NCPD

2.5 ANCC Contact Hours

A Population Health Perspective on Racism and Racial Microaggressions

Yuri Jadotte ▼ Susan Salmond ▼ Virginia Allread

Racism, one of the social determinants of health, often goes unnoticed by those less affected by its pernicious effects. The lived social experience of race has been linked to significant physical and mental health disparities. Individually or together, we know that racism and discrimination are associated with poorer health of persons from racial minority groups as evidenced in higher rates of mortality, earlier onset of disease, greater severity and progression of disease and higher levels of comorbidity and impairment. These disparities are persistent over time and, although may lessen in degree, are evident at every level of income and education. This article provides a glimpse of the impact of racism on individuals and groups, with a focus on microaggressions as a subtle but pervasive form of racism, and how it is an underlying causative factor for health disparities.

With the growing advent of paradigm-shifting socioprofessional movements such as health disparities research, diversity, equity and inclusion initiatives, and population health, both the healthcare and public health enterprises are increasingly seeking to address the social determinants of health via clinical practice and policy, respectively (Jadotte et al., 2019). Recent reviews of this literature have clarified the importance of recognizing that the social determinants of health (e.g., age, race/ethnicity, occupation, socioeconomic status) (Kindig, 2007) work in concert with the environmental determinants of health (e.g., climate change, pandemic viruses, toxic exposures) to impact the biological factors (e.g., genetics, epigenetics) that then ultimately shape the inequitable distributions of patient and population health outcomes (Jadotte et al., 2022). Yet, among the social determinants of health, some factors, such as racism, have proven to be particularly pernicious and persistent in their effects for some groups whereas, for other groups, the experiences of racism are less pernicious or nonexistent. Because of this, racism often goes unnoticed by those less affected by its pernicious effects.

The lived social experience of race has been linked to significant physical and mental health disparities (American Psychological Association, 2016). Too often these disparities have been framed in terms of biological difference and individual behavior when in reality there are social and structural factors that generate and perpetuate health issues and disparities (Chadha et al., 2020; Graves & Goodman, 2021). Racism is a structure and ideology that oppress and limit resources to individuals or groups because of racial or ethnic group affiliation, manifest attitudinally as prejudice or behaviorally as discrimination, and are structurally woven into social systems, institutions, and policies (Clark et al., 1999). Racism underlies disparities and needs to be examined and discussed in health professions education and practice. Individually or together, we know that racism and discrimination are associated with poorer health of persons from racial minority groups as evidenced in "higher rates of mortality, earlier onset of disease, greater severity and progression of disease (higher burden of disease), and higher levels of comorbidity and impairment" (Williams & Mohammed, 2013, p. 1153). These disparities are persistent over time and, although may lessen in degree, are evident at every level of income and education (Braveman et al., 2010; Williams et al., 2019). This article provides a glimpse of the impact of racism on individuals and groups, with a focus on microaggressions as a subtle but pervasive form of racism, and how it is an underlying causative factor for health disparities.

Racism in Its Many Forms

Racism is part of the fabric of life for People of Color (see Box 1) and is among the causes of enduring negative health outcomes (Harrell et al., 2011). Racism is premised on the categorization and ranking of groups of people based on nationality, ethnicity, or other observable characteristic of social difference, which captures differential access to power and resources in society (Williams et al., 2019). A key component of this definition is differential access, whereby

Yuri Jadotte, MD, PhD, MPH, FACPM, School of Nursing, Rutgers University–The State University of New Jersey, Newark; and Department of Family, Population and Preventive Medicine, Renaissance School of Medicine at Stony Brook University, Stony Brook, NY.

Susan Salmond, EdD, RN, ANEF, FAAN, School of Nursing, Rutgers University–The State University of New Jersey, Newark.

Virginia Allread, MPH, BA, School of Nursing, Rutgers University–The State University of New Jersey, Newark.

The authors have no conflicts of interest to disclose.

Correspondence: Susan Salmond, EdD, RN, ANEF, FAAN, 65 Bergen Street, Suite 1127 Newark, NJ 07101 (salmondsu@sn.rutgers.edu).

DOI: 10.1097/NOR.0000000000000834

Box 1. Language Used In The Article

Throughout this article, we have used the term "People of Color" to refer to individuals who do not identify as White. "White," as a race, is defined using the U.S. Census Bureau definition: "A person having origins in any of the original peoples of Europe, the Middle East, or North Africa." Note that an individual's response to a question about race is based on self-identification.

Language is dynamic and is constantly changing; we considered using the term "BIPOC" (Black, Indigenous, and People of Color), but this is a relatively new term and is currently not without its critics. We do recognize that People of Color includes people of many ethnicities and races including African Americans, Asian Americans, Native Americans, Pacific Islander American, multiracial Americans, and some Latino Americans and that members of these communities are more likely to identify through these communities than as People of Color. "People of Color," however, does emphasize the common experiences of systemic racism faced by most, if not all, non-White communities.

Figure 1. Inequity resulting from structural racism (www.emanu.se). Reprinted with permission.

"power is unevenly distributed along racial lines resulting in the oppression and exclusion of non-White groups" (Harrell et al., 2011, p. 144). A salient outcome of racism is racial discrimination, or action, whether intentional or not, which imposes burdens on an individual or group, not imposed upon others, or which withholds or limits access to benefits available to other members of society. Racism can manifest at an interindividual level but most importantly is woven into the fabric of society as structural mechanisms where there are advantages or privileges associated with being White and disadvantages associated with being a Person of Color (Bonilla-Silva, 2006).

Healthcare disparities exist at a population level and require a consideration of structural processes and practices of power. Jones' (2000) framework, which examines racism at three levels, provides a lens for understanding the impact of racism on health. *Institutionalized or structural racism* refers to the differential access to opportunities, services, and goods within the society based on race. Structural barriers limit access to quality health care, quality education, safe housing, safe environment, and gainful employment. Racism is maintained as differential access and is codified in societal customs, norms, practices, and law. This type of racism imposes barriers to nondominant groups and brings unearned privilege to the dominant group. It is based on the assumption that the dominant group is intrinsically better. As the dominant group has experienced this benefit or privilege across time, it is assumed to be normal, and the privilege may be unseen or unrecognized by the individual. Figure 1 illustrates the inequity that results from structural racism in a simplistic but powerful cartoon. Structural racism has imposed racial hurdles, barriers, and burdens for nondominant groups. To achieve success, some (People of Color, women, LGBTQ) must jump over the hurdles and around the barriers while carrying a greater load in order to get to the finish line. In contrast, others (White, male) simply run to the finish line without the same hurdles. The pathway to success is not equitable.

