SPECIAL REPORT

Racism in pediatric health

and How to talk to children about racism

JENNIFER WALTON, MD, MPH; BRANDI KAYE FREEMAN, MD, MS; YASMIN TYLER-HILL, MD; OLIVER BROOKS, MD; LYNN SMITHERMAN, MD

Dr Walton is a developmental behavioral pediatrician and assistant professor of pediatrics, Nationwide Children's Hospital and the Ohio State University in Columbus, Ohio, and chair of the pediatric section of the National Medical Association.

Dr Freeman is an assistant professor of pediatrics, associate vice chair for diversity, equity and inclusion, department of pediatrics, University of Colorado School of Medicine in Aurora, Colorado and speaker of the house of delegates of the National Medical Association.

Dr Tyler-Hill is the department chair and associate professor of pediatrics at Morehouse School of Medicine in Atlanta, Georgia.

Dr Brooks is a pediatrician and chief medical officer of Watts Healthcare Corporation in Los Angeles, California.

Dr Smitherman is associate professor of pediatrics and vice-chair of medical education, Department of Pediatrics, Wayne State University School of Medison in Detroit, Michigan.

Since the inception of the United States, social, economic, political, and scientific institutions have been built on a foundation emphasizing the inferiority of individuals related to phenotypic differences.[1] This hierarchy ensconced white individuals as superior to all other groups with Native Americans and Blacks on the bottom. Centuries of flawed scientific theory supporting racial inferiority/superiority remained until it was definitively disproved with the sequencing of the human genome at the cusp of the 21st century. Some fifty years after the discovery of the genetic code, at a White House ceremony in 2000 to announce the discovery, Craig Venter, a pioneer of DNA sequencing, observed, "The concept of race has no genetic or scientific basis."[2] We can now definitively declare that genes play little to no role in the health inequities disproportionally experienced by people of color (POC). Racism, not race or genes, has a profound impact on the health of children of color.[3]

Racism is defined as prejudice, discrimination, or antagonism directed against someone of a different race (social construct defined by phenotypic features and assigned a social value) based on the belief that one's own race is superior. It is the belief that all members of each race possess characteristics or abilities specific to that race, especially to distinguish it as substantially inferior or superior to another race or races.[4] In order to exist, racism must include 2 components, racial prejudice and social power. Racial prejudice is a set of discriminatory or derogatory attitudes based on assumptions deriving from perceptions about race or skin color. Social power is the historically social, political, and economic privilege bestowed upon some groups. Higher parental unemployment affecting health care access, infant mortality rates, and inequities in the juvenile justice system are disparities we all know; the root of these inequities is more than just poverty or zip code: It is based on how the US social structure was established.[5] Given this definition and the current evidence, racism is a social determinant of health (SDOH).[5]

Levels of racism

Structural or institutional racism occurs on the macro level and is described as access to goods, services, and opportunities for society based on race. It cannot be attributed to an individual or group of individuals, but rather is based on laws, precedents, policies, and interventions that disadvantage people based on race. As suggested by the "racial iceberg," structural racism is usually below the surface and often difficult to identify since over time it has become the status quo.[6] As documented by several scholars, one way this type of racism can manifest is by access to power. It has been well established that segregation is a major contributor to structural racism. By limiting where individuals can live and access community resources such as transportation and grocery stores, the overall well-being of those in under-resourced communities is lower than that of those in well-resourced communities. This also leads to inequities in access to appropriate medical care, education, and a clean environment. Individuals who live in under-resourced communities tend to be POC. As of 2019, 17% of children in the United States were living in poverty; of all Black children this equates to 31%, American Indian 30%, Hispanic 23%, and White children 10%.[7] In addition, structural racism also impacts access to power as can be seen with voter suppression; lack of racial representation in positions of power, such as elected officials; and control of the media.[8]

For children of color, internalizing negative traits can lead to self-loathing and a desire to change their appearance.

