate resolution of individual difficulties, this pattern of diverted race-related conversations delays the organization's recognition of any problems and does not promote longer-term changes within the organization. This pattern may also have career consequences for minority physicians since external networking hinders the career advancement of racial/ethnic minorities in the business professions.[12–14]

To address these potential difficulties, safe environments should be created before initiating race-related dialogue. Safe environments are workplaces in which individuals can express personal experiences without fear of dismissal or punishment, where differences across perspectives are explored respectfully, and where confidentiality is assured to prevent subsequent career consequences. Creating a safe physician workplace for race-related conversations will require a cohesive, coordinated initiative with input from members across racial identities, given that race and ethnicity influence the interpretation of shared experiences and shape the professional identity of all physicians and healthcare providers. Although we found that race is an important dimension of physician identity, it is critical to recognize the inherent risk of stereotyping based on

this study's findings. Therefore, the insights presented here are intended as a starting point, not a substitution, for an exploratory process within individual organizations.

It is important to consider the limitations of the study. Our sample was purposefully limited to physicians of African descent living and practicing in the six New England states. Therefore, these findings may not fully characterize the experiences of all physicians of African descent, physicians from other racial/ethnic backgrounds or physicians in other geographic areas. We developed a sample that was nevertheless diverse in terms of potentially relevant characteristics, including a range of academic and nonacademic work settings, clinical specialties, and age groups. Despite this diversity, these physicians shared common views on how race shapes their professional identity and perspectives that may affect their participation in workplace conversations about race. Other strengths of the project include a 100% participation rate, research and coding team diversity, and racial concordance with a physician interviewer. In addition, we used several recommended strategies to ensure scientific rigor, including consistent use of the discussion guide, audio-taping interviews, professional transcript preparation, standardized coding and analysis of the data, participant confirmation of findings, and maintenance of an audit trail to document analytic decisions.[18,21,29,30]

Creating a healthcare work environment that successfully supports diversity is as important as recruiting diversity across the workforce. In addition to the fundamental creation of a safe place for open dialogue, close attention should also be paid to the development and enforcement of specific institutional policies that target discriminatory experiences. Larger initiatives can utilize existing institutional incentives, such as the accreditation and licensure process, to support change.[31] Raising awareness and drafting policy recommendations at the national level can also result in important regulatory and protective guidelines as attempted by other health systems.[32] Developing constructive ways to discuss race and race relations among colleagues in the workplace is a key step towards creating a supportive environment for employees and patients from all backgrounds.

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