The imposed barriers manifest, in part, as a greater social burden. Social disadvantages and stressors often cluster in people and places due to structural racism. The living and working conditions created by racism can initiate and sustain differential exposure to a broad range of social stressors such as neighborhood and housing conditions, financial stress, relationship stress, violence, and limited access to health care, which result in both physical and mental health disparities (Pearlin et al., 2005; Williams, 2018).

Internalized racism occurs when individuals of nondominant groups accept the stigmatized negative messages about their own abilities, characteristics, and intrinsic worth. It manifests in acceptance of stereotypes and discriminatory beliefs wherein their own racial group is viewed as inferior, less capable, and less intelligent than the racial majority group (Williams & Williams-Morris, 2000). Accepting the imposed limitations and embracing "whiteness," the individual changes who they are, how they feel, and what they dream of based on fitting into the dominant society (Jones, 2000). This can rob an individual of their sense of value. Internalized racial oppression has been linked to negative mental health outcomes and negative physical health outcomes (Gale et al., 2020). Sosoo et al. (2020) report that anxiety symptom distress is greater in the presence of stronger internalized racism.

Personally mediated racism (also known as individualized racism) encompasses prejudice and discrimination. Prejudice refers to the differential assumptions of a group's abilities, motives, and intentions based on their race (see Box 2). The same process occurs within other nondominant groups where we see stereotypes drawn on the basis of religion, gender, sexual orientation, ability, and so on. Personally mediated racism is fueled by cultural racism in which people are continuously exposed to media images portraying the superiority and goodness of Whites and the inferiority and inherently bad characteristics of People of Color. Personally mediated racism can be conscious or unconscious. It presents as attitudinal and discriminatory behavior that demonstrates a lack of respect, suspicion, devaluation, and dehumanizing of a racial group. Personally mediated "racism can occur explicitly through blatant discriminative encounters, as well as through microaggressions" (Cruz et al., 2019, p. 1).

Box 2. Dressing Racism As A Compliment

- An Asian American man, when in school, often heard classmates comment: "Ah, you must be great at math!"
- An Asian American woman is often sought out by her work colleagues to troubleshoot computer problems, even though she is neither a computer expert nor hired to work in IT.
- An Asian American man and an African American man, both of whom are company directors for the same company, have been asked to give permission to have their photographs and job titles posted on the company website leadership page. Other than the two of them, the leadership page features only company vice presidents, presidents, and the board chair (all of whom are White and earn at least 50% more than they do).

Although these scenarios might sound like compliments, the first two are based, like other forms of racism, on stereotypes that are not borne out by evidence. These scenarios, in effect, objectify the recipients of the comments as math machines or techies rather than as individuals. They pit non-Asians of color as mathematically inferior and can be a source of pressure for Asian students (Shah, 2017). The final scenario is tokenism, a perfunctory effort to be inclusive to give the appearance of equality (in this case, racial equality, but it can refer to gender or other forms of equality). It is done to give the impression of inclusiveness and diversity where such diversity clearly does not exist. Often those who are the "token" Persons of Color feel not only offended by the hypocrisy but also feel used to create a false image.

Note. IT = information technology.

Understanding Racial Microaggressions

Racial microaggressions have been defined in different ways and are related to many other well-known concepts such as implicit bias, racism, everyday racism, and racial bias. For the purpose of this article, the following definition is preferred: "deniable acts of racism that reinforce pathological stereotypes and inequitable social norms" (Williams, 2020). This definition has a threefold utility. First, it makes it clear that these acts are deniable, in the sense that those who perpetrate them and those who bear witness to them can claim that they are not happening. This plausible deniability is largely due to their subtle nature, in direct contrast with overt racism, which is very visible to all involved in such instances. Yet, at the same time, it is critical to recognize that these incidents often do not go unnoticed by the recipient or victim of the racist act. This dichotomy is valuable in that it reveals the duality of microaggressions: They can be perceived as unreal for some but still received as real for others.

Research evidence from the fields of social psychology, sociology, and anthropology suggests clear sociocognitive pathways via which norms act to influence health, beginning with their significant influence on perceptions. A review of this evidence suggests the existence of a stepwise process of social construction of reality, via legitimization of perceptions into values and beliefs, attitudes and behaviors, and ultimately norms and institutions, with the potential for a reversed flow that allows norms to negatively impact perceptions by modulating behaviors and codifying beliefs (Jadotte, 2020). By traveling along these sociocognitive pathways, racism and microaggressions can effectively cause harm to targeted persons, while allowing perpetrators to avoid taking responsibility for their actions and simultaneously deny both the acts and their health impacts.

Second, the notion of reinforcing pathological stereotypes is paramount in that it makes a clear connection to the impact of microaggressions at the individual level, because stereotypes are a widely accepted social construct whose physiological, psychological, and pathological impacts are understood (Kwate & Meyer, 2011). Finally, this definition reinforces the idea that microaggressions have an inequitable social impact. This means that they influence not just the individuals who are targeted in one instance of microaggression but also a wider set of similar persons in a population via the establishment of norms that can then further perpetuate the microaggressions (see Box 3).

Microaggressions are the subtle, brief, verbal, behavioral, or environmental slights and insults directed toward stigmatized groups (gender, ethnicity, color/race, sexual orientation), which convey oppressive ideology about power or privilege against marginalized identities (Santiago & Willner, 2011; Sue et al., 2019). Although some microaggressions can be intentional, they are more likely unintentional and unconscious. At an unconscious level, verbal and behavioral microaggressions are linked to the world views that one has and are reflections of one's views of superiority, inferiority, inclusion, exclusion, normality, and abnormality (Sue et al., 2019). They are outside conscious awareness, but they are still there, and the microaggression sends a hidden or implied message. Racial microaggressions are linked with aversive racism, a form of interindividual racism where the individual lacks explicit racial prejudice (i.e., has sympathy for those who were victimized by injustice in the past and is committed to principles of racial equality) but has *implicit biases* that favor people who are White over people who are Black or other Persons of Color. Discriminatory or biased behavior can occur secondary to implicit bias, even though the perpetrator does not intentionally mean to discriminate (Dovidio et al., 2005). Systematic organizational practices have normalized these insensitive interactions and have failed to respond to microaggressions with systems for surveillance, policies, or accountability procedures (Gómez, 2015; Sittner et al., 2018).