Interpersonal or personally mediated racism, on the other hand, is more easily identified. It is where prejudicial thoughts are acted out between individuals in the form of discrimination based on race. It can be as subtle as microaggressions or as obvious as violent acts, racial slurs, or exclusionary practices. This form of racism may be unintentional or unconscious, as seen with implicit bias, or intentional, as seen with discriminatory hiring practices or subjective grading.[7] Interestingly, this type of racism can be easily taught to young children. The social experiments that Jane Elliott did with her third-grade students the day after Martin Luther King Jr was shot are a prime example of how quickly prejudice and discriminatory practices can be taught, embraced, and internalized within a few hours. Her White students, who had been separated into blue-eyed groups and brown-eyed groups, and told the blue-eyed group were smarter because of their eye color, quickly learned who was superior and inferior in the world of their classroom.[9]

Finally, *internalized racism* occurs when individuals accept the negative stereotypes and messages about themselves and their race. This is best demonstrated in the Black doll/White doll experiments of Drs. Kenneth and Mamie Clark in the 1940s and has since been replicated several times.[10,11] These experiments demonstrate that preschool children assign positive attributes to White dolls and negative attributes to Black dolls. For children of color, internalizing negative traits, especially when reinforced by adults around them, can lead to self-loathing and a desire to change their appearance by straightening hair, using bleaching creams for their skin, etc.

Internalized racism coupled with a distrust of the health care system may cause certain POC to not seek out preventive health care or wait

too long to seek care for an acute problem.

Racism and its effect on pediatric health

Racism, as it applies to health care, has been shown to contribute to the overall health disparities that we see in communities of color. With structural or institutional racism, there is decreased access to health care and resources for education, leading to lower health literacy and fewer health care providers of color.[12, 13] Over time, this has led to a distrust of the health care system as a whole by POC due to widely publicized historical events such as the Tuskegee Syphilis Study and the Marion tuberculosis outbreak. It is well chronicled that poor neighborhoods have higher incidences of behavioral problems, poor mental and physical health, delinquency, crime, and risky sexual behavior.[14] Asthma and coronavirus disease 2019 (COVID-19) are examples of pediatric chronic health disease where racism has demonstrated a negative impact.

One of the most common chronic illnesses among children in the United States is asthma, accounting for a considerable number of inpatient and outpatient visits and affecting school attendance.[15] When sociodemographic characteristics, health behaviors, and the child's health at birth were controlled, the interaction between race and ethnicity and income is statistically significant. In fact, non-Hispanic Blacks have a higher prevalence of recurrent asthma exacerbations and hospitalizations than Whites after adjusting for demographic and socioeconomic factors.[16] One study revealed that with non-Black children, poor children were 45% more likely than children who were not poor to have asthma. However, there was no statistically significant difference found between income groups with Black children.[15]

The COVID-19 pandemic highlights how SDOH shaped by institutional racism impact a new disease. Researchers at a children's hospital found that infection rates differed significantly among racial and ethnic groups. Only 7% of non-Hispanic White children tested positive for COVID-19, compared with 30% of non-Hispanic Black and 46% of Hispanic children.[17] The study found that children who lived in households with lower incomes also tested positive at higher rates than wealthier children, though the study states the racial and ethnic disparities in infection rates "only slightly attenuated after adjustment for socioeconomic status."[17]

With regards to personally mediated racism, implicit bias has surfaced as a strong driver for health care disparities between White and minority children. This can be seen in pain management. One study in pediatric emergency departments demonstrated racial differences in analgesic administration for children presenting with acute abdominal pain and appendicitis.[18] For those children who receive a diagnosis of appendici-

TABLE 1 Understanding how children become racially aware at various ages and how to approach anticipatory guidance.

