Medical Education Must Start Teaching About Racism

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FAR FROM COLORBLIND

As a child psychiatry trainee, when someone mentions preventive medicine, I immediately think about preventing childhood trauma—the trauma of racism and anti-Blackness. But how can I prevent a trauma so deep and insidious, with roots over 400 years old? The trauma of racism is not inflicted by one person but is imposed by an entire system. It is a trauma that is often explained away or hidden, despite beginning at a terrifyingly young age.

“I wish I was white and had blonde hair and blue eyes. Then, I would be smart and pretty,” said my friend’s 5-year-old daughter after her first week of kindergarten at her predominantly white school. Tears filled my eyes. Her mother and I had been expecting this moment, like waiting for a storm to hit. Those words had been echoed by countless Black/African American girls we knew.

I thought of the famous Doll experiment, conducted by Drs. Mamie and Kenneth Clark in the 1930s. The study visually exposed the effects of negative self-esteem on Black/African American children due to segregation and the promotion of white people as superior and more deserving. When given the choice, Black/African American children preferred the white doll [1]. Dr. Margaret Beale Spencer re-created this study in 2010, this time with drawings and with both Black/African American and white children. Sadly, all of the children demonstrated positive attitudes towards whiteness and negative attitudes towards Blackness. These beliefs were most pronounced in white children [2].

When people tell me that their children are colorblind, it is like parents exclaiming that their newborn baby recognized them and held their hand. As doctors, we know that babies have a grasp reflex and will hold anything. As a child psychiatrist, I know about child development and racial recognition. Children are far from colorblind. I know that babies start to recognize race at 3 months of age [3]. By 30 months, most children use race to determine their playmates [3]. Racist beliefs continue from there and begin to take hold. By age 4 or 5, white children show a strong preference for whiteness and all children, including my friend’s 5-year-old daughter, have already learned that some racial groups are associated

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Abbreviations: ADHD, attention deficit/hyperactivity disorder; OBGYN, obstetrics and gynecology.

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with higher status than others [3]. If we are to prevent the trauma of racism, we need to get busy doing it—and early. There is a major problem, though: standard medical education does not teach us about racism—but it should.

THE SILENCED NARRATIVE

When we learn about child psychiatric practices, from psychotherapy to psychopharmacology, the effects of racism on child mental health often go unmentioned. The work of Claude Steele on stereotype threat, described in his acclaimed book *Whistling Vivaldi* showed that Black/African American students performed worse on standardized tests when told that the exam was a measure of their intellectual ability, and better when given the exam without that description [4]. This is due to pervasive racist stereotypes that Black/African American children are less intelligent, which has been shown to affect their academic achievement. A recent study showed that racist beliefs are alive and well in the minds of teachers: compared to white students with comparable test scores, teachers rated Black/African American students as having lower math skills [5].

The American Academy of Pediatrics released a 2019 policy statement that named racism as a driver of health inequities, which the American Academy of Child and Adolescent Psychiatry publicly supported [6]. In child psychiatry, Black/African American youth are more likely to be diagnosed with disruptive behavioral disorders, such as oppositional defiant disorder, compared to white youth with comparable behaviors, who are more likely to be diagnosed with attention deficit/hyperactivity disorder (ADHD) [7]. This is not surprising, given that Black/African American boys as young as 5 are more likely to be viewed as aggressive when compared to their white peers of similar age [8]. Black/African American youth suicide has been on the rise, with data from 2001-2015 showing that Black/African American youth at ages 5-12 are two times more likely to commit suicide than their white peers [9]. Yet, my psychiatry note template still prompts me to include “white race” as a risk factor. Black/African Americans have been voicing concerns about the impact of racism on their children for centuries, but this narrative has been minimized or silenced. Child psychiatrists are trained to cite poverty and child attachment issues, without understanding the additional and independent impact of racism on Black/African American children and families. Yet, experiences of racism have been linked to greater susceptibility to illness [10], worsened sleep [11], and depression [12]. Racism is trauma and it is recognized as an adverse childhood experience [13]. If we as adults, are not even trained to learn the impact of racism, how can we expect to stand up against racism in real time?

