“Bring it to the forefront so everyone knows and can make positive changes”

A Qualitative Study of Provider Perspectives of Racial Inequities in the NICU

Krystal Austin BA[1], Olga Smith RN[2], Brittany Chambers Butcher PhD MPH[3], Monica McLemore PhD MPH RN[4], Sarah Lewis-Zhao PharmD[5], Safyer McKenzie Sampson MSPH PhD[6], Taylor Washington BS [7], Elizabeth Rogers MD[2], Kayla Karvonen MD MAS[2]

[1]University of Colorado School of Medicine, [2]University of California San Francisco, [3]University of California Davis, [4]University of Washington, [5]Touro University College of Pharmacy, [6]Stanford University, [7]University of Virginia School of Medicine

Introduction

Racism pervades healthcare outcomes on many levels and contributes to racial disparities in preterm birth and low-birth weight, in addition to differences in quality of care and outcomes.[1]

Structural racism, or macro-level conditions that limit opportunities, resources, power, and well-being of individuals and populations based on race/ethnicity, perpetuates this phenomenon. Recent examples of how structural racism is operationalized include disparate use of child protective services referrals, urine toxicology screening, security calls, and behavioral contracts amongst racialized groups.[2]

Family fears of being mistreated are not unfounded, with instances of providers admitting that they have less empathy for minority patients. Fear-based responses lead to providers limiting the therapies they offer, with providers describing minority groups as more intimidating due to their appearance.[3] Other studies have shown that providers of color experienced racist microaggressions both from patients and staff, and these were positively correlated with a measure of secondary traumatic stress.[4]

With this study, we aimed to elucidate how racism is operationalized and may be addressed in the NICU from the provider perspective.

Methods

Settings and Participants Convenience sampling was used amongst all staff members employed in the NICU from April 2021-October 2022 that spoke English primarily. Staff were recruited to participate via email and in-person.

Procedures & Measures Staff were invited to participate in semi-structured, virtual 1hr interviews and surveys that included:

1. Demographic questions
2. The everyday medical discrimination scale
3. Open-ended questions regarding their general experiences working in the NICU
4. Specific experiences with witnessing and experiencing racism and discrimination

The provider interview guide probed for:

1. Relevant identities of staff members
2. Experiences with and key drivers of racial inequities in neonatal outcomes
3. Experiences with and solutions for combatting racism at the individual, institutional, and structural levels

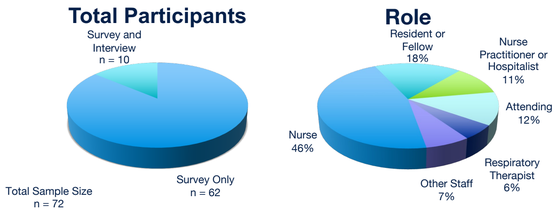
Methods – cont.

Sessions were audio recorded and transcribed. Participants received $50 for their participation in interviews only.

Data Analysis

The analysis was conducted by two members of the research team who independently coded the transcripts using a codebook of inductive and deductive codes. The coding team coded transcripts independently, compared and resolved coding differences, and analyzed the data using thematic analysis. Themes were generated and refined through discussion, any disagreements on themes were resolved over several sessions. Thematic saturation was reached, in that no new observations were noted, and no further themes were identified.

Results - Demographics



Results

Theme 1. Healthcare workers generally accept racism as a possibility in healthcare, although perceptions of racism existing locally ranged from denial to recognition.

- “I know that there is disparities but I can’t quantify it, nor do I have that data to prove it but I think intuitively and in other research that’s been published, it’s known that the neonatology world can be a little biased sometimes.”
- Amongst the participants that did not recognize the impact of racism on health outcomes, all were non-underrepresented minorities (URM).
- Several providers named unconscious bias as a leading cause of disparate care, while there were others that denied the possibility that they themselves would ever let bias influence their provision of care.
- Solution: Continuing educational sessions about unconscious bias and rejecting the biological fallacy of race as a source of health disparities.

Theme 2. Strengths and weaknesses in unit culture & relationships facilitated or protected healthcare workers against experiences of racism.

- Many providers highlighted Division efforts to reduce the impact of racism on health outcomes and generally described the NICU as a good place to work.
- Providers of color noted experiencing a variety of microaggressions, while macroaggressions were rare.
- Patient to a Black provider: “Oh, you must be here to fix the plumbing. We had a problem with the sink.”
- Racially diverse providers who identified as women described sexism in addition to racism.
- Solution: More frequent anti-racist and Bystander Training.

Theme 3. Lack of workforce diversity representation and minority tax experienced by URM healthcare workers are manifestations of institutional racism.

- White providers described their own lack of comfort relating to families of color, noting that “it’s more challenging for people to like empathize and serve a population that they don’t see themselves in.”
- Many providers of color mentioned taking on a disproportionate amount of patient advocacy.
- Solution: Recruit and retain providers of color and reduce minority tax.

Theme 4. The manner in which healthcare workers talk to and about patients compounds with racism, leading to miscommunications and biased provider interactions.

Results – Themes cont.

- Non-English-speaking families received unequal care that manifested mainly as less frequent parental updates: “I myself have avoided giving a family an update in some situations because it takes extra time to get an interpreter etc. when I would have given the same family an update had they spoken English.”
- Time-restrictions, competing duties, lack of access to in-person (gold standard) interpreters, and practical inconveniences led to providers resorting to communicating in English, insufficient Spanish, or using translation websites.
- Labelling families with negative adjectives resulted in provider distancing from families: “it’s like [Black families] have a scarlet letter on [their] door.”
- Solution: Full-time in-person interpreters; continuing education on cultural competency.

Theme 5. Patients experience racism through inadequate institutional resource allocation & biased communication.

- Higher socio-economic background/White families were more likely to get desirable single room assignments and longer interactions with attending physicians, while “[Families of color receive] noticeably less attention from the medical team including attending physicians and nurse managers.”
- Providers noted more tolerance for typically unacceptable behaviors and more laxity with unit rules for White families.
- Solution: Evaluate and modifying policies that uphold racial inequities i.e. the primary nursing system, rounding structure, enforcement of policies.

Conclusion

Racism in all its forms remains impactful in the NICU, affecting patient care and outcomes, in addition to the providers that staff the unit. The NICU provider team appears ready and willing to continue to make anti-racist strides with continuing education efforts and a commitment to equitable hiring and resource distribution.

References

1. Karvonen KL, McKenzie-Sampson S, Baer RJ, et al. Structural racism is associated with adverse postnatal outcomes among Black preterm infants. Pediatr Res. 2023;94(1):371-377. doi:10.1038/s41390-022-02445-6.
2. Karvonen KL, Anunwah E, Chambers Butcher BD, et al. Structural Racism Operationalized via Adverse Social Events in a Single-Center Neonatal Intensive Care Unit. J Pediatr. 2023;260. doi:10.1016/j.jpeds.2023.113499
3. Sim W, Lim WH, Ng CH, et al. The perspectives of health professionals and patients on racism in healthcare: A qualitative systematic review. PLOS ONE. 2021;16(8):e0255936. doi:10.1371/journal.pone.0255936
4. Serafini K, Coyer C, Brown Speights J, et al. Racism as Experienced by Physicians of Color in the Health Care Setting. Fam Med. 2020;52(4):282-287. doi:10.22454/FamMed.2020.384384