DEVELOPMENTAL AGE	ANTICIPATORY GUIDANCE
Preschool (3-5 years): Children are interested in physical characteristics and may begin to notice differences in people around them.	■ Adopt positive messaging about each person's uniqueness ■ Read books about different cultures ■ Expand social circles to include different cultures/activities
Early school–aged children (6-9 years): Children become aware of social groups and recognize in-groups and out-groups. Children may start to develop prejudices based on exposure of those around them.	■ Ideal time to discuss race, bias, diversity, and inclusion ■ Discuss themes seen on TV or on social media ■ Ask the child their thoughts about community events
Late school–aged children (9-12 years): Learn that they can belong to more than one group. As children become capable of understanding others' perspectives, empathy may emerge at this age.	■ Opportune time to discuss prejudice and bias to interrupt racism ■ Continue to expand social circles to include different cultures/activities
Adolescence (12+ years): Values are solidified including prejudices.	■ Discuss community events ■ With adolescent male patients of color, need to address interactions with law enforcement

Racial identity and/or awareness is a process like other developmental domains. Discussions regarding race can occur at any age and should be included in anticipatory guidance.[31, 32]

tis, Blacks in moderate pain were less likely to receive any pain medication than Whites, and Blacks in severe pain were less likely to receive opioid medication than Whites.[18] Another study showed that when looking at optimal pain reduction, minority children were more likely to be discharged home in significant pain than their White counterparts.[19] Even after adjusting for injury severity and pain intensity, minority children were less likely to receive opioids for the treatment of fracture pain than non-Hispanic White children with similar injury severity and pain scores.[19]

In sickle cell disease (SCD), a genetic disease found predominately in individuals of African and Mediterranean descent, personally mediated racism is clearly evident. This has been documented in one study, where 20 individuals with SCD aged 13 to 21 years were interviewed using the Perception of Racism in Children and Youth (PRaCY).[20] Participants reported having racial bias experiences, with a total of 104 racial bias events, including community experiences such as being closely watched or insulted by someone else, and medical experiences such as being treated inappropriately in an office visit or emergency room visit.[20] About half of the participants reported racist events caused by authority figures, 23.7% described events triggered by people of similar age, and about half of the events perceived by participants were explicit by the perpetrator. "The number of events of racial bias perpetrated by authority figures is concerning and has considerable school and community implications,"

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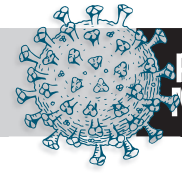
the researchers said.[20] Not surprisingly, these experiences were associated with several negative emotions, including generalized dissatisfaction with life in 27.9% of participants, anger in 20.9%, inferiority in 16.3%, and anxiety in 9.3%.[20] This finding suggests that these racist events can severely impact young patients' lives and affect their health outcomes.

Mental health is also affected by personally mediated racism. Young children who experience discrimination are at an increased risk for mental health and behavior problems, but less so if they have a strong sense of racial and ethnic identity.[21] Investigators studied more than 170 children, with more than half of the children Latinx, about 20% Black, and the rest mixed race. Children who reported discrimination and had low ethnic-racial identity scores were at high risk for anxiety, depression, oppositional behavior, and other mental health and behavior problems.[21] However, the effects of discrimination were muted among children with a strong sense of ethnic-racial identity, according to the report.[21]

As children are raised in a climate embedded with institutionalized racism, then exposed to prejudice and discrimination (ie, personally mediated racism), certain values may be instilled, resulting in the development of internalized racism. This is concerning as it relates to pediatric health. Schmeer and Tarrance expanded the concept of "weathering" to childhood (how adverse societal hardships influence negative health effects), via a study where children's c-reactive protein (CRP) levels were measured for low-grade inflammation (considered for levels between 1-10 mg/L).[22] Among children born to parents born in the United States, low-grade inflammation was found in 17% of White children, compared with 22% and 26% for Black and Hispanic children, respectively, and 19% for children of other races. Low-grade inflammation was higher in children of foreign-born parents: 31% for Hispanic, 26% for Black, and 22% for children of other races.[22]

In the study by Coker and colleagues on perceived racial/ethnic discrimination among fifth-graders, 15% of children answered yes that they were treated poorly because of their race, ethnicity, or color of their skin (wording based on child's understanding of the question). Also, 80% of those who answered yes also stated that they were treated poorly in school.[23] In addition, those children who reported perceived discrimination had symptoms of

KSENIIA@STOCK.ADOBE.COM



To read about **how racial disparities play a role in MIS-C**, go to **bit.ly/3s00ybl**