Microaggressions, as the name implies, are not "micro." The prefix "micro" only speaks to the subtle manner in which this kind of discrimination happens, making it difficult to address, detect, and recognize (Sue et al., 2019). Microaggressions are brief and occur quickly, and before the targeted person has a response, the situation may have moved on (see Box 4). If the perpetrator of the microaggression is called out, its insidiousness allows the person to deny any problem and often implies that the targeted person or group is overly sensitive. Table 1 gives definitions and examples of the three types of microaggressions—microassaults, microinsults, and microinvalidations. Although subtle and brief, the cumulative effect of ongoing microaggressions is of

Box 3. Mary's Story

Mary (not her real name), an African American DNP-qualified nurse practitioner, had injured her foot in the spring of 2021. Within a couple of days after the injury, it was obvious that she needed to get her leg x-rayed to determine if it was more than the sprain or tear that she had assumed it was. She left her two young children with her husband and reported to the nearest urgent care center.

Mary was initially attended by the medical assistant, who was noticeably rude and terse. When the physician came in, he too was cool. When the physician asked what pain medication she had been taking, Mary responded that she had been alternating between Motrin (ibuprofen) and Tylenol (acetaminophen) due to the severity of the pain (which was severe to the point of bringing her to tears) and to reduce the breakthrough pain. Mary then recommended that he prescribe a nonopioid drug to further reduce discomfort. Given the professional level of her response, the physician asked Mary if she was a healthcare provider, which she confirmed. The physician followed her recommendation for pain relief and ordered an x-ray. Mary could not help but notice that after she stated that she was a nurse that the demeanor of both the medical assistant and the physician changed. As if she was seen initially, as Mary explained, "as another one" (i.e., another Black woman), but once they found out that she was articulate, knowledgeable, and a healthcare provider like them—she was then seen not as Black but as a nurse.

The medical assistant at the urgent care center accompanied Mary to the car. The medical assistant knew that Mary had children at home because of something that she had mentioned during the consultation, seeing Mary struggle to get into the car she asked, "Do you have anyone at home to assist you." Although this is a routine question, given the context, Mary felt that the underlying subtext was an assumption that she was a single Black mother with limited support, who would most probably struggle to manage her children and home by herself with a broken foot. Mary politely replied that her husband would assist with both her and her children's needs.

Box 4. Dave's Story

Dave (not his real name) is an EMT with 8 years' experience. He works as an EMT in a town in New Jersey. As was usual, Dave was paired with his regular partner, who happens to be a White woman. Dave is in his late-20s and identifies as Asian American. In late spring of 2020, early in the COVID pandemic, Dave and his EMT partner had been dispatched by 911 to the home of a patient. Dave and his partner, both wearing P100 masks, goggles, and other personal protective equipment, went into the patient's home and initiated the standard assessment. Dave undertook the physical assessment, whereas his partner documented the findings. However, shortly into the assessment, the patient asked that Dave's partner undertake the physical assessment (rather than Dave). Dave asked the patient if there were any concerns. The patient responded "no" but again stated that he preferred Dave's partner to undertake the assessment.

Although one might think that maybe the patient was expressing a preference for a female EMT, or the EMT that was assumed to be better qualified (both were similarly qualified), keep in mind that this patient had just called for an ambulance. One does not typically have—nor expect—the luxury of choice of providers during an emergency. Given the situation, the nonverbal cues from the patient, Dave felt certain that the patient was expressing a preference for a provider who did not look Asian. This was not the first time Dave had experienced a situation such as this; however, early in the COVID pandemic, these behaviors were more frequent.

Note. EMT = emergency medical technician.

concern. Often referred to as "death by a thousand cuts," the cumulative effect of microaggessive behavior toward a person can have major effects for that person's physical health, mental health, and well-being (Nadal et al., 2014).

The Direct and Indirect Impact of Racism and Microaggressions on Health Outcomes

Racism may impact health directly and indirectly. Directly, there are psychophysiological processes that connect racism, microaggression, and disease. Indirectly, racism may shape health-related behaviors of oppressed groups (Harrell et al., 2011).

Direct Acute Pathophysiological Pathways of Microaggressions

Racism and microaggressions impact health first and foremost through the mind–body connection. In other words what a person perceives, meaning what is detected via the physical senses, can stimulate different physiological responses. For example, the role of light, in particular sunlight, in the entrainment of the circadian sleep–wake cycle and the rhythmic fluctuations of serum cortisol levels is well understood (Hadlow et al., 2014). When a person sees a dangerous animal, there is an instantaneous release of adrenaline, which initiates rapid physiological changes such as increased heart rate and respiration. These two well-defined pathways are the central elements of the traditional stress and coping or adaptation model: the hypothalamic–pituitary–adrenal (HPA) axis, and the sympathetic–adrenal–medullary axis (SAM). Using the HPA axis, the body is able to initiate changes to metabolism, the immune system, and the brain that allow the organism to adapt to a stressful environment. The SAM axis, on the other hand, leads to rapid changes to cardiovascular function, including increasing the heart rate, constricting blood vessels, and increasing blood pressure and blood flow.

