Ensnared by Colorblindness: Discourse on Health Care Disparities

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Objective: Race consciousness serves as the foundation for Critical Race Theory (CRT) methodology. Colorblindness minimizes racism as a determinant of outcomes. To achieve the emancipatory intent of CRT and to reduce health care disparities, we must understand: 1) how colorblindness "shows up" when health care professionals aim to promote equity; 2) how their colorblindness informs (and is informed by) clinical practice; and 3) ways to overcome colorblindness through strategies grounded in CRT.

Design/Setting/Participants: We conducted 21 semi-structured interviews with key informants and seven focus groups with personnel employed by a large Minnesota health care system. We coded transcripts inductively and deductively for themes using the constant comparative method. We used a race-conscious approach to examine how respondents' accounts align or diverge from colorblindness.

Results: Evading race, respondents considered socioeconomic status, cultural differences, and patients' choices to be the main contributors to health disparities. Few criticized the behavior of coworkers or that of the organization or acknowledged structural racism. Respondents strongly believed that all patients were treated equally by providers and staff, in part due to race-neutral care processes and guidelines. Respondents also used several semantic moves common to colorblindness to refute suggestions of racial inequality.

Conclusions: Colorblindness upholds the racial status quo and inhibits efforts to promote health equity. Drawing on CRT to guide them, health care leaders will need to develop strategies to counter personnel's tendency to focus on axes of inequality other than race, to decontextualize patients' health

Introduction

Colorblindness is "a mode of thinking about race organized around an effort to not 'see,' or at any rate not to acknowledge racial differences."[1] A powerful part of the post-Civil Rights American worldview, colorblindness makes certain beliefs and actions—typically those that minimize racism and uphold the racial status quo—more acceptable than others. Critical race theory (CRT) examines knowledge production, specifically how a field's norms and conventions reproduce the current racialized power structure.[2] Millions of people interact with the health care sector as employees, patients, and consumers of biomedical information, making health care an important site of knowledge production. Knowledge is transferred through discourse. To the extent that

colorblindness shapes discourse within institutions, it becomes embedded in institutional practices. Colorblindness is the dominant framework that White Americans and a growing number of Black Americans use to interpret inequality.[3-5] We examine its discursive power in health care. To achieve the emancipatory intent of CRT and to reduce disparities, we must understand: 1) how colorblindness "shows up" when health care professionals aim to promote equity; 2) how their colorblindness informs (and is informed by) clinical practice; and 3) ways to overcome colorblindness through strategies grounded in CRT.

Colorblindness creates major barriers to reducing racial disparities in care.[6] Its emphasis on individualism and meritocracy suggests that everyone has an equal opportunity for good health.[7] Racial minorities' worse

health outcomes result from individual or cultural shortcomings rather than discriminatory social systems.[3,5] Consistent with this, research shows that health care personnel are reluctant to acknowledge that they may contribute to racial disparities in care.[8,9] Many define racism as "isolated incidents"[10] of hostility or intolerance rather than ingrained in society. The inclination to

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avoid race leads to a variety of semantic moves, such as using coded language, for example the use of "urban" as a euphemism for Black.[11] Given its pervasiveness, colorblindness could be considered a "deep structural schema" because it occurs "in a relatively wide range of institutional spheres, practices, and discourses,"[12] with the effect of maintaining White advantage. By promoting certain actions and inhibiting others, colorblindness may affect the ability of health care systems to reduce health disparities.

METHODS

Our data were collected as part of a larger project on "health equity climate" conducted in 2014 in Minneapolis, MN, in one of the state's largest health care systems. The sys-

tem's workforce and patient populations reflect Minnesota and thus are predominantly White and commercially insured. In 2005, the system consolidated its corporate services at an inner city location close to its flagship hospital, a large private tertiary care hospital with a wide catchment area. Leadership cited its mission to serve its communities as a main driver in the site selection process.

The objective of the parent project was to use qualitative methods to identify factors that enable or impede uptake of health equity as an organizational goal. The project was conducted through a partnership with the health system's research division. At the time, the research division was the driving force behind the system's engagement with health equity. Members of the research division introduced the principal investigator (PI) to organizational stakeholders and provided "on-the-ground" knowledge throughout the project. Members of the research division did not participate in recruitment, data collection, or the below analysis.

The PI conducted 21 hour-long key informant interviews and seven focus groups, which ranged from 60-90 minutes in duration, with 46 participants. Key informants were purposefully sampled based on their role in the health care system. Interviews were conducted with top executives at the C-suite level, ie, the highest level managers whose titles start with "chief" (N=4); division heads (N=8); directors, or intermediate-level managers (N=4); and Equity Team members (N=5), which included individuals working on community engagement, equity research, and population health. Focus group participants (FGPs) were recruited

from existing clinical workgroups and included: 1) senior administrators who were collectively responsible for the entire organization's operations; 2) clinical service line leaders, responsible for one or more specific types of care; 3) senior nurse leaders from across the organization; 4) inpatient nurse managers at one hospital; 5) cancer care providers; 6) cancer clinical staff (eg, social workers, care coordinators, etc.); and 7) primary care providers.