TABLE 2 Addressing racism in your pediatric practice

The following guidelines can be used to support patients and families in your practice.[3]

	GUIDELINES
STEP 1 Start with yourself	**Embark on your own personal journey:** ■ Understand your own biases ○ Implicit.harvard.edu/implicit ■ Broaden your cultural circle ○ See resource list ■ Learn more about racism and how to become antiracist ○ See resource list ■ Speak up when you witness racist events
STEP 2 Create a culturally safe medical home	**Infuse equity, diversity, and inclusion (EDI) in the clinical setting:** ■ EDI initiatives in early literacy programs (Reach Out and Read, etc) ■ Acknowledge important events/ celebrations of different cultures in waiting areas and exam rooms ■ Develop a resource list for families that want to learn more about becoming antiracist ○ See resource list ■ Conduct quality improvement and quality assurance to increase quality of care based on race/culture
STEP 3 Patient encounters	**Be proactive regarding the impact of racism on your patients and families:** ■ Check in with your patients at each visit ○ Acknowledge if the patient is *not* OK and offer support ○ Use standardized questionnaires and discuss answers ■ Provide anticipatory guidance on racism to all patients ○ Discuss community events ○ Openly discuss concerns patients/parents may have ■ Discuss positive supports and resilience that counter racism ○ Family ○ Friends ○ Encourage diverse activities and exposures ■ Oppose negative messaging ■ Counter negative messages with positive ones

RESOURCE LIST:

Books:

1. Celano M, Collins M, Hazzard A. S*omething Happened in Our Town: A Child's Story About Racial Injustice.* Magination Press; 2019.
2. Williams D. Beyond the Golden Rule: A Parent's Guide to Preventing and Responding to Prejudice. *Teaching Tolerance*; 2008.

Websites:

1. Embrace race: Resources to support those wishing to know more about race, culture, bias and racism. http://www.embracerace.org
2. Healthy children: The American Academy of Pediatrics' parenting website. http://www.healthychildren.org

Commentaries:

1. Siegel E. Six steps anyone can take to become an ally in White, male-dominated workplaces. *Forbes.* Octboer 25, 2019. https://www.forbes.com/sites/startswithabang/2019/10/25/6-steps-everyone-can-take-to-become-an-ally-in-white-male-dominated-workplaces/?sh=1997e47949fd
2. Hanna-Attisha M. I'm sick of asking children to be resilient. *New York Times.* May 12, 2020. https://www.nytimes.com/2020/05/12/opinion/sunday/flint-inequality-race-coronavirus.html

depression, attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder.[23] Specifically, Black, Hispanic, and children of other races had an association between perceived racial/ethnic discrimination and depressive symptoms, while White children did not.[23]

Over the past few decades there has been a concerning trend in the suicide rate in school-aged children, specifically among Black children. One study highlighted the increase of the suicide rate in Black children younger than 12 years of age.[24] Robinson and colleagues demonstrated that Black girls reported increased suicidal ideation compared with White girls, and Black girls were more likely to report suicidal ideation at lower levels of depressive symptoms.[25] Suicides in Black girls were 1.2 per 100,000 in 2007 and increased to 4.0 per 100,000 in 2017.[26]

It is time to acknowledge the factor of racism in this trend in order to establish appropriate treatment and prevention efforts.

How to talk to children and families about racism

Illustrating the adverse effects of racism on pediatric health and how to combat this disparity is part of the mission of the Pediatric Section of the National Medical Association (NMA), in addition to providing comprehensive updates on recent advances in pediatrics and addressing issues of national importance. Pediatricians are the first line in providing anticipatory guidance on the promotion of child health and development, including the impact of racism and how children can be resilient despite the effects of racism. The first step to address racism with families and patients is for pediatricians to first address their own bias and prejudice. Evidence has shown that awareness of bias and taking con-