Normally, these pathways are adaptive and are required to allow the organism to respond appropriately to external threats in the environment. But the problem with microaggressions is that whenever they occur or their threat occurs, they are pervasive and their effects sustained by the aforementioned social–cognitive pathways, resulting in ongoing activation of both the HPA and SAM axes (Berger & Sarnyai, 2015). Ample research has documented this sustained activation of the HPA and SAM axes in response to microaggressions (Berger & Sarnyai, 2015; Huynh et al., 2017; Seaton & Zeiders, 2021), so the verdict is very much in on this issue. What is often forgotten is that these overactivations are inequitable, meaning that they are unfair, unjust, and wholly avoidable (Whitehead, 1991). In addition, the consequences of these overactivations are often dismissed by those who are not subject to the microaggressions, yet these consequences are devastating and explain a great many racial health disparities. For example, African Americans are known to have poorer

Table 1. Three Types Of Microaggressions With Real-Life Examples

Subtypes and Definitions[a]	Sample Scenarios	Explanation of the Microaggression
Microinsult: A microinsult is characterized by communication that conveys rudeness and insensitivity and demeans a person's racial heritage or identity. Microinsults represent subtle snubs, frequently unknown to the perpetrator, but clearly convey a hidden insulting message to the recipient of color.	A group of White women sees a Black man walking on the same side of the street (a Black man who is not disheveled or behaving oddly) in broad daylight with lots of other people around and in a very nice and typically safe town's business district, and they hurriedly cross to the other side of the street while clutching their purses a little tighter than usual.	It is broad daylight, the man is well dressed and not displaying any odd behaviors, and there are plenty of other people around, but the White women communicate to the man in their body language and demeanor that he makes them afraid for their personal safety and the safety of their belongings. The Black man notices and then he has to internally process their frightened reaction to his mere presence on the same sidewalk. This happens to him more times than he cares to remember, but each time he notices this, it takes up his attention even if only for a minute or so.
Microassault: A microassault is an explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim through name-calling, avoidant behavior, or purposeful discriminatory actions.	A Black woman goes to the cafeteria in her workplace regularly. The Asian cashier says hi and good morning to every non-Black person but never conveys any greeting to the Black woman. The Black woman notices this but does not say anything.	The cashier is pleasant to every non-Black person (she is not *unpleasant* to any Black person, but she is also not pleasant with them either), and the Black woman notices this behavior every day and now has to process it internally. (Did she do something wrong to this person? Is this person prejudiced against Black persons? What problematic interpersonal interactions should she anticipate today from this person? Do other people notice these things or is she just being crazy and paranoid? Will people think she is just being paranoid if she tells them, especially her White and Asian coworkers?) She decides to just not tell anyone about it and accepts that it is just the way things are. In Mary's Story, in Box 3, the medical assistant and physician's coolness, which is received by Mary as rudeness, is an example of a microassault.
Microinvalidation: Microinvalidations are characterized by communication that excludes, negates, or nullifies the psychological thoughts, feelings, or experiential reality of a Person of Color.	A Black male college student submits a paper to a college professor, and the professor (who is a White woman) is visibly surprised (but very pleased) that this student is able to write so well, and she congratulates him on being able to write so well both in private and in front of the whole class.	While the professor should be (and is correctly) pleased to have a student who can write very well in her class (every professor's dream!), her look of surprise/overtly expressed surprise covertly communicates to this student that this professor may harbor the implicit bias (i.e., unconscious bias) that Black male college students do not know how to write well. This is disappointing to the student who is academically stellar, unbeknownst to the professor at the time. The student however processes this recognition internally, acknowledges the microaggression for what it is, but carries on seemingly unbothered. This is known as *cognitive appraisal* and is the main recommendation that is often given as the preferred response to microaggressions.

[a]Source of definitions: Data from "Racial Microaggressions in Everyday Life: Implications for Clinical Practice," by D. W. Sue, C. M. Capodilupo, G. C. Torino, J. M. Bucceri, A. M. B. Holder, K. L. Nadal, and M. Esquilin, 2007, *The American Psychologist, 62*(4), pp. 271–286 (https://doi.org/10.1037/0003-066X.62.4.271). Copyright 2007 by the American Psychological Association. All rights reserved.

cardiovascular health outcomes than other racial groups in the United States, yet no genetic differences have been found to explain these differences and no systematic health behavioral differences between racial groups have been found to be meaningful explanatory variables (e.g., differences in nutritional habits and preferences).

Direct Chronic Pathophysiological Pathways of Microaggressions

What then are the next steps in the pathway between the sustained overactivation of the HPA and SAM axes and poorer health outcomes? Two key mechanisms have been proposed: allostatic load, and epigenetics. "Allostatic load" is a term to capture the collective impact of the chronic overactivation of the HPA axis in a way that is maladaptive and results in chronic wear and tear and eventually greater disease burden. More specifically, allostatic load results "when the allostatic systems are either overworked or fail to shut off after the stressful event is over or whenever these systems fail to respond adequately to the initial challenge, leading other systems to overreact" (McEwen, 1998). Effectively, the allostatic load theory suggests that microaggressions and the corresponding interpretation of and reaction to the challenge of microaggressions result in ongoing negative behavioral responses such as hypervigilance and helplessness, which themselves inappropriately and maladaptively stimulate the HPA and SAM axes, leading to corresponding neural, neuroendocrine, immune, cardiovascular, gastrointestinal, and other systemic effects. Narrower pathophysiological and age-specific linkages are increasingly being documented, such as neurological impacts on the anterior cingulate and prefrontal cortices (Berger & Sarnyai, 2015) and significant effects in childhood and young adulthood (Brody et al., 2014; Shonkoff et al., 2021). Nevertheless, it is these basic physiological systemic effects that later manifest as differential distributions of diseases in different population subgroups.

The other major chronic pathway of action for microaggression is epigenetics, which can be defined as the inheritance of traits without modifying the genetic sequence of DNA, both at the cellular level (i.e., from a parent to a daughter cell) and at the organismal level (i.e., from a mother to a child) (Jadotte, 2019). This pathway is considered chronic because epigenetic changes are independently sustained well after the stressor that initiated them has disappeared from the environment of the individual affected. In essence, chronic extracellular signals (e.g., hormones, such as cortisol, released because of chronic stress and the HPA and SAM axes) initiate epigenetic changes (e.g., methylation of specific segments of DNA, resulting in inhibition of gene expression at that location of the cellular genome), which then manifest as diseases via differential phenotypic expression of genes outside their normal function. But, perhaps, the most troubling implication of epigenetics is that these changes can become not only self-sustaining but also transmissible to future generations such that the microaggressions faced by the parents become imprinted in the children, resulting in the inheritance of health disparities (Jadotte, 2019). It is tragic that this generational health inequity, like the microaggressions that can generate it, also often goes unnoticed.