SAY SOMETHING. SAY ANYTHING.

Often, when I speak out about racism, I stand alone as people stare at their feet. When I hear a racist joke made about a Black/African American patient’s natural hair, or a racist comment made about a Black/African American patient’s name sounding “stereotypically Black,” I say something. Sometimes, my words are kinder and other times they are harsher. Each time I say them with the protection of my patients in mind. I was not always like this. There were times when I allowed racism to occur in front of my eyes as I debated with myself internally about whether to say something. I went home feeling sick to my stomach, as if I’d eaten something rotten. I had failed my child patients who counted on me. And while racism may start with jokes, it does not end there. Racism shows itself in differential treatment of patients, including the undertreatment of pain in Black/African American children [14]. Racism can be fatal, suggested by the recent study showing that Black/African American infants are three times more likely to die in the hospital, compared to white infants, when cared for by white doctors [15]. I have seen these statistics play out before my eyes as I watch providers roll their eyes at Black/African American children in pain, when these same providers gave pain medications to white children in pain. I see racism everywhere, whether I want to or not. And I have to decide whether to take a stand or not. At some point, I decided that I would risk my own discomfort and security to protect my patients because the alternative, saying nothing, would mean that racism continues, and children are not protected from it. As I have grown and developed clinically, I have also grown and developed verbally. I have learned to navigate situations of racism with craft and tact, as one would make a move in chess. Saying something each time allowed me to practice. And each time, I got better. I got better at shaping my response to racism depending on the situation and the aggressor. But each time, my heart still beats quickly, and my stomach still drops. It is no less scary, but it is easier to know what to say. But each time, I hope that speaking out about this instance of racism will help to prevent future instances—and I firmly believe it does. Each time, I know that standing up for children targeted by racism sends a clear message to them that I care about their safety and their identities. If we do not speak up, we cannot hope to prevent the trauma of racism in children. But, if medical education does not educate us about racism, we cannot be fully prepared to combat it.

“MedEd Makeover”

The historical and current underpinnings of racism should be interwoven throughout medical education.
Anti-racism should not be a supplemental elective, but a mandatory milestone. The effects of racism and anti-Blackness are vast and profound, and one cannot learn them without being intentional. Medical education can start by telling the full truth. Instead of teaching us that Dr. Benjamin Rush, the father of Psychiatry, was an esteemed individual, teach us the whole story. Teach us that Dr. Benjamin Rush coined the term “negritude,” the disorder of being Black, an ailment that could only be cured by becoming white [16]. When teaching us about the vesicovaginal fistula procedure perfected by Dr. James Marion Sims, the father of obstetrics and gynecology, teach us that he perfected this routine by experimenting on African female slaves without anesthesia before performed them on white women with anesthesia [17]. Continue on by educating us about how he chose to use solely Black infants in his neonatal tetanus experiments [17]. When teaching us about haloperidol, a common medication used in psychiatry for behavioral disturbances, teach us that haloperidol was marketed as a way to quell “protest psychosis” during the 1960s, when Black/African Americans were protesting for basic human rights [18]. Teach us that the advertisement for haloperidol, also known as Haldol, included a racist caricature of a Black/African American man [18], and that today, anti-psychotics, like haloperidol, are more likely to be prescribed to Black/African American patients in higher doses than white patients with comparable symptoms [19]. The medical system is not stained with isolated historical atrocities like Henrietta Lacks, Havasupai, and Tuskegee; it is soaked with racism. Teach us that the American medical system has been a dehumanizing experience for Black/African Americans, and many other minoritized groups, since its inception. If we do not know about the racism inherent in the medical system, we can have no hopes of dismantling it. As leaders of child mental health, we, as child psychiatrists, must do more. We, as health professionals, must do more. We must read more. We must learn more. We must speak more. The children are counting on us.

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