Race Dialogues and Potential Application in Clinical Environments: A Scoping Review

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ABSTRACT

BACKGROUND: Race dialogues, conversations about race and racism among individuals holding different racial identities, have been proposed as one component of addressing racism in medicine and improving the experience of racially minoritized patients. Drawing on work from several fields, we aimed to assess the scope of the literature on race dialogues and to describe potential benefits, best practices, and challenges of conducting such dialogues. Ultimately, our goal was to explore the potential role of race dialogues in medical education and clinical practice.

METHODS: Our scoping review included articles published prior to June 2, 2022, in the biomedicine, psychology, nursing and allied health, and education literatures. Ultimately, 54 articles were included in analysis, all of which pertained to conversations about race occurring between adults possessing different racial identities. We engaged in an interactive group process to identify key takeaways from each article and synthesize cross-cutting themes.

RESULTS: Emergent themes reflected the processes of preparing, leading, and following up race dialogues. Preparing required significant personal introspection, logistical organization, and intentional framing of the conversation. Leading safe and successful race dialogues necessitated trauma-informed practices, addressing microaggressions as they arose, welcoming participation and emotions, and centering the experience of individuals with minoritized identities. Longitudinal experiences and efforts to evaluate the quality of race dialogues were crucial to ensuring meaningful impact.

DISCUSSION: Supporting race dialogues within medicine has the potential to promote a more inclusive and justice-oriented workforce, strengthen relationships amongst colleagues, and improve care for patients with racially minoritized identities. Potential levers for supporting race dialogues include high-quality racial justice curricula at every level of medical education and valuation of racial consciousness in admissions and hiring processes. All efforts to support race dialogues must center and uplift those with racially minoritized identities.

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INTRODUCTION

Racism is a societal issue that profoundly impacts public and personal health.[1–3] Addressing racism requires interventions at multiple levels of society, from national and institutional policies that distribute resources and opportunities equitably, to changes in individual clinician behaviors that shape healthcare interactions.[4] Recent literature has called for the application of antiracist practices to medicine in order to acknowledge and reduce disparities.[5–7] Yet, many clinicians remain uncertain about how to best address racism.[8–10] Race dialogues present one possible tool for doing so effectively.

Race dialogues are one–on-one and group conversations on the topic of race and racism among individuals holding different racial identities.[11] Such conversations aim for participants to explore their social identities and experiences in relation to those of others, which may translate into greater awareness of racial biases, understanding, and empathy, as well as increased anti-racist action among dialogue participants. Still, despite positive potential outcomes, such conversations can also be inefficacious, harmful, or traumatic if not carried out skillfully.[12] Training and instruction for facilitating race dialogues are not commonplace, and many clinicians may be unprepared for carrying out such dialogues in a meaningful manner.

Towards addressing this gap, we sought to conduct a scoping review on race dialogues within the biomedicine, psychology, nursing and allied health professions, and education literature. We aimed to describe the benefits, best practices, and challenges of conducting race dialogues, with the ultimate goal of exploring the potential role of race dialogues in medical education and clinical practice.

METHODS

Overview We conducted a scoping review of the literature informed by the PRISMA-ScR (Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews) guidelines.[13] The scarcity of relevant research on race dialogues in the biomedical field and the exploratory nature of our study objective lend themselves to a scoping review approach with a broader search field.

Search Strategy In collaboration with a research librarian, we developed and refined a search strategy. We used the following keyword terms for title and abstracts: "race," or "racial," or "racism," or "anti-rac*," or "cross-racial," or "interracial," or "inter-racial" AND "dialog*," or "talk," or "convers*," or "communicat*," or "discuss*." We searched the following databases: PubMed (biomedical), CINAHL (nursing and allied health), ERIC (education), PsycINFO (psychology), and EBSCO (race relations). Additional details can be found in Appendix Table 2. The search included papers published prior to June 2, 2022. Queries were limited to the English language. Resulting records were pooled from each database search and duplicates were removed. We used Covidence (Covidence systematic review software, Veritas Health Innovation, Melbourne, Australia. Available at www.covidence.org) to screen, tag, and extract data, as well as to catalog and compare relevant concepts and findings while reviewing articles.