Indirect But Potent Pathways Contributing to Health Disparities

Racism adversely affects health by triggering negative emotional reactions that can lead to altered physiological reactions. In addition to direct physiological reactions, racism may indirectly impact health behaviors and health interactions contributing to poor health outcomes of oppressed groups (Gibbons et al., 2014).

As noted when discussing structural racism, the *living and working conditions* created by racism can initiate and sustain differential exposure to a broad range of stressors associated with social disadvantage. Social determinant stress, notably socioeconomic stress, poor housing, and neighborhood conditions, can trigger a range of acute and chronic secondary stressors (Turney et al., 2013). In high-poverty areas, we see that residents are exposed to high levels of stressors linked to the social environment, including witnessing shootings, seeing drug activity, being vulnerable to high levels of break-ins and theft, and an ongoing worry about child safety (Turney et al., 2013; Williams, 2018). Moreover, stressors linked to the physical environment, including "broken elevators, roach and rodent infestation, trash buildup, dampness in the walls, extremely hot (or cold) interior temperatures, the absence of green open spaces, crumbling sidewalks, graffiti, litter, and inadequate lighting" (Williams, 2018, p. 471), are stressful exposures that can be linked to both physical and mental health disparities (Pearlin et al., 2005; Williams, 2018).

Under these living conditions created by concentrated poverty and segregation, along with co-occurring racial frustration and upheaval, it is more difficult for residents to practice healthy behaviors. Individuals may engage in a number of negative health behaviors, for example, smoking, alcohol use and abuse, drug use, and overeating, in attempts (conscious or unconscious) to cope with the stressors of daily life. These contribute to negative individual and group health outcomes (Harrell et al., 2011; Jackson & Knight, 2006; Williams & Mohammed, 2008). It must be noted that there is a strong tendency for the healthcare enterprise to frame these negative outcomes in terms of deficits or problems with individual behavior and fail to acknowledge the social and structural factors perpetuating these behaviors and outcome. These stratified socioeconomic opportunities and behavioral responses are indirect mechanisms whereby racism "gets under the skin" and contributes to health disparities.

The *negative health impact of internalized racism* can be a contributing factor to poorer health outcomes among racialized groups. By advancing the affirmation of beliefs about the innate deficiencies of one's self and one's group, internalized racism can result in lower self-esteem and psychological well-being. This, in turn, has an adverse impact on health and health behavior (Kwate & Meyer, 2011). A recent review of existing research found that internalized racism was positively associated with alcohol consumption, psychological distress, being overweight, abdominal obesity, blood pressure, and high fasting glucose levels (Williams & Mohammed, 2008).

Research also reveals that the poor health of persons in racial minority groups is further exacerbated by racial differences in access and quality of care (Williams & Mohammed, 2013). Some of the differences in healthcare access is due to geographic and payment issues; however, there is evidence that access may also be influenced by cultural racism in the form of *implicit or unconscious bias* on the part of healthcare providers that can lead to discrimination, which, in turn, influences health-seeking behavior and the provider–patient relationship (Williams et al., 2019).

There is now about 35 years of research from neurology and social and cognitive psychology that has established that hidden biases operating largely under the scope of human consciousness influence the way that we see and treat others, even when we are determined to be fair and objective (Staats et al., 2017). Even when a healthcare practitioner holds no explicit biases, implicit biases (both favorable and unfavorable), especially about age, gender, race, and role, are activated involuntarily and without one's awareness or intentional control (Rudman, 2004). Consider walking into a room and seeing your newly assigned patient. There is a rapid, automatic association that occurs between people, ideas, and objects and the unconscious attitudes or stereotypes that we have learned from the dominant cultural message as to superiority, inferiority, inclusion, exclusion, normality, and abnormality. These automatic associations will potentially affect our understanding, actions, and decisions (Staats et al., 2017) and may result in differential treatment recommendations. Evidence of these automatic associations includes the following: non-White patients receiving fewer cardiovascular interventions and fewer renal transplants, non-White patients being less likely to have pain medications (non-narcotic and narcotic) prescribed, and patients of color more likely to be blamed for being too passive about their healthcare or nonadherent with healthcare recommendations (FitzGerald & Hurst, 2017; The Joint Commission, n.d.).

Underlying implicit bias can also negatively influence the patient–provider relationship and communication quality (Cooper et al., 2012; van Ryn et al., 2011). Structural characteristics of the environment, such as artwork, diversity of staff, time it takes to get appointments, types of magazines available for patients in the waiting room, and treatment hours and practices, may send cues as to the true inclusiveness of the practice. Implicit bias may influence our interactions with the patient—our warmth, time spent communicating, interest in the person, and the types of questions we ask or fail to ask. With unconscious bias prevailing, the provider may make assumptions about a non-White patient—that they are experiencing poverty or financial disadvantage, that they are nonadherent with their treatment regimen, that they are drug seeking. Similarly, the communication process may be nontherapeutic and the perspectives of the patient may be dismissed and not listened to, the person may be chastised for crying over pain or other discomfort, the tone and content of communication may be paternal and disrespectful, and it may be suggested that the patient is personally to blame for their health problems. These examples are not overexaggerated but a reality for many historically marginalized groups. These microaggressions create a hostile and invalidating climate that can sap their spiritual and psychic energies, causing psychological difficulties and problems.

The patient similarly brings to the encounter their own experiences with the healthcare encounter. A recent poll by Kaiser Family Foundation/The Undefeated Survey on Race and Health (Hamel et al., 2020) found that 70% of African Americans believe that people are treated unfairly based on race or ethnicity when they seek medical care. With a legacy of centuries-long unfair treatment of Black people, and other People of Color being treated poorly in healthcare, it is no wonder that 55% of African Americans said they distrust the healthcare system (Hamel et al., 2020). Clearly, when many African Americans and People of Color enter the doors to healthcare institutions, they bring these anxieties with them. Their experience puts them on alert for *stereotype threat*, where they are at risk of judgment or mistreatment based on their racial identity (or other marginalized identities) (van Ryn et al., 2011). Experiencing stereotype threat (Figure 2) results in physiological and emotional changes that reduce performance on cognitive and social tasks and negatively impact the patient–clinician relationship as it impairs communication and leads to less involvement in care (Burgess et al., 2010; Schmader et al., 2008; Steele & Aronson, 1995).