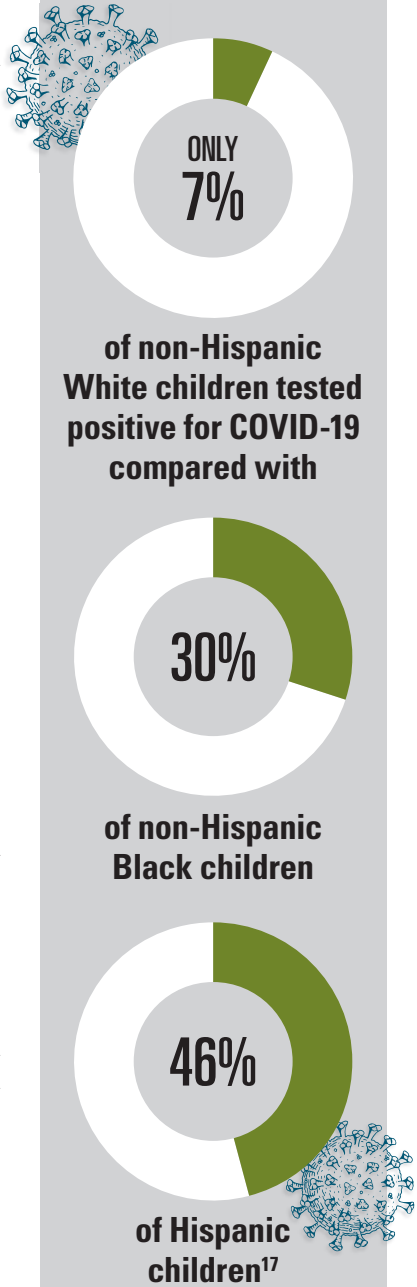
scious action to mitigate bias can have a significant impact on how the message is received.[27] Exploring one's biases through assessments such as Harvard's Project Implicit[28] can be effective in understanding how biases may unconsciously impact everyday interactions. This can be the start toward understanding the actions, policies, and institutions that contribute to racism. Ibram Kendi, in his *New York Times* best-selling book *How to Be an Antiracist*, defines being an anti-racist as "one who is supporting an antiracist policy through their actions or expressing an antiracist idea."[29] Pediatricians taking an antiracist approach can have beneficial effects in addressing racism with patients and families.

In terms of creating an environment in the clinical setting that reduces bias, pediatricians should take action to improve the practice environment. Diversifying the pediatric workforce is an integral part of the NMA's mission as the oldest and largest organization of physicians of African descent. Additionally, bias and antiracism training for all clinical staff and professionals is vital.[3] Furthermore, we must not be afraid to ask the necessary questions to understand how patients and families may have been impacted by racism and bias in the clinical setting. This can be done by adjusting patient satisfaction surveys to include questions that allow patients to fully describe their clinical interaction and having a comprehensive system for addressing such grievances when they are reported.

In clinical interactions, pediatricians have the unique opportunity to directly impact the understanding of racism by patients and families. For example, in well-child visits, pediatricians can provide anticipatory guidance for parents on what to look for regarding a child's development of racial awareness/identity. Pediatricians can provide advice on how to approach discussions about race

FIGURE

COVID-19 INFECTION RATES DIFFERED SIGNIFICANTLY AMONG RACIAL & ETHNIC GROUPS



in a developmentally appropriate manner.[30] Additionally, providing resources that promote the development of a diverse cultural outlook, such as information about diverse community events, or providing books with diverse protagonists through https://www.reachoutandread.org, can be an effective way that pediatric offices support patients and families working to understand and address racism. When approaching your pediatric patient, it is important to note that children do become racially aware developmentally as with all other domains (**Table 1**). There are resources in addressing racism for yourself, your patients, and your practice (**Table 2**).[30]

Discussions with patients and families around racism can be difficult, especially when there is racial discordance between providers and families. Become comfortable being uncomfortable in order to truly help families understand and address racism. Pediatricians should approach these conversations with honesty: it is our role to help every child achieve their best while understanding the truths in society. ■

COMMENTS? Email them to llevine@mjhlifesciences.com

For references and resource list, go to ContemporaryPediatrics.com/racism-in-pediatric-health

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