Study Selection Following the identification of articles based on search terms, the abstracts were independently reviewed for relevance by two research team members based on eligibility criteria for inclusion in full text review. Generally, articles were included if they pertained to conversations about race occurring between adults possessing different racial identities. A full list of inclusion and exclusion criteria used to evaluate articles is included in Appendix Table 3. Articles with disparate decisions from the two reviewers were reviewed and discussed together by the research team to reach a consensus decision.

Data Extraction and Analysis Four research team members participated in the full text review, which involved confirming paper eligibility and synthesizing key takeaway points. Following data collection and critical appraisal of the sources, we engaged in iterative discussions to identify takeaways from each article, group them into broader categories, and ultimately identify cross-cutting key themes. The analysis included summarizing and reporting these themes, as well as drawing comparisons between and among them to synthesize the literature. Members of the research team held diverse racial/ethnic identities, and throughout the research process, team members engaged in reflexive practices to understand how their own positionality influenced their reaction to and analysis of papers.

RESULTS

Our search yielded 1363 citations. After removing duplicates, we screened 846 unique abstracts for eligibility. After excluding 770 articles that did not meet inclusion criteria, we completed full text review of 76 articles. An additional 22 articles failed to meet inclusion criteria upon full review, resulting in a final sample of 54 articles. We illustrate the process of the identification, screening, and inclusion of articles in Fig. 1.

Characteristics of Included Studies

The resulting relevant literature on race dialogues included research studies, perspective pieces, and curricula that explore different types of race dialogues (e.g., group or one-on-one) occurring in various settings (e.g., educational, medical, psychological, or personal). The majority of articles ($n = 29$) came from the education literature and explored race dialogues in classroom settings such as college or graduate school courses. A smaller body of literature explored race dialogues with patients in medical and behavioral health settings. In Table 1, we have classified the articles included in this scoping review based on the type of race dialogue described and the setting of the race dialogue.

We identified three major themes during our analysis of the included literature which represent various processes that occur during the execution of race dialogues, specifically: preparing for the race dialogue, leading the race dialogue, and following-up after the race dialogue.

Theme 1: Preparing—Race Dialogues Necessitate Preparation and Reflection. Self-reflection Numerous articles identified the importance of race dialogue facilitators reflecting on their own identities in preparation for a race dialogue, carefully considering the ways in which their own identities might affect the dialogue. For example, in her exploration of race dialogues occurring in group psychotherapy sessions, Ribeiro notes,

> *…group therapists need to first examine the intersectionality of their own privileged and marginalized identities to better prepare for their clients' examination of their identities and the processes that occur within the group. When race and other social identities go unexamined, the therapist, whether consciously or unconsciously, may cause or allow undue harm in the group in the form of microaggressions.*[52]