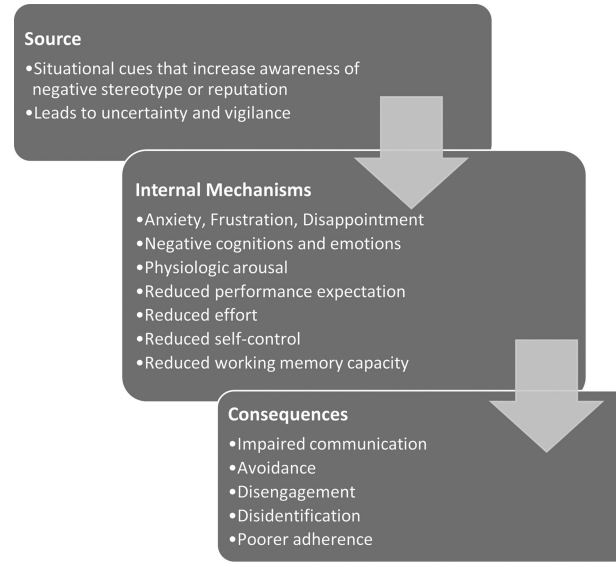

Figure 2. Physiological and emotional changes resulting from stereotype threat. Data from "Stereotype Threat and Health Disparities: What Medical Educators and Future Physicians Need to Know," by D. J. Burgess, J. Warren, S. Phelan, J. Dovidio, and M. van Ryn, 2010, *Journal of General Internal Medicine, 25*(Suppl. 2), pp. 169–177 (https://doi.org/10.1007/s11606-009-1221-4).

A Call to Action

To use the words of Dr. Martin Luther King, "Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane." The population-level data on health disparities are undebatable. A problem exists and the problem must be solved. Healthcare disparities exist at a population level. Racism is a significant contributor to the disparity. It is the responsibility of the organization and the clinicians within the organization to actively work to address this problem.

Skills That Lessen Racial Bias

All health professionals must begin by acknowledging that the problem is real, that the size of the problem is simply unacceptable, and that the problem is linked to racism. Know and understand the racial/ethnic and cultural background of the patients cared for in your facility. Seek out data to examine inequities in your own organization, in your community. Accept that care is influenced by explicit and implicit racial attitudes and examine your own implicit bias. Be motivated to invest in learning interaction and communication approaches to de-bias patient care—practicing with cultural humility, using perspective-taking and empathy to understand your patient and reduce bias and inhibit unconscious stereotypes and prejudices, invest time and energy to build trust, and empower patients in care planning and shared decision-making to develop a sense that they are on the same "team" and working toward a common goal.

The literature on coping has proposed the concept of cognitive appraisal (Folkman et al., 1986) as a method by which affected individuals themselves can learn to process the internal challenges brought about when they face microaggressions. Cognitive appraisal is a process by which an individual determines the potential threat and overall impact that a life event, such as a racial microaggression incident, can have on their well-being, requiring a "primary appraisal" or "rating of how affecting or meaningful the event is," and a "secondary appraisal" or "contemplation of the availability of resources to assuage the potential impacts of the stressor" (Delapp & Williams, 2015). Although affected individuals

Box 5. Addendum To Mary's Story

Going back to Mary's story, which appeared earlier in this article. Mary added the following from her perspective as a patient and from the perspective of someone who has been at the receiving end of microaggression.

By the time she left the urgent care center, Mary was convinced that she had been treated differently because of the color of her skin. Experiences such as this have convinced her that racism will be challenging to eradicate; the subtleness of these microaggressions makes it difficult to identify and address. However, she feels that her response to the microaggressions that she has experienced has made all the difference to how she internalizes these experiences. She feels strongly that her resilience, a product of her life's experiences and upbringing, combined with her values and family support, allows her to cope with these experiences in a constructive way. Mary's processing of her negative encounter in the urgent care center is an example of cognitive appraisal.

certainly need to process their thoughts and emotions generated by microaggressions (so as to stave off the negative pathophysiological effects of these incidents), it is clear that cognitive appraisal is not an equitable strategy to systematically address this problem, as it relies on the victims to mitigate a problem that extends well beyond themselves as individuals (see Box 5).

It is also imperative to go beyond the individual clinician level and hold the organization accountable for addressing structural racism. Institutional racism is the most powerful form of racism and addressing internalized and personally mediated racism in the absence of institutional racism will not mitigate the problem. As suggested by van Ryn et al., (2011), this can begin with an evaluation of the racial climate—both from employee feedback and from patient and community feedback. Examine the environment or setting to ensure that someone walking into the facility will recognize themselves and feel included. Examine policies and practices to determine whether fostering diversity and eliminating discrimination are a priority in the organization. Ensure that there is a formal process for patients and employees to share concerns and to investigate subtle and overt discrimination and unfair treatment. Establish monitoring systems in which processes and outcomes of care can be tracked to determine the presence of inequities and effectiveness of measures to decrease inequity. Develop interdisciplinary teams to generate creative solutions and create accountability for improvement. Develop, implement, and evaluate clinician development programs to ensure that all have the knowledge and skills needed to prevent racial biases from affecting patient care and care outcomes. A final, but perhaps most critical, strategy is to promote racial diversity at all levels of the organizational hierarchy and facilitate positive intergroup interaction.

Conclusion

The foreword to *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*, highlights that nurses can play a central role in addressing health inequities. In fact it emphasizes that "the nation cannot achieve true health equity without nurses (National Academy of Medicine et al., 2021, p. xi). This article provided an overview for understanding how racism contributes to health inequities. Knowledge and awareness are the first step. The next step comprises action and advocacy.

References

American Psychological Association. (2016). *Stress in America: The impact of discrimination*. Stress in America™ Survey. https://www.apa.org/news/press/releases/stress/2015/impact-of-discrimination.pdf

Aronson, J., Burgess, D., Phelan, S. M., & Juarez, L. (2013). Unhealthy interactions: The role of stereotype threat in health disparities. *American Journal of Public Health*, *103*(1), 50–56. https://doi.org/10.2105/AJPH.2012.300828

Berger, M., & Sarnyai, Z. (2015). "More than skin deep": Stress neurobiology and mental health consequences of racial discrimination. *Stress (Amsterdam, Netherlands)*, *18*(1), 1–10. https://doi.org/10.3109/10253890.2014.989204

Bonilla-Silva, E. (2006). *Racism without racists: Color-blind racism and the persistence of racial inequality in the United States*. Rowman & Littlefield.

