The Transformer: the UW Medicine Podcast
Episode 8: The Toxic Stew of Microagressions

Opening Soundbite: The idea of microaggressions is not that it's all racist all the time, all white people are horrible people. It's that racism is part of the stew here. It's like if you have somebody with a peanut allergy, you don't have to feed them a whole bag of peanuts. But if there's peanuts as one of the ingredients in the stew, then the whole stew becomes toxic and poisonous for that person.

[Musical interlude begins playing]

Josh Kerns: Greetings and welcome to another edition of The Transformer: the UW Medicine Care Transformation podcast. I'm your host Josh Kerns. In a recent episode, we discussed our core belief that everyone is entitled to the highest level of care but that institutional racism has created inequities even within our own health system, and those inequities result in health disparities. We also talked about UW Medicine's commitment to righting this wrong and some of the programs taking shape here to do so. In this episode, we'll take a closer look at the everyday bias against patients and providers alike that remains far too common. It's often subtle but can result in insidious harm. Experts call these microaggressions. Today our expert panel will discuss what they are and why eliminating them is a critical step in delivering the best care for our patients and a truly inclusive work environment for ourselves. And greetings doctors, welcome. Great to have you back, Drs. Dawson and Houston for another conversation. Dr. Kanter, welcome. First of all, go ahead and introduce yourselves so that the folks listening can know who you are.

Pat: Yes, hi, I'm Dr. Patricia Dawson. I'm the medical director for healthcare equity for UW Medicine.

Paula: And I'm Paula Houston. I am the director of healthcare equity for UW Medicine.

Jonathan: And I am Jonathan Kanter. I am a clinical psychological scientist in the Department of Psychology and I'm director of what we call the Center for the Science of Social Connection.

Josh: In a previous episode, Drs. Dawson and Houston, we had a very insightful and really informative conversation and I want to go back for those who have not heard that and just sort of recap for us what are the objectives of UW Medicine’s healthcare equity blueprint. Tell us a little bit about the work that you've been doing.

Pat: Our blueprint has three main strategic objectives. One has to do with the workforce and that involves education, training policies to increase cultural humility and to decrease microaggressions and racism and other isms. We really basically want to have our workplaces be welcoming for all providers and all patients so that providers can bring their full selves to work and patients can get good care. The second one has to do with community and community outreach. So we want to eventually develop an Advisory Council and to that end we're having community conversations and participating in community events. And then the third goal has to do with reducing disparities by using our available data to pinpoint where we can get the best outcomes with our resources.

Josh: I have been impressed in working with the University of Washington Medical system over the last year since we started these conversations with the level of commitment that the organization has given to this initiative and the amount of work you and your dyad

partner here have been putting in, for those who don't really realize the priority of this. I mean this is a major, major frontline initiative for UW Medicine.

Paula: Yes it is. Along with our Financial Improvement Transformation, our FIT initiative, our leadership has said that equity, diversity, inclusion is one of the major priorities for the institution.

Josh: Dr. Kanter, tell me a little bit about your role, what is it that you actually do, what does your organization do?

Jonathan: Well, we have a research center in the psychology department and we have several different arms of research but the one that's relevant here is the research on microaggressions and racism and we have a bunch of projects on these topics. First, we've been spending a lot of time talking to people of color, other people with minoritized and stigmatized identities about their experiences of microaggressions just to make sure we understand the experience as deeply as possible, just assuming that we don't know what that is.

Josh: How would you define a microaggression, what is it? Give us some examples.

Jonathan: I think the easiest way to define a microaggression is to start by saying what it's not. And so, traditionally in this country when we talked about racism and oppression, the dialogue has primarily been about really explicit and obvious acts of racism. So, like using the N-word or lynchings or really just obviously horrible things that most people would agree are pretty bad. The idea of microaggressions is pretty much everything else that happens in interpersonal interactions, all of the subtle things that go on in day-to-day interactions between people of color and others, all of the not so subtle things that still, when you ask the white person about it, they will get defensive and they will say, oh I didn't mean to offend you, I didn't mean to be racist. So, microaggressions are sort of a very large umbrella term for a whole set of interactions and conversations and behaviors that are experienced by people of color or others with minoritized or stigmatized identities as racially offensive in some way, at least partially.

