

# Breaking the Silence: Time to Talk About Race and Racism

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## Abstract

Recent events in the United States have catalyzed the need for all educators to begin paying attention to and discovering ways to dialogue about race. No longer can health professions (HP) educators ignore or avoid these difficult conversations. HP students are now demanding them. Cultural sensitivity and unconscious bias training are not enough. Good will and good intentions are not enough. Current faculty development paradigms are no longer sufficient to meet the

educational challenges of delving into issues of race, power, privilege, identity, and social justice.

Engaging in such conversations, however, can be overwhelmingly stressful for untrained faculty. The authors argue that before any curriculum on race and racism can be developed for HP students, and before faculty members can begin facilitating conversations about race and racism, faculty must receive proper training through intense and introspective

faculty development. Training should cover how best to engage in, sustain, and deepen interracial dialogue on difficult topics such as race and racism within academic health centers (AHCs). If such faculty development training—in how to conduct interracial dialogues on race, racism, oppression, and the invisibility of privilege—is made standard at all AHCs, HP educators might be poised to actualize the real benefits of open dialogue and change.

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Not everything that is faced can be changed, but nothing can be changed until it is faced.

—James Baldwin<sup>1</sup>

**R**ecent events in the United States<sup>2,3</sup> have catalyzed the need for all educators to begin paying attention to and discovering ways to dialogue about race. All includes us: educators in the health professions

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(HP). No longer can we ignore or avoid these discussions. As Brooks,<sup>4</sup> a fourth-year medical student, has aptly written, “if we refuse to deeply examine and challenge how racism and implicit bias affect our clinical practice, we will continue to contribute to health inequities in a way that will remain unaddressed in our curriculum and unchallenged by future generations of physicians.” Our students are now demanding open dialogue, and we educators are currently denying them.

As many have recognized, cultural sensitivity training, through which participants learn about cultural differences and the importance of not assigning more value to one culture over another, is not enough.<sup>5–7</sup> Such training provides a starting point, but it does not prepare faculty to talk about race and racism in the classroom or at the bedside. Likewise, unconscious bias training is not enough. Unconscious bias training assists faculty members with self-reflection and identifying personal biases,<sup>8</sup> but it does not provide a deeper understanding of how and why we are impacted by race. Nor does it provide the skills to dialogue about race especially with students, staff, and faculty of other races and ethnicities. Both cultural sensitivity training and unconscious bias training are important, but faculty need more. HP faculty need not only the ability to recognize prejudice and discrimination but also the tools to speak up against it when they witness it.

Currently, in most cases faculty do not speak against, or even about, racism. In her essay, “The Patient Called Me ‘Colored Girl’—The Senior Doctor Training Me Said Nothing,” Okwerekwu writes, “Every one of us needs to own the principles that protect us and our patients from racism and bias. That means learning to see prejudice and speaking up against it.” She also admits that “that is far, far easier said than done.”<sup>9</sup> She experienced faculty who chose to avoid the discussion, or worse, were silent and acted as if the discriminatory incident never occurred. She stopped questioning the faculty in fear of retribution and the impact it might have on her evaluation.<sup>9</sup> Her experience highlights the need for training that goes beyond learning about cultural sensitivities and unconscious bias. HP faculty need deeper training because, as Okwerekwu writes eloquently in a second essay, “Silence in the face of injustice not only kills any space for productive conversations, but also allows cancerous ideas to grow.”<sup>10</sup>

We believe that now is the time to stop the silence. We also acknowledge, however, that, as Murray-García and colleagues<sup>11</sup> suggest, these experiences—witnessing discrimination and openly discussing racism—can be overwhelmingly stressful for untrained faculty “who may quickly leverage their authority to divert these awkward dialogue opportunities to less threatening, more safe ground, role modeling the very avoidance behavior we are trying to identify and transform in trainees.”

At our own academic health center (AHC), HP students have indicated that they *need* to talk about these issues. Students are looking to faculty to catalyze conversations about race and racism, but faculty have been largely silent and unengaged. Students attending the local first-year anniversary event celebrating White Coats for Black Lives hypothesized about why local faculty (the overwhelming majority being non-Hispanic white) did not talk about race and racism. They shared the following insights:

“Faculty are not interested.”

“Faculty don’t think it’s their problem or issue.”

“Faculty feel too vulnerable to talk about such a sensitive topic.”

“Faculty don’t want to be ‘found out’ [i.e., some faculty have deep-seeded bias and prejudice that they do not want to reveal].

“Faculty don’t know how to talk about race.”

“Faculty fear that they will say the wrong thing and sound like a racist or a bigot.”

“Faculty worry that they will become defensive.”

We could not agree more with the students’ provocative insights. To meet the contemporary learning needs of students, the faculty teaching them need the proper skills; they need faculty development programming that addresses their fears and any other reasons for avoiding dialogues about race, racism, and other difficult topics.