Braveman, P. A., Cubbin, C., Egerter, S., Williams, D. R., & Pamuk, E. (2010). Socioeconomic disparities in health in the United States: What the patterns tell us. *American Journal of Public Health*, *100*(Suppl. 1), S186–S196. https://doi.org/10.2105/AJPH.2009.166082

Brody, G. H., Lei, M. K., Chae, D. H., Yu, T., Kogan, S. M., & Beach, S. R. (2014). Perceived discrimination among African American adolescents and allostatic load: A longitudinal analysis with buffering effects. *Child Development*, *85*(3), 989–1002. https://doi.org/10.1111/cdev.12213

Burgess, D. J., Warren, J., Phelan, S., Dovidio, J., & van Ryn, M. (2010). Stereotype threat and health disparities: What medical educators and future physicians need to know. *Journal of General Internal Medicine*, *25*(Suppl. 2), 169–177. https://doi.org/10.1007/s11606-009-1221-4

Chadha, N., Lim, B., Kane, M., & Rowland, B. (2020). *Toward the abolition of biological race in medicine: Transforming clinical education, research, and practice*. Othering & Belonging Institute.

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist*, *54*(10), 805–816. https://doi.org/10.1037/0003-066X.54.10.805

Cooper, L. A., Roter, D. L., Carson, K. A., Beach, M. C., Sabin, J. A., Greenwald, A. G., & Inui, T. S. (2012). The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *AJPH American Journal of Public Health*, *102*(5), 979–987. https://doi.org/10.2105/AJPH.2011.300558

Cruz, D., Rodriguez, Y., & Mastropaolo, C. (2019). Perceived microaggressions in health care: A measurement study. *PLoS One*, *14*(2), e0211620. https://doi.org/10.1371/journal.pone.0211620

Delapp, R. C., & Williams, M. T. (2015). Professional challenges facing African American psychologists: The presence and impact of racial microaggressions. *The Behavior Therapist*, *38*(4), 101–105.

Dovidio, J. F., Gaertner, S. L., & Pearson, A. R. (2005). On the nature of prejudice: The psychological foundations of hate. In R. J. Sternberg (Ed.), *The psychology of hate* (pp. 211–234). American Psychological Association. https://doi.org/10.1037/10930-010

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics*, *18*(1), 19–19. https://doi.org/10.1186/s12910-017-0179-8

Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., DeLongis, A., & Gruen, R. J. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping, and encounter outcomes. *Journal of Personality and Social Psychology*, *50*(5), 992–1003. https://doi.org/10.1037//0022-3514.50.5.992

Gale, M. M., Pieterse, A. L., Lee, D. L., Huynh, K., Powell, S., & Kirkinis, K. (2020). A meta-analysis of the relationship between internalized racial oppression and health-related outcomes. *The Counseling Psychologist*, *48*(4), 498–525. https://doi.org/10.1177/0011000020904454

Gibbons, F. X., Kingsbury, J. H., Weng, C.-Y., Gerrard, M., Cutrona, C., Wills, T. A., & Stock, M. (2014). Effects of perceived racial discrimination on health status and health behavior: A differential mediation hypothesis: Discrimination, racism, and health. *Health Psychology*, *33*(1), 11–19. https://doi.org/10.1037/a0033857

Gómez, J. M. (2015). Microaggressions and the enduring mental health disparity: Black Americans at risk for institutional betrayal. *Journal of Black Psychology*, *41*(2), 121–143. https://doi.org/10.1177/0095798413514608

Graves, J. L., Jr., & Goodman, A. H. (2021). *Racism, not race: Answers to frequently asked questions*. Columbia University Press.

Hadlow, N. C., Brown, S., Wardrop, R., & Henley, D. (2014). The effects of season, daylight saving and time of sunrise on serum cortisol in a large population. *Chronobiology International*, *31*(2), 243–251. https://doi.org/10.3109/07420528.2013.844162

Hamel, L., Lopes, L., Munana, C., Artiga, S., & Brodie, M. (2020). *Kaiser Family Foundation (KFF)/The Undefeated Survey on Race and Health*. https://www.kff.org/report-section/kff-the-undefeated-survey-on-race-and-health-main-findings

Harrell, C. J., Burford, T. I., Cage, B. N., Nelson, T. M., Shearon, S., Thompson, A., & Green, S. (2011). Multiple pathways linking racism to health outcomes. *Du Bois Review: Social Science Research on Race*, *8*(1), 143–157. https://doi.org/10.1017/S1742058X11000178

Huynh, V. W., Huynh, Q.-L., & Stein, M.-P. (2017). Not just sticks and stones: Indirect ethnic discrimination leads to greater physiological reactivity. *Cultural Diversity & Ethnic Minority Psychology*, *23*(3), 425–434. https://doi.org/10.1037/cdp0000138.

Jackson, J. S., & Knight, K. M. (2006). Race and self-regulatory health behaviors: The role of stress response and the HPA axis in physical and mental disparities. In K. W. Schaie & L. L. Cartensen (Eds.), *Social structures, aging, and self-regulation in the elderly* (pp. 189–239). Spring Publishing.

Jadotte, Y. T. (2019). Epigenetics: The process of inheriting health disparities. In *Social pathways to health vulnerability* (pp. 143–156). Springer.

Jadotte, Y. T. (2020). Shades of skin, shades of power: Social constructionism as the grand theory for the structure/agency and reality/identity conundrums. *Rose+Croix Journal*, *14*, 12–47. www.rosecroixjournal.org

Jadotte, Y. T., Caron, R. M., & Kearney, G. D. (2022). Ecosystemic theory, practice, and policy: Training recommendations for environmental public health. *AJPM American Journal of Preventive Medicine*, *62*(1), 135–144. https://doi.org/10.1016/j.amepre.2021.09.004

Jadotte, Y. T., Leisy, H. B., Noel, K., & Lane, D. S. (2019). The emerging identity of the preventive medicine specialty: A model for the population health transition. *AJPM American Journal of Preventive Medicine*, *56*(4), 614–621. https://doi.org/10.1016/j.amepre.2018.10.031

Jones, C. P. (2000). Levels of racism: A theoretic framework and a gardener's tale. *AJPH American Journal of Public Health*, *90*(8), 1212–1215. https://doi.org/10.2105/AJPH.90.8.1212

Kindig, D. A. (2007). Understanding population health terminology. *Milbank Quarterly*, *85*(1), 139–161. https://doi.org/10.1111/j.1468-0009.2007.00479.x

Kwate, N. O. A., & Meyer, I. H. (2011). On sticks and stones and broken bones: Stereotypes and African American health. *Du Bois Review: Social Science Research on Race*, *8*(1), 191–198.