Josh: Not just race though, I would assume gender, etc., so anything that is potentially harmful to another human being basically.

Jonathan: Right. The term itself was coined way back in 1970 by Chester Pierce, who is a black psychiatrist at Harvard, and when he talked about it and wrote about it back in the 70s, he was really referring to experiences of black Americans. But since then, especially since the mid 2000s, about 2007, the term has really had a surge of interest and it's now being applied, rightfully so, across the whole spectrum of people who are experiencing oppressive and discrimination. People in the LGBTQ community, gender microaggressions, religious microaggressions, and so forth. Wherever there's a difference in identity based on power and privilege and interaction and the more powerful person is saying things that are offensive based on that difference, that's what we call microaggression these days.

Josh: And I know sometime in the past, Dr. Dawson or Dr. Houston, one of you referenced, it's almost analogous to the death by a thousand paper cuts, that may not be, it's not necessarily, to Dr. Kanter's point, just one incident, but it is the repeated everything else under the umbrella. But the cumulative effect could be equally devastating.

Pat: Definitely, it's the cumulative effect that results in stress, and stress can result in wearing effects on the body, so it can increase one's self-susceptibility to illness, to poor outcomes. Bad maternal fetal outcomes have been linked to stress that can be linked to microaggressions.

Jonathan: I'd like to add something to this, if I can. I think there's a common misperception about microaggressions that, okay yes, they are offensive and we shouldn't be offending people, but maybe people are making too big a deal of this. I mean, after all, isn't this just sort of a minor thing that happens in conversations. And I think there is increasing evidence, good science actually, that suggests that these subtle incidents that we call microaggressions, when they accumulate over time, when you're living in a society where you're experiencing these in an unpredictable but chronic fashion, can actually add up to potentially more significant health effects or at least as significant health effects as experiencing really explicit and violent acts of hatred and racism. There's research, for example, that suggests that if you experience a subtle act of racism where the other person denies it and it just leaves you kind of confused and unsure and stunned but not really sure what to say, that has more effects on your physiology in terms of stress and arousal and depletion of cognitive resources than does experiencing a really obvious act of hatred. Because the obvious act of hatred, you know how to categorize that, you know how to categorize that person, but when it's subtle and it happens quickly and unpredictably and the person denies it, it can leave you really confused and the research actually suggests that this can accumulate over time and produce essentially living in a situation of chronic stress. And we know as medical professionals what chronic stress can do to the body and to health.

Josh: Would it be helpful to give a couple of examples of what a microaggression might look like or sound like?

Jonathan: Very common classic ones would be if someone is interacting with a black woman who has African-style braided hair and just noticing her hair and going up to her and saying, Hey can I touch your hair. That's sort of a classic microaggression. Or interacting with a person of Asian descent and asking where are you from. And then when the person says, oh I'm from California, they say, no, I mean where are you really from? Because you've been kind of hooked by their Asian features and you're wanting an Asian-themed response. Other examples of microaggressions have to do with saying things that suggest a colorblind way of looking at the world. So, colorblindness would be in the discussion of Black Lives Matter and police violence, saying well, I believe all lives matter, I don't like focusing just on one race. So all lives matter is sort of a classic microaggression at this point. So, those are sort of classic ones, but I think in everyday interaction there are a lot of microaggressions that don't get talked about, which are more subtle than these sort of obvious examples, and these are just things like when a white person is just giving either verbal or nonverbal indicators of anxiety or stress or threat in an interaction. So, for example, a medical doctor is more likely to use the first person plural pronoun when working with black patients versus first person singular pronoun. In other words, the doctor will say something like, well, we really want to help you here, instead of I really want to help you here. And we know that when you distance yourself in those ways, that's sort of a sign of anxiety. Or a doctor will just not make as good eye contact or will have shorter visits with a black patient. So, these are more subtle things that probably happen much more regularly than these sort of classic microaggressions like can I touch your hair or where are you from to an Asian person.

