Identification and Management of the Consequences of Racism and Discrimination:
The Crucial Role of Primary Care Providers

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LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Have you ever wondered whether and how exposure to racist rhetoric can be translated into a physiologic stress response? Have you been unsure about how experiencing racial discrimination can contribute to anxiety, posttraumatic stress, depression, somatic symptoms, or poor health outcomes? Have you been uncertain about how best to intervene with your patients who encounter microaggressions or experience acculturative stress? If you have, the following case vignette and discussion should prove useful.

CASE VIGNETTE

Ms A, a 16-year-old Latina girl, reported to her primary care physician/pediatrician that she had been having an upset stomach and weight loss. In addition, she acknowledged that she was struggling to concentrate in school, feeling apprehensive about going to school, and feeling overwhelmed and isolated.

She had immigrated to the United States 2 years earlier with her mother and 2 younger siblings. Her father was already living in the United States. The school in which she enrolled had little ethnic diversity; she was 1 of only 3 Latino/a students.

The medical workup ordered by her pediatrician sought to identify a gastrointestinal etiology for her symptoms. She was also screened with the Pediatric Symptom Checklist (PSC)[1] (score = 38) and the 9-item Patient Health Questionnaire (PHQ-9)[2] (score = 16) for symptoms of depression, anxiety, and substance use. Since the results of the medical tests (screening for celiac disease, inflammatory markers in blood and stool, abdominal ultrasound, and endoscopic procedures) failed to reveal a medical etiology, her pediatrician referred her for therapy to a Spanish-speaking bicultural Latina therapist. The patient had requested to see someone who spoke her language and understood her culture. In addition, her pediatrician provided her with information about stress, anxiety, and depression so that she could learn more about what she was experiencing.

DISCUSSION

What Is Meant by Systemic Racism and Microaggressions?

Racism is a "system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race') that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources"[3(p231)] (Table 1 provides definitions of key terms[3–9]). Racism can be manifest on 3 levels: personally mediated (interpersonal), internalized, and systemic (institutional or structural).[6] Systemic racism is expressed through patterns of social institutions (eg, governmental organizations,

Clinical Points

- Racism and microaggressions can increase levels of stress hormones that signal the body of potential danger, leading to chronic stress, depression, anxiety, and substance use disorders.
- For those who screen positive for depression, anxiety, or posttraumatic stress symptoms, follow-up with education and treatment within the primary care practice or referral to a specialty provider is indicated.
- Providers should engage in self-reflection and learn about implicit bias, privilege, racial injustice, and racial identity.

health care institutions, schools, banks, courts of law) that implicitly or explicitly discriminate against individuals from marginalized groups.[10] Dr Camara Phyllis Jones[6] uses an allegory of a gardener who has 2 flower boxes (1 with rich, fertile soil and 1 with poor, rocky soil). The gardener has 2 seeds of the same type of flower, but with different colored flowers (red and pink). The gardener prefers red over pink, so she plants the red seeds in the fertile soil and the pink seeds in the rocky soil. At the end of the flowering season, she notes that the red flowers flourish better than the pink flowers, which reinforces her preference that "red is better than pink," rather than examining the reason for why the red flowers are more vibrant.[6] Using this metaphor, examples of systemic racism would include the gardener preferring red over pink flowers over time and choosing to place the red flowers in the fertile soil and not addressing the differences between the soils over the years.[6] Current examples of systemic racism include redlining (or bank practices that favor one race over another in providing housing loans) or racial health disparities in COVID-19 infections and deaths. In this way, systemic racism manifests in institutions that govern everyday life and perpetuate differential treatment of people.

Whereas systemic racism operates at an organizational level, microaggressions often occur among individuals (at an interpersonal level). Microaggressions (ie, verbal, behavioral, and environmental indignities that communicate hostile and derogatory slights and insults toward members of a marginalized group) can be intentional or unintentional and result from bias about a person or a group.[8] The term *microaggression* was first coined in the 1970s by Harvard Medical School psychiatrist Dr Chester Pierce in response to observing insults exchanged between White and Black students. Although racism and discrimination are often overt and explicit, they can be subtle and perceived as harmless. However, over time they can cause suffering. For example, Ms A might be asked "where are you *really* from?" Although Ms A might have been asked this question out of curiosity, the words chosen could have made Ms A feel like an outsider or a perpetual foreigner, as someone who does not belong. Sometimes, microaggressions can be hidden in the form of what appears to be a compliment. For example, Ms A shared that one of her peers complimented her for speaking English without an accent. While words and actions can be well-meaning, they may have unintended and hurtful consequences to members of our community.