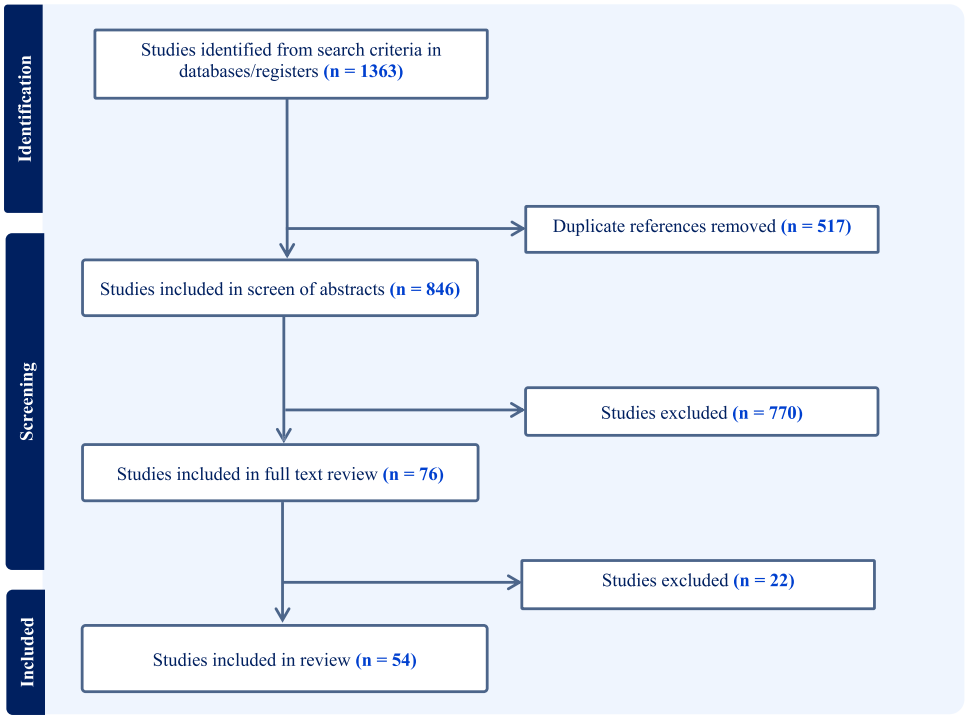

Figure 1 Identification, screening, and inclusion of articles in scoping review.

Table 1 Classification of Race Dialogue Articles by Dialogue Type and Setting

		Dialogue type	
		Group	**One-on-one**
Dialogue setting	**Educational**	*Between students in the classroom* Ashby et al.[14]; DeKoven[15]; DiAngelo and Sensoy[16]; Fishman and McCarthy[17]; Flanagan and Hindley[18]; Ford and Malaney [19]; Johnson and Mason[20]; Maxwell and Chesler[21]; Maxwell and Chesler[22]; McGowan et al.[23]; Mulvey and Richards[24]; Murray-Johnson[25]; Nagda and Zúñiga [26]; Quaye[27]; Quaye[28]; Ramasubramanian et al.[29]; Rodríguez et al.[30]; Sue and Constantine[31]; Sue et al.[32];Sue et al.[33]; Sue[34]; Walls and Hall[35]; Tatum et al.[36]; Weinzimmer and Bergdahl[37] *Between educators, administrator, and/or parents* Cook et al.[38]; Kohli[39]; Henze et al.[40]; Manglitz et al.[41]; Murray-Johnson et al.[42]	
	Medical	*Between medical school faculty* Hardeman et al.[43]; Acosta and Ackerman-Barger[44] *Between medical school students* Bright and Nokes[45]; Brooks et al.[46]; Murray-Garcia et al.[47] Peek et al.[48]	*Between patient and physician* Diop et al.[49]; Saha and Cooper[50]; Shankar et al.[51];
	Psychological	*In the group therapy setting* Ribeiro[52] *Between psychology and social work trainees* McDowell et al.[53]; Brady et al. [54]; Chung et al.[55]	*Between therapist and client* Bartholomew et al.[56]; Cardemil and Battle.[57]; Fripp and Adams[58]; Delapp and Delapp[59]; Straker[60];Thompson and Jenal[61], Zhang and Burkard[62] *Between therapist and supervisor* Estrada et al.[63]; Schen and Greenlee[64]; White-Davis et al.[65]
	Personal		*Between friends* Sanchez et al.[66] Parker and Wittmer[67]

Further, in their exploration of how Black faculty facilitate difficult dialogues on racism in the college classroom, McGowan and colleagues add,

> *The preparation process was sometimes harder than the actual facilitation. In addition to accounting for our biases and assumptions, we were always aware of our racialized and gendered beings and the ways in which we showed up when engaging this work.*[23]

Several authors highlight the particular importance of this deep and introspective preparatory work for White-identified individuals leading race dialogues.[44,59,64]

> *Many may assume that because faculty members are highly educated instructors well versed in their fields, they have the skills to openly dialogue with students about difficult topics, yet, for the most part, health professions faculty are not even formally trained to teach, let alone trained to teach about race… to constructively facilitate conversations about race, many faculty members need to examine and talk about white privilege and how this impacts their teaching, how it impacts their perspective of students of color, and how it impacts their clinical decision making for patients who are of a different race or ethnicity than they are.*[44]