[Musical Interlude]

Josh: Along with Dr. Kanter's detailed analysis, we thought it would be valuable to also offer a couple of reenactments of real life interactions illustrating different types of microaggressions as they might present themselves. The first one is what it might sound like when a provider microaggresses against a patient worried about ovarian cancer.

Patient: So how are my MRI results, Dr. Snyder? What does the cyst look like?

Doctor: Let's pull the image up there. Do you see? Just look at that skinny woman in there trying to get out.

Patient: Oh, OK. But what about the cyst?

[Musical Interlude]

Josh: So, Doctor, this scenario, tell me about the microaggression here and why it's so significant.

Jonathan: Yeah, I think two things briefly. Number one, it's a good example of how microaggressions are not just directed towards people of color but can be directed towards anybody with a marginalized, stigmatized or otherwise shamed identity. In this case, we're talking about size, and number two, it's a good example of several key processes that happen when people microaggress. Number one, the doctor's objectifying her, making a joke about size. Number two, the doctor is engaging in just a stereotype. And number three, there's probably some anxiety in the doctor that is causing the doctor to make this joke in the first place instead of just staying focused on what the patient needs.

Josh: Our next example illustrates a peer-to-peer microaggression.

Colleague 1: So did you hear that Dr. Rodriguez got tenure?

Colleague 2: I haven't worked with him but Dave has, right, Dave?

Dave: Yes.

Colleague 1: What, has he published twice? That certainly sounds worthy of merit.

Colleague 2: Yes. America, land of equal opportunity.

Dave: Wow.

Josh: Well, so, doctor, in this case, some obvious microaggression but also potentially some more subtle microaggression involving the bystander here.

Jonathan: Well, yes, I think it raises the difficult and interesting issue of how do we help peers and colleagues stand up to and speak out when they hear these kinds of comments. I mean this is clearly a fairly offensive comment about Dr. Rodriguez and it puts Dave in an awkward situation where he'd have to challenge both of his colleagues in the moment to try to do right here in this scenario.

Josh: We have another peer-to-peer microaggression, in this case, hearing how employees are treating another staff member wearing a religious head covering who's come in for a required annual safety test.

Technician: Thanks for coming into the employee health center for your respirator fit test today, Miss Abduallah. Can you please take off your hijab so we can conduct the test?

Miss Abduallah: I can't do that. I've had this test done previously and did not have to take it off.

Technician: Well, I'm asking you to take it off.

Miss Abduallah: No I cannot. Why would I need to? As I mentioned, I've done this test for the last 10 years and I've never needed to do so.

Technician: Well I'm going to bring my supervisor in to settle this.

Supervisor: Miss Abdullah, we need you to take your hijab off to take the test.

Miss Abdullah: I can't do that. And you've given me no reason why I must. No one has ever asked me to do this before.

Supervisor: Harumph, well, fine. Mark, just give her the test.

Josh: So, Doctor your thoughts on this particular scenario here.

Jonathan: Well, I think this raises an interesting issue with microaggressions, in that often the person who's committing the microaggression will stand really firm behind whatever they perceive their reason for doing it to be. And those reasons are, of course, not related to race or racism. In this case, the technician is standing firm behind his belief that you need to take the hijab off in order for the test to occur, which isn't accurate. The other thing I think is that this kind of thing probably has a really big impact on Miss Abdullah. I could imagine her being pretty shaken and upset about this for a while and it really changing her level of trust and safety in the employee health center that this occurred in.

Josh: In our last example, we have a patient showing microaggressive biased behavior toward providers.

[knock on door]

Male caregiver: Good morning.

Female caregiver: Hi Mr. Baker, I'm…

Mr. Baker, interrupting female: Maam, can you empty my bedpan?

Female caregiver: Good morning Mr. Baker, I'm Dr. Edwina Jackson. This is Nurse Murphy and he would be happy to help you. Now, tell me how you're feeling.