How Can Exposure to Racist Rhetoric or Behaviors Translate Into Physical Symptoms?

Stress can help us survive in our environment. For example, if we see a bear while hiking, our central nervous system-endocrine connection triggers a "fight-or flight" response that allows us to run from the bear toward safety. Racist rhetoric and behaviors are stressors. Racism and microaggressions can lead to chronic stress that increases levels of stress hormones and creates oxidative stress at the cellular level[11] and inflammatory reactions that predispose people to chronic diseases.[12] Therefore, racist behaviors that trigger stress responses can lead to physical symptoms and problematic behaviors intended to dampen this stress response (eg, drinking alcohol or overeating to decrease anxiety).

Ms A shared that she felt isolated at school. Her teachers did not understand her world view, and her grades declined because of this disconnect. She enjoyed writing; however, some of her teachers disagreed with her conclusions in her written assignments. Ms A wanted to make her family proud, but when her grades declined, her stress levels increased, and her abdominal pain worsened.

This process is further illustrated by the impact of adverse childhood experiences and adversity (eg, abuse, neglect, interpersonal violence, caregiver mental illness), which are associated with poorer outcomes (including depression, suicide, and chronic illness).[13] Although this association is likely multifactorial, "toxic stress" can explain how adverse childhood experiences trigger biological reactions with worse outcomes. However, the study of adversity also offers a glimmer of hope, as it shows that people can be resilient and engage in adaptive coping, particularly when they have supportive and loving relationships.

Ms A did not think it would be appropriate for her to talk to her teachers about her distress. Over time, she spoke with her teachers and explained her point of view; this enabled her to shift the dynamic of her relationship with them, and she started to work on special assignments that focused on topics of interest to her. She even wrote an impressive personal piece for which she earned an award. At one point, Ms A worked on a school project that focused on advocating for a program that would allow all immigrant students to have several sessions with a therapist.

What Types of Psychiatric Manifestations Can Arise From Exposure to Systemic Racism?

Individuals who are exposed to systemic racism can develop chronic stress (with deleterious effects on physical and mental health). Over time, this can lead to depression, anxiety, and substance use disorders.[14] Experiencing emotionally painful, sudden, and uncontrollable racist encounters can create race-based traumatic stress.[15] These problems frequently coexist and exacerbate the health-depleting impact of specific stressors. Taken together,

Table 1. Glossary of Key Terms

Term	Definition
Race	Term created by society (hence a social construct; not based on biology) to describe a group of people who share physical characteristics; examples include Black, White, Asian, Native American, Native Hawaiian, or Other Pacific Islander[4]
Ethnicity	Unlike race (which is a category based on how one looks), this is a broader term used to describe a group of people based on their race, nationality, tribe, religion, language, or cultural origin/background; a few examples include Caribbean, Italian, Latinx, and Jewish[5]
Racism	System of structuring opportunity and assigning value based on the social interpretation of how one looks ("race") that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources[3]
Racial discrimination	Unfairly treating a person or group of people because of their race
Systemic racism	Level of racism (the other 2 being interpersonal or internalized racism) in which social institutions (eg, governmental organizations, health care institutions, schools, banks, courts of law) implicitly or explicitly discriminate against individuals from marginalized groups[6]
Acculturation	Assimilation to a different culture, typically the dominant one[7]
Acculturative stress	Psychosocial stressors experienced by marginalized individuals as they navigate and adapt to the host culture[7]
Microaggression	Verbal, behavioral, and environmental indignities that communicate hostile and derogatory slights and insults toward members of a marginalized group[8,9]
Bias	Preconceived notions (that can be implicit or explicit) based on beliefs, attitudes, and/or stereotypes about people pertaining to certain social categories[8]

exposure to systemic racism and mental health inequities can lead to the experience of a syndemic or simultaneous and synergistic epidemic[14,16] with negative physical and mental health outcomes.