One tool proposed to support facilitators in self-examination prior to race dialogues is the "8S Self-Reflective Framework," which invites facilitators of race dialogues to pause and ask themselves, "do I know me in the context of this discourse?…How might my race, gender, and other identity impact the moment?".[25]

Logistical Preparation The importance of being well-versed in the content and structure of a race dialogue was also described by several authors. For example, in Brooks and colleagues' workshop for third year medical students on talking about racism in the clinical setting, faculty facilitators began preparing for the session several months in advance, which included completing extensive readings and meeting with an expert facilitator.[46] Shankar and colleagues further note the importance of equipping individuals leading race dialogues with strategies to address bias and racism in the moment.[51] For example, in their workshop, medical students are encouraged to think about how they would respond to witnessing an attending physician discriminate against a patient and are shown an example of how they might best respond to such an occurrence. By pre-emptively equipping students with language to initiate a race dialogue and an opportunity to practice the conversation, the authors highlight the value of intentional preparation.

Expectation Setting When engaging in group race dialogues, many articles called for setting ground rules upon which all participants agree.[23,40,44,48,51,54] This practice promotes an emotionally safe environment and serves as a guiding framework to return to when conversations veered in a challenging direction. In Chung and colleagues' study of race dialogues in graduate psychology classrooms, they advised facilitators to begin race dialogues by asking students to generate ground rules for respectful and open discussions.[55] They also discussed the importance for faculty members to pre-emptively "normalize strong emotional reactions such as guilt, anger, embarrassment, tension, hurt, and anxiety as part of the discussions." At the same time, some authors highlight the tendency for ground rules governing race dialogues to perpetuate White norms, catering to White fragility, and call for awareness of facilitators to this dynamic.[16,34] For example, DiAngelo and Sensoy describe a tendency for White students to feel "attacked" during race dialogues, and as a result, efforts are often made by facilitators to increase safety for White students reacting to the realities of racism in this way.

> *In practice, the expectation that safety can be created in racial discussions through universalized procedural guidelines can block students of Color from naming the racial violence they experience on a daily basis, as well as the racial violence they may experience in the discussion itself. In other words, the discourse of safety in the context of race talk is always about White safety.*[16]

Theme 2: Leading—Race Dialogues Require Intentional Communication and Adaptability. Using Trauma-Informed Practices Several authors recognized that having conversations about racism can raise challenging emotions and evoke prior traumatic experiences for participants.[19,35,60] They described how strategies used in the treatment of post-traumatic stress disorder can be applied to navigating race dialogues in order to minimize risks of perpetuating trauma for participants. Such strategies include, for example, asking for consent before initiating a race dialogue, reminding participants of their right to stop the conversation at any time, empowering participants to share as much or as little as they feel comfortable with, allowing participants to direct the conversation, and listening intently without interrupting.

Addressing Microaggressions Numerous authors highlight the importance of acknowledging and addressing microaggressions and overt racism that arise during race dialogues in order to maintain an environment where all participants can feel safe and seen.[29,31,33,52] Saha and Cooper name common pitfalls that occur in race dialogues, such as doubting experiences of racism, acting overly surprised that something racist occurred, becoming defensive, shifting focus onto something else instead of racism, and qualifying condemnations of racism.[68] Authors also highlight the inevitability that microaggressions will occur in these conversation; as Sue puts it, we must "be open to racial blunders…it is how you recover, not

how you cover up, that is important."[34] Ribeiro discusses responding to microaggressions that occur in race dialogues in the group therapy setting, highlighting the importance of holding space for an apology by the person who committed the microaggression, but being cautious to ensure that "the leader or member does not over-apologize to the point that the targeted person or other group members feel the need to take care of the person who committed the microaggression."[52] Ribeiro calls on facilitators to listen intently when group members share how microaggressions made them feel and to avoid perpetuating dynamics where the experiences of individuals with minoritized identities are discounted.