Josh: Doctor, your thoughts on this particular scenario.

Jonathan: Well, I think it's a fairly ubiquitous example of how patients make these assumptions based on skin color, race, and also on gender and often ascribe the highest status to whoever the white male is in the room. And our experience talking to providers of color is this is probably the most common microaggression that they experience

repeatedly day after day over the course of their careers, and it's undoubtedly exhausting for them.

Josh: You said something really interesting, which is the notion that people think that they can get off the hook by simply saying they weren't aware of it, they didn't mean it, as if somehow that mitigates the actual microaggression.

Jonathan: Right. I think at this point we have to recognize that behavior is complicated. Whenever we engage in behavior or say something, it's not as if there's just one single obvious source of influence on why we do what we do, or why we say what we say. There are always multiple sources of influence. And the idea of microaggressions is that one of those sources of influence is sort of coming from a racist process or a biased process. The idea of microaggressions is not that it's all racist all the time, all white people are horrible people. It's that racism is part of the stew here. It's like if you have somebody with a peanut allergy, you don't have to feed them a whole bag of peanuts. But if there's peanuts as one of the ingredients in the stew, then the whole stew becomes toxic and poisonous for that person. So microaggressions are I think, I hope that analogy is OK and not offensive to people with peanut allergies or to people of color, but , I think microaggressions are kind of like that, where the racist process is part of the stew of influence, but because it's in there the whole thing becomes toxic.

Josh: Beyond the context of why this is so important for humanity in terms of, specifically the operations of UW Medicine, why is this so critical to creating a better UW Medicine system?

Pat: I think it's absolutely critical that our staff and providers understand microaggressions, understand how they may be perpetuating them and what they can do to disrupt them. I think it's critical because it will help make a better workforce environment for people to come to work, but it will also make a better environment for our patients to receive care

Josh: Well, then ultimately the performance, I would think that delivery of that care just across the board, just how much it will make the organization function better as well as society functioning better at the end of the day.

Paula: Absolutely, I mean, you think about people of color and LGBTQ and women who are microaggressed all the time throughout their lives. We're trying to make it that once they come in the doors of UW Medicine, that they're gonna have a different experience, a more positive experience. And that's why we are doing this work. We want to make sure that we have a workforce that understands that these things have a very negative effect and we want to make sure that we have a workplace that's free from harassment and discrimination and out and out racism. One of the things that Dr. Dawson and I most recently had the opportunity to talk with people about is the microaggressions that happen from patients towards staff and clinicians. And we here at UW Medicine have a philosophy that we work off of called Patients are First, and that's absolutely true, our patients are the first thing we want to think about, that's why we're here. But, many staff have then decided that that means that staff are last, and we want to make sure that they understand that we are not expecting them to have inappropriate comments made towards them, that they have no recourse for. So, we've been working with staff about how to address that and letting them know that they can set boundaries. We have disruptive patient policies that we're now looking at and having those policies better address something like a microaggression as well, rather than a fully disruptive patient. But, just an inappropriate comment that is hurtful to staff is still damaging to the patient and provider relationship.

Josh: How do you then begin to not just provide the information to increase the awareness, but get people to change, especially those in the case, Dr. Kanter, as you mentioned, people I didn't mean that, and we see in our everyday discourse now, more and more defensiveness and polarization in so many of our conversations. How do you get people to not only understand but then to actually change?

Jonathan: It's important to recognize again that microaggressions are not one thing, it's a catchall category for a variety of interactions and a variety of responses that people make. So I think some of these actions and comments are going to be easier to change than others. First, I think there's this notion that microaggressions are associated with implicit bias. In other words, you're saying it but you're not conscious of the racist process behind it, but it actually is the case that some microaggressions are actually fairly explicit. People know that they're saying them and they know why they're saying them and they just think it's okay to say it. So, I think in general, it really depends on the nature of the context, and the person, how you intervene. Some people are going to remain defensive, I think, even against the best intervention efforts. But I think many people if they can be made more aware of what microaggressions are, all different kinds of microaggressions, how they're harming people of color and others with stigmatized identities, how we can increase awareness of the processes that happen in ourselves that fuel these microaggressions, then I think change can happen and I think it can probably happen quicker than people realize.