The consequences of psychiatric illness among Black, Indigenous, and people of color (BIPOC) individuals are long-lasting. Moreover, these individuals often face a disproportionately higher burden of disability and negative consequences due to oppression, prejudice, and inadequate access to resources. BIPOC youth with behavioral problems, due to psychosocial risk, are more readily referred to the juvenile justice system than to specialty primary care clinics compared to White youth.[17] Similarly, BIPOC youth are more likely to be expelled or to be more harshly disciplined, which further increases their rate of entry into the juvenile justice system.[17] Overall, psychiatric conditions are common among defendants in the criminal justice system, which has a disproportionate number of individuals from BIPOC communities.[18]

A lack of cultural understanding by health care providers may lead to underdiagnosis or misdiagnosis of psychiatric illnesses in people from racially and ethnically diverse populations. Cultural factors, including language differences among patients and providers, stigma toward mental health among underserved communities, and cultural presentation of symptoms, can contribute to misdiagnoses. Whereas research about the true rates of psychiatric illness among racially and ethnically diverse individuals is limited, people from BIPOC groups are less likely to receive mental health care than those from other groups.[19,20] Moreover, access to care for people from BIPOC groups is reduced due to a lack of insurance, mental health stigma, lack of diverse or culturally competent providers, language barriers, and mistrust in the health care system as well as other factors.[19,20]

Prolonged exposure to racism can stimulate symptoms like those of posttraumatic stress disorder (PTSD)[15] (eg, depression, intrusive thoughts, headaches, chest pain, insomnia, hypervigilance, low-self-esteem).[21] These symptoms (that can look different across different cultural groups) may arise in someone with race-based traumatic stress. Unlike PTSD, race-based traumatic stress is not considered a mental health disorder; instead, it is thought of as a mental injury that results from living within a racist system or experiencing racist events.

How Does Systemic Racism Impact the Delivery of Health Care?

People from racialized groups face multiple barriers to accessing health care, which are partly responsible for the higher morbidity and mortality rates in these populations. Some of these barriers include lack of or a less desirable insurance,[22] transportation issues, childcare issues, and ability to take time off from work. Cultural differences between patient and provider including language barriers, as well as historical injustices and inequities in treatment,[23] make it harder to access preventive, routine, or specialty medical care. As a result, patients present for medical care with more advanced diseases that are difficult to treat.[24] These inequities have been brought to the forefront by the current COVID-19 pandemic, which showed that members of BIPOC communities are disproportionately affected by the virus and have less access to care including vaccinations.[25]

Prior research has shown that compared to Whites, Black and Hispanic individuals face multiple barriers to timely access to health care. For example, compared to Whites, Black and Hispanic individuals have to wait longer, on average, for their medical appointment,[26] wait longer to be seen by a medical provider in a clinic,[27] and are asked much more frequently about their insurance status when trying to make an appointment.[26] These challenges may lead BIPOC individuals to seek health care from physicians and hospitals that are unable to provide high-quality care to all of their patients and generally see few White patients.[28] Research also shows that physicians provide differential

treatment to BIPOC individuals as compared to Whites. For example, physicians are not aware of race-specific statistics and lack differential recognition of disease and symptoms in the underserved. Physicians also make different referral decisions for Blacks versus Whites, even when these 2 groups have similar insurance benefits.[29]

Who Is at Risk for Physical and Mental Complications From Exposure to Systemic Racism?

Systemic racism can adversely affect health through interrelated pathways. Chronic stress is linked with a reduced access to employment, housing, and education. Frequent exposure to micro- or macroaggressions and to high-risk racially motivated situations increases allostatic load while decreasing involvement in healthy behaviors (eg, sleeping soundly and exercising) and increasing unhealthy behaviors (eg, drinking alcohol, using drugs, and smoking cigarettes) as a means of self-regulation.[30] Unfortunately, most of the leading causes of death within the United States (eg, heart disease, cancer, stroke, diabetes, kidney disease, and hypertension) arise in individuals who identify as Black, and these individuals have higher death rates than Whites.[31]

Research reveals that bias and discrimination lead to adverse health outcomes across racial and ethnic groups. For example, a national study of Asian Americans, a study of Filipino Americans in San Francisco and Hawaii,[32] and an African American sample in the CARDIA study[33] found a positive association between discrimination and chronic health conditions or other self-reported indicators of ill health (including self-rated health, physical functioning, mental health, cigarette smoking, and self-reported cardiovascular disease).