Centering the Experience of Individuals with Minoritized and Historically Marginalized Identities Several authors underscore that the experience of engaging in race dialogues is not equivalent for all people, and race dialogues cannot be approached in a race-neutral way that assumes all voices will be heard equally.[20,51,60] For example, Hardeman and colleagues convened two different groups of professionals at a medical school to discuss racism.[43] The first group included primarily women of color, and the second group added White, primarily male colleagues to the first group. In the second group, the dynamic shifted markedly,

> *What we see in this process is that even among racially aware allies, racialized and socialized roles can easily dominate, resulting in the perpetuation and replication of power structures in spaces where the intent to avoid doing so is quite explicit.*[43]

Hardeman and colleagues call for interracial groups discussing racism to apply a race-conscious lens to their interactions with each other, which requires participants to explicitly acknowledge and grapple with their own racial biases, turning inward and asking themselves at every step while engaging in race dialogues, "how is racism operating here?"[43] Others, too, call out the need to cultivate a critical racial awareness amongst race dialogue participants, with explicit conversation about differences in privilege and power within the group.[17,26,53] As illustrated in Hardeman and colleagues' work, intersectionality—in this case the intersection of racial identity and gender identity—is key to understanding the way privilege and power manifests within a group engaging in race dialogues.[69]

In the clinical setting, multiple authors describe the potential value of acknowledging identity differences between clinicians and patients with minoritized racial identities.[61] Delapp and Delapp agree with the importance of clinicians being open to discussing identity differences, but also underscore the importance of not making assumptions about how patients feel about those differences.[59] They encourage clinicians to empower patients to lead through statements such as, "I would be happy to discuss how our differences impact how it feels to talk about your experiences now or at any point during our work together."

Finally, authors acknowledge the toll that race dialogues can take on racially minoritized individuals. Several authors describe "racial battle fatigue" whereby faculty with minoritized identities are tasked constantly with the burden of work involved in these conversations.[23,34] Authors note the importance of peer mentorship and "sanctuary spaces" for people of color facilitating race dialogues with interracial groups.[23,25]

Theme 3: Following-up—Impactful Race Dialogues Involve Continued Engagement Beyond Initial Conversations. One-Off Experiences Are Insufficient Numerous authors underscore the importance of race dialogue experiences that are sustained over time. In their presentation of a stand-alone workshop, Brooks and colleagues note, "it is unlikely that just one session before starting clinical clerkships is enough to maintain the practice of sustained critical thinking regarding bias and racism in clinical medicine."[46] Murray-Garcia and colleagues go one step further, asserting that, "to not take this educational task seriously by offering only token, infrequent, or single sessions, without follow-up and trained facilitators, may be worse than doing nothing.".[47]

Measuring Impact Authors evaluated the impact of race dialogues in different ways including surveys assessing participants' self-reported awareness of and comfort with talking about race and racism[20,45,53], surveys assessing participants perception of curriculum quality[46], and qualitative interviews regarding participants' experiences of race dialogues.[17] Ashby and colleagues developed a new scale, the "Comfort With Racial Dialogues Scale (CRDS)," which consists of 20 questions aimed at evaluating individuals' comfort with "(a) Starting Conversations About Race (six items; e.g., "Initiating conversations about race does not feel difficult for me"), (b) Having Conversations About Race (six items; e.g., "I feel comfortable talking about race"), and (c) Challenging Racism (eight items; e.g., "When I witness racist incidents, I am likely to respond").".[14]

DISCUSSION

We performed a scoping review on race dialogues within the biomedicine, psychology, nursing and allied health, and education literatures. Our findings suggest best practices for conducting race dialogues beginning with the preparation of the conversation, leading the conversation, and finally following-up to ensure lasting impact. Preparing to facilitate race dialogues required significant personal introspection, logistical organization, and intentional framing of the conversation. Key to leading safe and successful race dialogues were use of trauma-informed practices, addressing microaggressions as they arose, welcoming participation and emotions, and centering the experience of individuals with minoritized identities. Finally, longitudinal experiences and

efforts to evaluate the quality of race dialogues were crucial to ensuring meaningful impact.