Josh: How do you, starting at the top, the very top, begin to have that work its way down through the entire system so that these objectives, these goals can actually be realized?

Paula: Well, the first thing we do is just make people aware that microaggressions exist and what they are, just giving them a very clear definition of what they are. We do a lot of small group work when we go in front of people and do presentations and we've explained what they are. We have people talk for a few minutes and say, what have you experienced, a microaggression in your personal or professional life. And we usually hear lots of great conversation going on and then we ask people to share what some of those are so that becomes real for them, that it's not just the definition on a piece of paper or something that's happened to somebody else out there, that they realize, oh, this colleague who's been sitting next to me has been experiencing this for several years since they've worked here. Oh, and they're experiencing it in their personal life as well. And so first, just letting them know what it is. Then, we discovered Jonathan Kanter and we've brought him in to be an adjunct member of the team here for healthcare equity and he's now been in front of our Leadership Development Institute which was 500 of the top leaders of UW Medicine and did a presentation there along with a breakout session and now he's going to be doing at least two more trainings throughout the year for us, where we hope leaders and others will come in and go deeper into this work so that they understand more about the harm that he just talked about that occurs when people experience microaggressions and then how do they disrupt them in themselves to keep them from happening.

Josh: I take it, it has to come though, at some point, it can't be just constantly coming from the top, that it has to get into the system. And so that it is being driven organically or maybe not organically but throughout, so that it is from the bottom up as much as it is from the top down.

Pat: Definitely, and with the formation of the Equity, Diversity and Inclusion committees, there are local champions in all of the entities who are also leading this work and talking to the people in their entity to move it forward.

Josh: A couple of the terms or a couple of things that I've heard from you. Cultural cognitions and actions scale. What exactly is that?

Jonathan: That's a scale that we've been developing as part of our research. Like I said earlier, the first thing we did is we asked people of color to help us understand the experience of microaggressions and then once we felt we had a really good handle on that we then asked white people, how likely are you to say or do these things that people of color feel are microaggressive, and that scale where we're asking white people how likely you are to say or do these things, is what we've been calling the cultural cognitions and action scale or the or the kick ass for short.

Josh: And how do you use that?

Jonathan: At the moment, we have four processes that we like to focus on. The first one is what we call objectifying. This is where the classic microaggressions, like can I touch your hair or speaking to an Asian person and asking where are you from, this is where those microaggressions fit in, because the common process underlying these microaggressions is that when we are interacting with somebody who's different from us, the first thing that happens is we notice that difference and sometimes you can get hooked by that difference and then what comes out of your mouth is an expression that you've been hooked by whatever is different about that person, whether it's their hair or their Asian features, or maybe it's a transgender person and you've gotten hooked because you can't figure out if they're a woman or a man and so you say something around that. Those are all experienced by the other person as objectifying. The second process is when what comes out of your mouth are really just fairly explicit negative attitudes or stereotypes directly. Unfortunately, we live in a society in which these negative attitudes and stereotypes are everywhere in media, in education, all over the place. And we can't help but internalize them and this is a lot of what we talk about with implicit bias. But the second set of microaggressions is when you're just stating something that's a stereotype. So, for example, a lot of minorities are just too sensitive these days. That's a stereotype around sensitivity, or, I think black people just need to work harder to fit into our society. That's a stereotype around black people being too lazy. So, a lot of these microaggressions are just expressions of stereotypes. The third I'd mentioned earlier is expressions of colorblindness. Like, all lives matter, not just black lives, or I don't see race, I see only one race, the human race. Color blindness is probably a more complex set of processes because color blindness is a fairly complicated belief system that many people learn in their church or as part of their family life. They learn this honestly and they believe this is the right way to get through life. But, it turns out, it is experienced as very racist by others. And then the fourth process is anxiety. Just when you are displaying indicators, nonverbal or verbal, of anxiety and avoidance to the other person, that just gives them the impression that you're uncomfortable around them, there's something about them that is experienced as threatening or something like that. So, in our work, we target these four processes.