Longitudinal analyses of the large cohort of the Black Women's Health Study identified a positive association between discrimination and the incidence of breast cancer.[34] Thus, provision of targeted relief to individuals who suffer from systemic racism and changes to public policy are needed to reduce the determinants and consequences of systemic racism and to improve mental and physical health within this population.[35]

Ms A was able to connect to behavioral health services as an adolescent. A few months after starting therapy, her abdominal pain subsided, and she began to gain weight. Not only did her mood improve, but she also engaged in extracurricular activities, started working, and thought about college and her future. On several occasions she expressed an interest in health policy.

Where Can One Receive Help to Manage Reactions to Discriminatory Comments or Actions?

Community and connection are antidotes to untoward reactions to discriminatory comments or actions. Therefore, one must become and remain close to those who can offer support. This may involve families, friends, colleagues, teachers, or other trusted individuals. Members of the LGBTQ+ community often talk about their "chosen or found families" and distinguish them from the families in which were born into, wherein rejection is far too common (as many as 39% of queer adults faced rejection from their birth families).[36] It is important to note that patients may use the term *Latinx* (in English) or *Latine* (in Spanish), a gender-neutral inclusive term, to self-identify. Others may choose the term *Latino* or *Latina*. As clinicians, it is important to ask your patients how they self-identify. Ms A self-identified as Latina.

When an individual is surrounded by people who are not considered as "safe," they should look to others in the community, such as those in religious organizations or health care settings, for support. Reaching out may be challenging when people feel vulnerable. However, seeking help and validation is crucial. People have an innate need to belong and to feel valued and connected to others.[37]

Social connections were important to Ms A. She consistently talked about her desire to make friends who shared her values. She enjoyed learning about the experiences of others and tried to make friends at school, at work, and at volunteer sites. At one point, she decided that she wanted to attend church. She enjoyed the connections she made there and valued the sense of belonging.

Why Is It Important to Identify and Treat Physical and Mental Symptoms Precipitated by Racism?

Social and environmental determinants of health focus on multiple factors that range from discrimination to structural violence, often created and perpetrated by socioeconomic policies and inequities and manifest at the individual level as excess morbidity and mortality.[38]

Racism poses a serious threat to public health that needs to be addressed. Although not a new problem, the United States has been increasingly bombarded by pervasive racist and anti-immigrant rhetoric in the news and on social media. Research has shown that even the anticipation of racism is enough to trigger a stress response,[39] and stress accelerates cellular aging, which can produce a variety of illnesses and premature death.[40] BIPOC individuals frequently experience elevated and prolonged levels of stress due to racism and discrimination, contributing to racial and ethnic health disparities in the United States. Repeated exposure to racial discrimination has been associated with depression, anxiety, and hypervigilance, with wondering when and how the next experience will occur.[41]

In addition, alarming rates of depression, suicidal ideation, and suicide attempts have been identified among second-generation immigrant youth (born in the United States to immigrant parents).[42] Acculturative stress (the stress that is associated with cultural adaptation) has been associated with depression and suicidal ideation in immigrants, as well as in adolescents and young adults of color.[43]

BIPOC children and adolescents face racial and acculturative stressors that can negatively impact their physical and mental health. Thus, it is imperative that providers focus on identifying children and adolescents at risk for such societal and systemic injustices and make appropriate referrals for support and treatment (involving

culturally sensitive interventions that can lead to healthier outcomes). Ms A's pediatrician took the time to ask important questions about her experiences. The screening questionnaires helped her pediatrician make appropriate referrals for support, which resulted in improved health and mental health outcomes. Ms A told her pediatrician she wanted to meet with a therapist who spoke her language and understood her culture. She wanted to meet with someone who would not judge her culture or her beliefs. Ms A's pediatrician was able to refer her to a bilingual/bicultural psychologist. However, it may not always be possible to find a therapist to fit the request. Still, primary care providers can encourage their patients to meet with a culturally aware therapist, as the benefits of receiving help will outweigh the delays caused by seeking a perfect match.

How Can Psychiatric Symptoms Be Identified in Primary Care Practices?

Organizations like the American Academy of Pediatrics and insurers like Medicaid now strongly recommend or require screening for overall psychosocial stressors as a part of the annual physical exams of children of all ages, as well as an additional screening for depression in adolescents.[44] As a result, many health care organizations have implemented routine screening protocols.