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, HP faculty are not even formally trained to teach, let alone trained to teach about race. Without training, faculty tend to teach how they were taught, and therefore, they tend to be more comfortable lecturing *to* students rather than dialoging *with* them. In doing so, faculty often take the privileged path of least resistance and avoid or ignore the topic of race altogether. In addition, to constructively facilitate conversations about race, many faculty members need to examine and talk about white privilege and how this impacts their teaching,<sup>12</sup> how it impacts their perspective of students of color,<sup>12</sup>

and how it impacts their clinical decision making for patients who are of a different race or ethnicity than they are.<sup>13</sup> When all is said and done, faculty development needs to be deliberate in addressing race, racism, and white privilege.

We argue that before any curriculum on race and racism can be developed for HP students, and before faculty can begin facilitating conversations about race and racism, faculty must receive proper training. AHCs need to provide, and faculty should actively pursue, the skills needed to catalyze conversations about race and structural inequality. HP students deserve faculty who have the skill sets and capacity to look introspectively first—that is, to discover how they themselves contribute to the difficulty in discussing race, to process and take ownership of their contributions—and then to move forward in participating in meaningful dialogues about race and racism in a safe environment.<sup>12</sup> As Wear and colleagues<sup>14</sup> state:

Good will and good intentions alone are insufficient to meet the educational challenges inherent in confronting race, power, privilege, and identity. Good intentions must be accompanied by the skills needed to facilitate open dialogue, preserve safety, and address conflicts—not in order to achieve “conflict resolution,” but in order to place one’s own and others’ views and assumptions into the open and to allow questioning so that all may achieve new perspectives, insights, and understanding.

### What Can Be Done?

If we swim against the “current” of racial privilege, it’s often easier to recognize, while harder to recognize if we swim with it.

—Robin DiAngelo<sup>15</sup>

Faculty development must be intentional, and it must stimulate deep introspection, a willingness to be honest, and a commitment to change. It must go beyond the usual (and safer) approach of completing online modules or reading books and journal articles on race and racism. Faculty development should encourage and facilitate fluid discourse on high-stakes issues such as racism, internalized dominance, internalized oppression, and the invisibility of privilege.<sup>15</sup> Spaces (e.g., trainings and faculty development) where faculty already meet and dialogue regularly represent

possible venues for developing authentic cognitive and empathetic connections with one another, for facing structural inequality, and for building familiarity with how to hold and facilitate difficult conversations with students. Wear and colleagues<sup>14</sup> suggest that faculty should be willing “to examine uncomfortable realities that are exceedingly difficult to confront” and should “practice fearlessness”; they propose applying the antiracist pedagogy—that is, critically reflecting on the ways in which oppressive power relations and embedded privilege are made visible within the institution and ultimately impact faculty, staff, students, even patients.

A prerequisite for dialoguing about race and racism is to understand the complexity of racism. In a 2000 article, Jones<sup>16</sup> neatly describes and exemplifies three levels of racism within institutions that can help faculty understand how race and racism can be operational in academic medical institutions, and how racism can lead to health inequities. *Personally mediated racism* is based on prejudice and discrimination, whether intentional or not. Prejudice refers to the beliefs and assumptions held by individuals about other groups which are often based on limited knowledge. Discrimination is action based on prejudice that includes things like poor quality or no service, suspicion, avoidance, surprise at competence, police brutality, and hate crimes.<sup>15,16</sup> *Internalized racism* refers to the acceptance of the assumptions, biases, and stereotypes placed on racial groups, and how they are supposed to be—for example, believing that because of their race or ethnicity people of color are not as capable of succeeding in HP and are therefore destined for jobs that require less rigorous education. *Institutionalized racism* entails the unspoken societal norms that are accepted and practiced within an institution that promote inequities. Institutionalized racism includes the historical accumulation and ongoing use of institutional power to support differential access by race to goods, services, and opportunities.<sup>15,16</sup> Sharing clear definitions and examining the levels of racism and how they exist in the health care setting will help faculty begin the difficult but necessary conversations about racial injustice. In turn, current and future generations of health care providers will be better positioned to ameliorate health disparities and promote health equity.