Josh: At its core, is a lot of this about empathy? About actually thinking of the other person and not just yourself. So it's very easy for me, I'm not racist, but regardless of that, if I say something that is offensive to somebody else, I have hurt them, I'm not being empathetic to that other person at all, and I'm somehow rationalizing, defending, justifying

my own. So, does it start at the core with, let's just begin with the fact that there's another person engaged in this conversation the moment you open your mouth.

Jonathan: I think that's right. And there are, unfortunately, obstacles to empathy when microaggressions happen, because the white person who has committed the microaggression is undoubtedly going to feel defensive and does not want to be accused of being a racist because that's a horrible thing, does not want to think they did something racist because it's horrible to even admit that to yourself. And when you're feeling defensive or threatened in this way, that you may be outed as something you don't want to think you are, it's very difficult in that moment to actually take the perspective of the other person. That's when it's hardest to take the perspective of another person and to have empathy. So, I think the first thing we have to do is work on that problem. In a way, we have to normalize the experience of microaggressions in order to make it easier to change, such that they become less normal.

Josh: Doctors, one of the things I've been impressed with since I started working with you is the acknowledgement by the top level leadership that, yes, we do have inequities here, we do have racial or institutional racism, and that there is a ways to go. How important is it to start from that baseline, that yes, indeed, we have things that need to change here.

Pat: It's crucial we have to acknowledge that there is institutional racism and that if we are not actively working to disrupt it, we are perpetuating it every day.

Josh: Going back to the microaggression specifically and the impact on UW Medicine specifically, when it comes to healthcare, I was so fascinated when we talked in our last conversation, about how much microaggressions, how much institutional racism affects the care of patients. I just had no idea. How much of an impact does this have on the actual delivery of healthcare on patient care?

Jonathan: At the patient level, there's a lot of interest right now in trying to reduce disparities associated with black birth rates and problems with the delivery and maternal care and so forth. And we know that black pregnant women are more likely to use less resourced hospitals and to show up later for prenatal care than white women. And a lot of that comes down to trust. Trust in the institution, trust in their doctors and UW Medicine is an incredible facility and an incredible operation in many ways. And these same problems and disparities of trust happen here. And so black women in Seattle are less likely to come here, to UW Medicine when they need it. And to the extent that trust is one of the drivers of this problem, relationships are one of the drivers of trust. And these kinds of small interactions and microaggressions are one of the drivers of successful relationships. And so it's all linked together. It's not as if microaggressions are sort of a separate topic. It's all linked together in a big in a big set of influences.

Josh: So what do we do then, Dr. Kanter? How do we make these changes now in the system? I want to give our listeners just a little more practical things to chew on. What are the cues on recognizing microaggressions and what tips do you have to use when you see one or you experience one?

Jonathan: Well, I think we can break it into three categories, right. So first, it's the person who has been microaggressed against. How do we help that person deal with it in the moment and cope. And in general, there are lots of good people I think trying to do that work, talking about how do we cope with microaggressions in healthy ways and in active ways. And it's not easy but I think that's one piece of the puzzle is helping those who

experience my regressions cope. And I think one of those pieces is what you said earlier, making sure there is institutional support for calling out microaggressions so people feel to the extent they can, as safe and protected as possible if they call out a microaggression, that there aren't going to be negative consequences for them because calling out microaggressions in assertive ways is actually healthy coping. And there are all sorts of obstacles for people to do that, where they don't feel safe to do that. So, I think that's one piece of the puzzle, how do we help people who experience them. Number two, what if you're a bystander and you're witnessing it. How can we empower you to speak up and do so in an effective way that both feel supportive to the person who experienced the microaggression, and actually creates growth experience and positive change experience for the person who committed the microaggression, rather than just punishing them such that they sulk away but haven't learned anything and are still likely to do it again in the future. And then, number three, is how do we help people get better at identifying the processes that may give rise to microaggressions in themselves so we can do the work ourselves, take a good hard look in the mirror and start to get better at understanding our own behavior and the processes that make it likely for well-intentioned white people to commit microaggressions so they can improve their own behavior.