In our case, Ms A had been screened for both overall psychosocial concerns (via the PSC) and depression (via the PHQ-9) at her last well-child visit. Her scores on those measures indicated significant concerns in both areas, and this was further supported by a lack of evidence for a medical etiology. Even if Ms A had not mentioned her concerns to her pediatrician, high scores on measures like these would have been signs of emotional or mental health distress. No matter how her concerns came to the pediatrician's attention, the next steps include discussing these difficult situations and creating an action plan. Guidelines for screening now require clinicians to formulate action plans with patients and to follow-up on the outcome of those plans. In the case of Ms A, a 3-month follow-up pediatric appointment was arranged to ensure that a successful referral was made to a Latina therapist.

What Is the PSC and the PHQ-9?

The PSC is a brief questionnaire (varying in length from 17, 33, or 35 items) used in pediatric and educational settings to identify children and adolescents with a wide range of psychosocial concerns so that they can receive help for these difficulties. The PHQ-9 is a brief screen for depression; it is used widely to assist with earlier identification and intervention. Both measures have been endorsed for routine psychosocial screening by organizations like the American Academy of Pediatrics and the National Quality Forum, organizations that set standards for quality care. Both measures are free, easy to score and interpret, and are feasible for use in a wide variety of settings with diverse populations. Both measures have been translated into Spanish and other languages. Studies have shown that use of the PSC[45] and PHQ-9[46] is associated with higher rates of identification, referral, and treatment.

When Should Symptoms of Anxiety, Posttraumatic Stress, and Depression Be Evaluated and Treated (and by whom)?

Primary care providers are in a unique position to screen for and evaluate symptoms of anxiety, posttraumatic stress, and depression in their patients. Many practices already routinely screen for physical and behavioral symptoms. Selection of the appropriate screening tools and thoughtful use of administrative algorithms and support (training of clinic staff and workflow protocols) are needed.

Selection of short screening tools with a high sensitivity increases the likelihood that people with anxiety, posttraumatic stress, and depressive symptoms will be identified. Such tools are ideal for practices that have patients with higher behavioral health needs (for example those with many individuals with subthreshold disorders) and with the resources to rapidly follow up with diagnostic assessments without a repeated screening.[47]

For those who screen positive, follow-up is imperative and can consist of educating patients and treating them within the primary care practice or referring them to a specialty provider.[48] Practices with ready access to behavioral health clinicians who can conduct a diagnostic assessment might prefer to use tools that assess a broad array of potential problems. Other practices might prefer to screen only for specific conditions or to build screening protocols slowly as their referral network expands.[47] In either case, having mental health clinicians colocated within the primary care practice achieves more integrated and equitable care.

How Can Health and Mental Health Care Providers Respond to Patients Who Share They Have Experienced Distress Due to Racism?

Once patients have disclosed their experiences of racism and discrimination, clinicians should make every attempt to validate patients' lived experiences and thank them for entrusting them with their narratives. The focus must remain on the patient and family and the impact the experience has had in their lives. The provider should not focus on deciphering the intent of the offender. Instead, the provider should focus on validating the emotions related to these experiences. Responses should express empathy. Do not make assumptions about how a patient might feel. Some ideas of ways to respond are as follows:

"Thank you for sharing that with me. I'm so sorry that happened to you. You deserve to be treated with respect and dignity."

"I know it's hard to talk about these experiences. I appreciate your entrusting me with this information."

"Thank you for sharing with me. Racism is not okay."

Similar to the handling of traumatic experiences, clinicians should explore issues of confidentiality with patients: how

patients and their families would like these experiences to be documented in their electronic medical record, with whom clinicians may share these experiences with the patients' care team, and if there is a role for additional clinical support for the patient and their family.

Finally, in the long term, clinicians must also make sure to highlight resilience and cultural strengths, as it is important for both White and BIPOC children and their families to understand the positives of different cultures and not just the struggles.[49]

What Types of Administrative or Legal Resources Can Confront or Reduce Racist Behaviors?

Providers should engage in self-reflection and education about implicit bias, privilege, racial injustice, and racial identity and find resources that have been created by BIPOC individuals to honor advice, lessons, and the emotional labor of those who have lived experiences of racial injustice and discrimination.[49] Once patients and their families have shared such concerns with their provider, a variety of resources can be shared with patients and their families. Providers can suggest connections with the child's school system (or reach out to the school system on behalf of the child, with the child and family's permission) to report instances of discrimination. Similarly, providers can suggest that patients connect with community or state agencies that focus on discrimination or file a report involving racism to the state's Attorney General's office (if this action does not put the family at risk).