Race dialogues occur in multiple health care settings, to which the themes identified in our scoping review may apply. These include clinical settings staffed by multi-disciplinary teams; academic divisions and departments; undergraduate, graduate, and continuing medical education programs; and conversations between clinicians and patients. Highlighted in many articles, the theme of preparation underscores the need for incorporation of high quality racial-justice curricula at all levels of medical training, from undergraduate to continuing medical education. Structural competency training represents one promising approach to centering racial-justice education in medical education.[70] Structural competency asks participants to recognize how structural determinants of health (i.e., racism, sexism, ableism) are operating in any given context and to consider how these structures underlie the social determinants of health (such as poverty, food insecurity, homelessness), which have been shown to greatly affect experiences of healthcare and health outcomes. Structural competency curricula can equip health professional who wish to engage in race dialogues with the ability to identify how and when racism might affect patients and communities in their setting.

Another important facet of preparing for race dialogues emphasized in many articles was self-examination and introspection. Authors noted that when race dialogue participants were unaware of or unintentional about their own identities as it related to the dialogue, so often the dynamics that arose recreated and perpetuated racism. At every level from medical school admissions to hiring Deans and Chief Medical Officers, admissions and hiring criteria should value candidates who are doing the work of deep introspection—reflecting on their own identities and relationship to privilege, power, and oppression. In their perspective on "Using Admissions to Address Racism in Medical Education," Anderson and colleagues call for more direct assessments of applicants' racial consciousness and attitudes.[71] They propose a variety of strategies that could be incorporated into the medical school admissions process including application essays that explicitly ask applicants to reflect on their own identities, interview questions that challenge candidates to describe how they would respond to witnessing discriminatory scenarios, and inclusion of community members from minoritized groups as interviewers and as members of admissions committees. These efforts recognize that being able to engage in thoughtful race dialogues is a pre-requisite to success in the field of medicine, with implications for individuals' ability to competently serve patients with minoritized identities and contribute positively to racially diverse learning and working environments.

Institutions committed to supporting race dialogues must take active steps to ensure safety, first and foremost, for participants with minoritized identities. Our review suggests that race dialogues have frequently been dictated by the needs of White participants. Occurring sometimes in subtle and implicit ways, prioritizing White comfort meant limiting emotional reactions, failing to recognize the presence of racial tensions, and engaging with defensiveness from White participants. Ultimately, race dialogues that center White needs are draining and serve to reproduce harm against individuals from racially minoritized groups, representing another form of minority tax whereby trainees and faculty with identities that are underrepresented in medicine are forced to take on additional, uncompensated labor and responsibilities.[72] Racial affinity groups, intended to support discussion of racism amongst individuals who share a racial identity can be important healing spaces for individuals with minoritized identities. They can also serve to facilitate learning and growth opportunities for White individuals to process their reactions to racism without taxing colleagues with minoritized identities.[73] Conversations occurring in racial affinity groups are not intended to replace interracial dialogues, but rather can occur alongside each other to enhance the safety and quality of interracial dialogues.

Our study has limitations. While our search strategy drew on best practices in conducting literature reviews, our use of specific terms and omission of papers written in non-English languages may have resulted in the exclusion of relevant papers. By design, scoping reviews intend to appraise a broad body of literature, which may sacrifice depth of analysis. Further, we did not assess the quality of the studies included in our review. Finally, while our review includes papers from a wide range of sources, all papers included were published in an academic journal. Thus, our study does not capture wisdom outside of the academic sphere, thereby perpetuating an epistemic injustice that exists within health equity research, whereby the production of knowledge often comes from places of power.[74]

CONCLUSION

Our scoping review describes the occurrence of race dialogues in a wide range of settings and highlights key strategies and common challenges. Supporting race dialogues within medicine has the potential to promote a more inclusive and justice-oriented workforce, strengthen relationships amongst colleagues, and improve the ability of healthcare providers to care for patients with racially minoritized identities. This will require investment by medical institutions in racial justice education, admissions, and hiring processes that promote a racism-conscious workforce, and promotion of race dialogues that center and uplift those with minoritized identities. Race dialogues between clinicians and patients has the potential to be particularly meaningful, and, when broached skillfully, can contribute to strengthening patient-clinician relationships. Ultimately, race dialogues likely represent an important aspect of societal and system level efforts to advance health equity.