The kind of training we advocate is currently outside the scope of topics broached in faculty development programs at most HP schools, so the need to confront race requires us to rethink what is possible and to consider approaches outside the HP education box. AHCs should consider piloting proven approaches from fields such as multicultural education that could provide the proper and intense dialogue training necessary for faculty to overcome the resistances and challenges they face in talking about race and racism. For example, the courageous conversation strategy and protocol<sup>12</sup> addresses the impact that race and racism have on the achievement of students of color. This dialogue strategy entails specific agreements, conditions, and monitoring that not only engage participants but also help sustain and expand interracial dialogue about race. The protocol requires a commitment from educators to adopt “four agreements” that define the conversation process:

1. “Stay engaged,”
2. “Speak your truth,”
3. “Experience discomfort,” and
4. “Expect and accept non-closure.”<sup>12</sup>

Collectively, these provide a space that is open, honest, and safe, ensuring more meaningful interracial dialogue. To support the four agreements, the strategy includes “six conditions” that serve as a road map to keep participants focused on the subject matter at hand. The six conditions are as follows:

1. “Establish a racial context that is personal, local, and immediate,”
2. “Isolate race while acknowledging the broader scope of diversity,”
3. “Develop an understanding of race as a social/political construction of knowledge, and engage multiple racial perspectives to surface critical understanding,”
4. “Monitor the parameters of the conversation by being explicit and intentional,”
5. “Establish agreement around a contemporary working definition of race,” and
6. “Examine the presence and role of Whiteness and its impact on the conversation.”<sup>12</sup>

Overall, a courageous conversation strategy “engages those who won’t talk” (first and second conditions), “sustains the conversation when it gets uncomfortable or diverted” (third and fourth conditions), and “deepens the conversation to the point where authentic understanding and meaningful actions occur” (fifth and sixth conditions).<sup>12</sup> In summary, courageous conversations serve as a dialogue tool to deinstitutionalize racism.

We recognize that there are many other models for learning how to dialogue about race and racism including, for example, those discussed by Wear and colleagues<sup>14</sup> and the Undoing Racism Methodology developed by the People’s Institute.<sup>17</sup> We invite others to bring their educator’s attention to some of these approaches, to share their strategies, and to discuss the outcomes they have witnessed and/or experienced. We believe that the Association of American Medical Colleges (AAMC) should develop a repository of best practices and make them accessible to all AHCs for faculty development. Additionally, the AAMC should develop its own faculty development model that member institutions could adapt and benefit from. After all, the communication of these resources should be an integral component of Diversity 3.0.<sup>18</sup>

## Conclusion

The time to break the silence and embrace our vulnerability is now. Recent events are pressuring HP educators to lean in and learn how best to engage in, sustain, and deepen interracial dialogue on race within AHCs. If we can make faculty development training in interracial dialogue on race, racism, oppression, and the invisibility of privilege standard at all AHCs, HP faculty and learners might be poised to actualize the real benefits of open, honest, safe discussions about race. Effecting positive change may lead some AHCs to achieve inclusion excellence—that is, to nurture within the workplace a learning environment where faculty, staff, and learners are validated and valued; where they can share their voices safely; where they can be open, genuine, and respected—no matter their race; where the intersection of their multiple identities are celebrated; and where everyone feels a sense of belonging,

a sense that they are part of the organizational fabric.<sup>8,19,20</sup> HP educators will be better prepared to design and implement curricula that shape future health care professionals who, in turn, have the skills to have difficult conversations about difficult topics (racism, prejudice, biases) not only with their peers and their faculty but also with their patients, their patients’ families, and the communities they serve.

To attempt to create such a curriculum without engaging in an antiracist framework and the pedagogy of discomfort would be discordant. Actually, having faculty and students experience discomfort after talking about race and racism should not necessarily be considered a poor outcome. Learning how to push past the discomfort, to confront it, and to effect positive change is the goal. Like any lifelong learning skill, dialoguing about race with members of other races and ethnicities requires frequent practice and the desire for continuous improvement. Further, we must be cognizant that the discomfort that faculty experience while simply discussing race and racism does not begin to compare with the very real discrimination many students, faculty, and staff of color still experience daily. As Paulo Freire<sup>21</sup> states, “Sometimes a simple, almost insignificant gesture on the part of a teacher can have a profound formative effect on the life of a student.” Being on the receiving end of a “simple, almost insignificant” microaggression can trigger a deep reaction in students, staff members, or faculty members of color no matter how resilient they might be. Several faculty of color have recently described such experiences.<sup>22,23</sup> For example, Montenegro,<sup>22</sup> a Latino physician, was dressed formally while attending a professional dinner at a hotel and was repeatedly mistaken for the valet. Olayiwola,<sup>23</sup> an African American physician, relays a racist rant she received from a mental health patient who refused to have her “touch him with her black hands.” Instantly, she writes, “racism stripped me of my white coat, my stethoscope, my doctor’s badge, my degrees and credentials, my titles, my skills, and my determination to serve.”<sup>23</sup> To some, the rant or mistaken identity may seem negligible, and those experiencing these events have even been accused of overreacting.<sup>22</sup> However, “the sense of ‘otherness’ builds with every

occurrence, be it overt or accidentally scarring.”<sup>22</sup> These experiences serve to “silence us and enforce an uncomfortable environment that is not conducive to professional development.”<sup>22</sup>

Now is the time to break that silence and change the environment. No longer can we afford to ignore racism; no longer can we avoid talking about its real and damaging effect on all of us.

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