How Can Psychological Reactions to Acculturative Stress in Children and Adolescents Be Addressed and Managed?

The process of acculturation is marked by psychosocial stressors while an individual navigates and adapts to the host culture (ie, acculturative stress).[7] While it is important for providers to be aware of potential stressors, assumptions about patients' experiences should be minimized, allowing providers to ask appropriate questions so that proper supports and referrals can be made.

Risk factors for immigrants with diverse ethnicities include intergenerational cultural conflicts (due to differing cultural expectations between parents and children,[50] family communication challenges, lack of cohesion in a new social context, and increased likelihood of discrimination).[51] To address these challenges, children and youth can be referred to psychologists, therapists, or programs with experience supporting patients who face acculturative distress. This means identifying individuals who are bilingual or bicultural or who have received training in multicultural psychology. The focus of therapy should be to help patients develop positive racial and ethnic identities. Mental health care providers can help patients better navigate a potentially threatening world. Providers should validate the distress associated with change from facing an unjust discriminatory system. In addition, mental health providers can provide emotional support while their patients develop racial and ethnic identities in a setting wherein they will not feel judged. Racial and ethnic identity development relates to empowerment, a process through which ethnic youth foster greater self-efficacy while negotiating the systemic imbalances of power.[52] The overall goals of this approach are to support patients while developing cultural and ethnic pride and to allow them to develop a sense of self that integrates values from the 2 (or more) cultures that influence their lives. Awareness and resistance to stereotyping and its negative effects are essential components of healing and resiliency.

What Happened to Ms A?

Ms A consistently attended her weekly therapy sessions and chose to have her sessions conducted in Spanish even after she had become comfortable speaking English. At the outset, validation for the challenges she was facing at school and at home was offered. On several occasions she shared that her family did not understand her or her loneliness. They told her she had nothing to "be sad about." Ms A's parents believed that access to education is what mattered most, and she should be happy. However, Ms A felt there were other areas of her life that mattered and needed attention. For example, she wanted to make meaningful social connections with her peers. At the same time, Ms A valued her family and repeatedly said that her family came first. Her mother joined several sessions and learned about the process of acculturation in youth. Ms A now talks to her mother about her concerns and no longer feels judged by her. On the contrary, communication has improved, and she feels supported by her mother.

Ms A returned to the country where she was born on several occasions. The trips were both exciting and disappointing, as the country she left as a child had changed significantly. Nevertheless, she enjoys visiting the country where she was born and enjoys spending time with her family when she visits. While Ms A values her heritage, she occasionally becomes distressed when one of her siblings no longer holds on to cultural traditions. For example, she believes that holidays and celebrations should be spent with the family enjoying traditional home-cooked meals.

Because Ms A loves her culture and language, she enjoys giving back to her community by volunteering to teach English to adults in a community program. She has explained that when she starts a family, she would like to pass on some of her family's customs, to the degree that she is able. She noted that she would like her children to speak Spanish and to practice some of the cultural customs she grew up with.

Ms A graduated from high school with an impressive grade point average. At present, she is attending a well-known university in the United States and is thinking about becoming a pediatrician.

How Can Health and Mental Health Care Providers Combat Racism and Discrimination?

The topic of racism and discrimination deserves time and attention in a provider's quest to treat the whole person

and to address stressors that may affect emotional and physical health. When engaging in a conversation about racism, providers must enter into the conversation without assumptions. Instead, providers should communicate to their patients that this topic "is" important. In addition, providers should demonstrate that they are there to listen to their patients with a willingness to identify appropriate supports and treatments.

Overall, talking about issues of racism and discrimination may feel daunting for a provider, which may lead to avoidance. However, it is important to be reminded that as members of a community of healers, clinicians are called to heal, wherever there is pain. Providers may not always say the "right thing." Still, patients will appreciate knowing that their provider is making an effort.

Patients who endure unequal treatment related to racism often experience chronic stress, which has deleterious effects on both physical and mental health. Health equity matters, and there are many ways to intervene and support in creating a more just system. Providers who ask their patients about issues of racism and discrimination have the opportunity to provide much needed support that can have a short-term and long-term positive impact in the physical and mental health outcomes of their patients.

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