APPENDIX

Table 2 Database Search Terms

Database	Discipline	Search terms
EBSCO	Race relations	Boolean Phrase: *TI (race OR racial OR racism OR anti-rac* OR cross-racial OR interracial OR inter-racial) AND TI (dialog* OR talk* OR convers* OR communicat* OR discuss*) NOT TI (car OR controller OR sensor OR driver OR mobile OR commercial OR pigeon OR device OR video OR vehicular OR automotive OR radio OR circuit OR wireless OR telephone OR satellite)*
ERIC	Education	Boolean Phrase: *TI (race OR racial OR racism OR anti-rac* OR cross-racial OR interracial OR inter-racial) AND TI (dialog* OR talk* OR convers* OR communicat* OR discuss*) NOT TI (car OR controller OR sensor OR driver OR mobile OR commercial OR pigeon OR device OR video OR vehicular OR automotive OR radio OR circuit OR wireless OR telephone OR satellite)*
CINAHL	Nursing and Allied Health	Boolean Phrase: *TI (race OR racial OR racism OR anti-rac* OR cross-racial OR interracial OR inter-racial) AND TI (dialog* OR talk* OR convers* OR communicat* OR discuss*) NOT TI (car OR controller OR sensor OR driver OR mobile OR commercial OR pigeon OR device OR video OR vehicular OR automotive OR radio OR circuit OR wireless OR telephone OR satellite)*
PsychINFO	Psychology	Boolean Phrase: *TI (race OR racial OR racism OR anti-rac* OR cross-racial OR interracial OR inter-racial) AND TI (dialog* OR talk* OR convers* OR communicat* OR discuss*) NOT TI (car OR controller OR sensor OR driver OR mobile OR commercial OR pigeon OR device OR video OR vehicular OR automotive OR radio OR circuit OR wireless OR telephone OR satellite)*
PubMed	Biomedical	Boolean Phrase: *(race[ti] OR racial[ti] OR racism[ti] OR anti-rac*[ti] OR cross-racial[ti] OR interracial[ti] OR inter-racial[ti]) AND (dialog*[ti] OR talk*[ti] OR convers*[ti] OR communicat*[ti] OR discuss*[ti]) NOT (car[ti] OR controller[ti] OR sensor[ti] OR driver [ti] OR mobile [ti] OR commercial [ti] OR pigeon[ti] OR device[ti] OR video[ti] OR vehicular[ti] OR automotive[ti] OR radio[ti] OR circuit[ti] OR wireless[ti] OR telephone[ti] OR satellite[ti])*

Table 3 Article Eligibility Criteria

Inclusion criteria (the article must meet all of the following relevance criteria)

Communication about race occurring between individuals holding different racial identities is a major focus of the article (this is inclusive of both structured and unstructured, private and public dialogues)

Communication about race refers to interpersonal discussion rather than a more theoretical/broad use of the word 'talk' or 'conversation' (e.g., if 'talking about race' referred to disseminating information on the existence of systemic racism rather than interpersonal discussion, the article was not relevant)

Communication about race is suggested, discussed, or implied to occur for an identified purpose (e.g., community engagement, discussing issues, building relationships, practicing democracy, raising voices or multiple perspectives) OR the article discusses factors which affect interpersonal communication about or relevant to race

Exclusion criteria (in order for a relevant article to be excluded from the study, the article will meet at least one of the following exclusion criteria)

The article pertains to conversations about race between individuals holding the same racial identity

The participants are children younger than 18 years old

The corresponding author of articles with relevant abstracts or titles with no full text available will be contacted – the article will be excluded if no contact is returned within two weeks

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Declarations:

Conflict of Interest: *The authors declare no competing interests.*

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