McEwen, B. S. (1998). Stress, adaptation, and disease: Allostasis and allostatic load. *Annals of the New York Academy of Sciences*, *840*(1), 33–44. https://doi.org/10.1111/j.1749-6632.1998.tb09546.x

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling & Development*, *92*(1), 57–66. https://doi.org/10.1002/j.1556-6676.2014.00130.x

National Academy of Medicine; National Academies of Sciences, Engineering, and Medicine; Committee on the Future of Nursing 2020–2030; Flaubert, J. L., Le Menestrel, S., Williams, D. R., & Wakefield, M. K. (Eds.). (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. National Academies Press.

Pearlin, L. I., Schieman, S., Fazio, E. M., & Meersman, S. C. (2005). Stress, health, and the life course: Some conceptual perspectives. *Journal of Health and Social Behavior*, *46*(2), 205–219. https://doi.org/10.1177/002214650504600206

Rudman, L. A. (2004). Social justice in our minds, homes, and society: The nature, causes and consequences of implicit bias. *Social Justice Research*, *17*(2), 129–142. https://doi.org/10.1023/B:SORE.0000027406.32604.f6

Santiago, J. A., & Willner, J. (2011). *What are microaggressions?* (Paper 121). Lesbian Gay Bisexual Transgender Queer Center. https://digitalcommons.uri.edu/glbtc/121

Schmader, T., Johns, M., & Forbes, C. (2008). An integrated process model of stereotype threat effects on performance. *Psychological Review*, *115*(2), 336–356. https://doi.org/10.1037/0033-295X.115.2.336

Seaton, E. K., & Zeiders, K. H. (2021). Daily racial discrimination experiences, ethnic–racial identity, and diurnal cortisol patterns among Black adults. *Cultural Diversity & Ethnic Minority Psychology*, *27*(1), 145–155. https://doi.org/10.1037/cdp0000367

Shah, N. (2017). Race, ideology, and academic ability: A relational analysis of racial narrative in mathematics. *Teachers College Record*, *119*(7), 1–42. https://doi.org/10.1177/016146811711900705

Shonkoff, J. P., Slopen, N., & Williams, D. R. (2021). Early childhood adversity, toxic stress, and the impacts of racism on the foundations of health. *Annual Review of Public Health*, *42*, 115–134.

Sittner, K. J., Greenfield, B. L., & Walls, M. L. (2018). Microaggressions, diabetes distress, and self-care behaviors in a sample of American Indian adults with Type 2 diabetes. *Journal of Behavioral Medicine*, *41*(1), 122–129. https://doi.org/10.1007/s10865-017-9898-z

Sosoo, E. E., Bernard, D. L., & Neblett, E. W. (2020). The influence of internalized racism on the relationship between discrimination and anxiety. *Cultural Diversity & Ethnic Minority Psychology*, *26*(4), 570–580. https://doi.org/10.1037/cdp0000320

Staats, C., Capatosto, K., Tenney, L., & Mamo, S. (2017). *State of the science: Implicit bias review*. Kirwan

Institute for the Study of Race and Ethnicity. http://kirwaninstitute.osu.edu/implicit-bias-training/resources/2017-implicit-bias-review.pdf

Steele, C. M., & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality and Social Psychology*, *69*(5), 797–811. https://doi.org/10.1037/0022-3514.69.5.797

Sue, D. W., Alsaidi, S., Awad, M. N., Glaeser, E., Calle, C. Z., & Mendez, N. (2019). Disarming racial microaggressions: Microintervention strategies for targets, White allies, and bystanders. *American Psychologist*, *74*(1), 128–142. http://doi.org/10.1037/amp0000296

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

The Joint Commission. (n.d.). *Quick safety 23: Implicit bias in health care*. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-23-implicit-bias-in-health-care/implicit-bias-in-health-care

Turney, T., Kissane, R. J., & Edin, K. (2013). After moving to opportunity: How moving to a low-poverty neighborhood improves mental health among African American women. *Society and Mental Health*, *3*(1), 1–21. https://doi.org/10.1177/2156869312464789

van Ryn, M., Burgess, D. J., Dovidio, J. F., Phelan, S. M., Saha, S., Malat, J., Griffin, J. M., Fu, S. S., & Perry, S. (2011). The impact of racism on clinician cognition, behavior, and clinical decision making. *Du Bois Review: Social Science Research on Race*, *8*(1), 199–218. https://doi.org/10.1017/S1742058X11000191

Whitehead, M. (1991). The concepts and principles of equity and health. *Health Promotion International*, *6*(3), 217–228.

Williams, D. R. (2018). Stress and the mental health of populations of color: Advancing our understanding of race-related stressors. *Journal of Health and Social Behavior*, *59*(4),466–485.https://doi.org/10.1177/0022146518814251

Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and health: Evidence and needed research. *Annual Review of Public Health*, *40*(1), 105–125. https://doi.org/10.1146/annurev-publhealth-040218-043750

Williams, D. R., & Mohammed, S. A. (2008). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine*, *32*(1), 20–47. https://doi.org/10.1007/s10865-008-9185-0

Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist*, *57*(8), 1152–1173. https://doi.org/10.1177/0002764213487340

Williams, D. R., & Williams-Morris, R. (2000) Racism and mental health: The African American experience. *Ethnicity & Health*, *5*(3-4), 243–268. https://doi.org/10.1080/713667453

Williams, M. T. (2020). Microaggressions: Clarification, evidence, and impact. *Perspectives on Psychological Science*, *15*(1), 3–26. https://doi.org/10.1177/1745691619827499

For additional nursing continuing professional development activities on orthopaedic nursing topics, go to nursingcenter.com/ce.