Josh: Doctors, looking at the work you've done over the past, how long has it been, a year, a little over a year?

Paula: A year and a half.

Josh: What are you seeing, are you seeing progress, growth? How are you feeling about the progress that has been made to date based on all of the work that's been done so far?

Paula: You know, we're actually feeling pretty good about it. One of the things that we're noticing, that we're trying to influence, that we're trying to encourage, is just getting people to talk about these issues. That hadn't happened. So our many, many trainings and presentations that we do always include time for people to just talk about it and that usually gives rise to people then emailing us, contacting us, asking us to come and give a more in-depth talk to maybe a smaller group, or they will come to us with an incident that happened, that was a microaggression or a macroaggression and ask us for advice about that. So there hadn't even been an opportunity to have the conversations and then there wasn't any place to go for people to get some feedback, get some support when things were happening. So that's just huge and in an institution this large. And then our equity, diversity and inclusion committees that are in the entities and departments and units are also kind of serving that purpose as well. So a place where people can go and start to have the conversation, start to do some reading, start to educate themselves about the fact that, yes, there's institutional racism here, here are all of the other things that happen under institutional racism and that we have a responsibility, not just as leaders, but staff and leaders together, to try to change it and make a better workplace.

Pat: What we found is that staff and leadership are incredibly receptive to this work. And I think people have really been looking for ways to have these kinds of conversations. And this is one way that they can start talking about things. What we'd really like to do is to have the equity work integrated into all the other work that people do. And so if we're talking about clinical situations, anytime there's a clinical situation that has race as a basis for something, to stop and think about why is that. How is race involved in that because it's not really a genetic condition. But if we're talking about other things, it's how do we integrate an equity lens into all the work that's happening.

Josh: Where do we go from here? Any last thoughts as we wrap up this edition?

Paula: Well we're going to keep doing more of what we're doing. We have our blueprint. What we've started doing I think has just whet people's appetite, gotten them thinking, so we're just going to continue to do more of that. Have some kind of regular standard trainings that we'll have. We'll hope that Jonathan wants to continue to work with us so we can have microaggressions be a standard part of what we do. We're bringing in some outside consultants to do some work around both equity, diversity, inclusion, along with conflict resolution, because that often comes up when there are issues around race and other isms, so how do we actually deal with that in a conflict resolution model. Yes, so just more of what we've been doing.

Pat: I think we're continually looking for creative ways to get people involved and invested. So, for example, today we will be having our first ever book club. We suggested that everybody in the organization read a book called, So You Want to Talk about Race, and we'll be having a book club conversation about it.

Paula: We've spoken to specialty groups, we spoken to palliative care, we've spoken to respiratory therapists, so as I said, anytime we do something in front of a big group of leaders, inevitably another leader will come up and say, can you just come and speak to my unit. So, this is how we are getting the information out into this huge organization.

Josh: And then the next step will be as, you reference doctor, that at some point, this just becomes part of the DNA.

Pat: Right, and that everybody that has a staff meeting has some part of their staff meeting focused on equity. Anytime a decision is made, the question is asked, how does this impact equity of care.

Josh: Dr. Patricia Dawson, Dr. Paula Houston, Dr. Jonathan Kanter, thank you all for such a fabulous conversation.

All: Thank you. Thank you.

[Music break]

Josh: And that's going to do it for this edition of The Transformer. In our next episode, you'll hear from leaders about how we're developing innovative clinical programs, educational resources and the evidence base to improve palliative care and deliver services to the right patients in the right location at the right time. I'm Josh Kerns. Thanks so much for listening and we'll talk to you again soon on the next episode of The Transformer.