The PI asked respondents to define health equity and to describe the organization's culture, approach to health equity to date, and barriers and facilitators to advancing health equity. The PI and a member of the research team coded all transcripts independently using the constant comparative method and reconciled their codes by consensus. High level codes, such as barriers, were developed deductively from the interview and focus group guides. The subcodes emerged inductively from the data. The research was approved by Quorum Review, an independent institutional review board. All procedures were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all participants included in the study.

During data collection, the PI, a Black health disparities researcher and physician employed by an outside organization, observed that despite the predominant focus on race in the health care disparities literature, race and racism were largely missing in respondents' accounts. As a physician, the PI has undergone the same socialization

processes as many of the respondents. However, her critical analysis of her daily lived experiences as a Black woman likely attuned her to the realities of racism in ways that members of this almost entirely White sample were not. For example, often race did not organically emerge in the discussion and the PI had to explicitly ask about race as a barrier to equity. In line with CRT methodology, the PI and a research assistant (not involved in the initial coding) used a race-conscious approach to interrogate the data for patterns in respondents' accounts that were consistent with colorblindness and to "dig beneath the surface"[13] to consider the implications for health care delivery.

RESULTS

Participants' responses about the causes of disparities evaded race or racism. Instead, they considered socioeconomic status, cultural differences, and patients' choices to be the main contributors to health disparities. Few criticized the behavior of coworkers or that of the organization or acknowledged structural racism. Respondents strongly believed that all patients were treated equally by providers and staff, in part due to race-neutral care processes and guidelines. Respondents also used several semantic moves common to colorblindness to refute suggestions of racial inequality. Major themes that emerged are presented below.

Race: One of Many Factors Associated with Health Care Disparities

Respondents often defined health equity as equal access to health care and attributed disparities mostly to a lack of affordable care or inadequate insurance. One nurse manager commented "*if nobody was poor,….disparities in health care…would go away*" (FG 02). Similarly a division leader commented: *"So once upon a time it might have been equity by race… But equity to me in the last 10, 15 years has been equitable access. Financial seems to be the most important.…It's [equity is] beyond race. It's race, economics, language barrier, size barrier, age barrier, and then homeless barrier, mental health, people who can't advocate for themselves. (Transcript 20)*

Another senior administrator also noted, "*It's more the other stuff that's the issue than race*" (FG 03). Perhaps because of the primacy placed on access, one senior executive boasted*, "I don't think that we have had any difficulty whatsoever with access"(Transcript 13),* noting that the flagship hospital served both local residents and patients from around the state.

Race: Less Important than Culture

Respondents frequently attributed worse health outcomes to cultural barriers: *FGP 1: Some people are less interested in seeking health care for certain things and that may be something based on their culture… FGP 3: We can look at the Minnesota Department of Health data on African Americans being diagnosed at a later stage for colon cancer. … well why is that? What's going on in the African American community that's? – (Cancer Clinical Staff, FG 06)* Because the last participant was interrupted, it is unclear if this person would have attributed the problem to

the community's internal characteristics as their colleague did or to structural forces that act "on" the community.

New immigrants were frequently discussed. The challenges associated with caring for new immigrants revolved around language barriers and interaction norms, not race. The system invested heavily in interpreter services; one interviewee stated: *Not a lot of conversation [around health equity]….Right or wrong, it doesn't come up very much, except in the context of I don't know how to get Somali women to get mammograms. Or …what are we going to do when she only wants a woman to deliver her [baby]? (Senior Executive, Transcript 2)*

A primary care physician explained: "*Everybody with dark skin in [rural city] either is Hispanic or Somali*" and because of that*, "there are bigger fish to fry here and now [than race]" (FG 04)*. No one mentioned mechanisms, such as segregation, that limit the full inclusion of African immigrants into society and create a particular, but nonetheless "Black," experience in America.

Discussions of Race Are Unnecessary Because We Treat Everyone Equally

Respondents believed that, once patients made it through the clinic or hospital doors, the same care was delivered to patients regardless of race or ability to pay. *FGP: … if you asked any of my colleagues if they treat all the patients equally no matter their race, their financial status, or anything, they would say absolutely we treat them the same. (Cancer Clinical Staff, FG 06)*

FGP: I don't think those conversations [about race] are happening

and I assume it's because…it wouldn't change what we do, you know, anyway. (Cancer Provider, FG 05)

The belief that all patients are treated the same was reinforced by the use of care algorithms, as noted by one interviewee: "*If it comes to like offering tests… We go by…guidelines. So I don't care if you're purple or have a dime*" (Cancer Clinical Staff, FG 06). In another focus group of unit nurse managers, a participant mentioned the "*docflow…an order set that's the same no matter what color, what sex*". By limiting discretion, the order set "*insulate[s] the staff from knowing all of that and then reacting differently*" (Unit Nurse Manager, FG 02). Nurses in this focus group also noted that they did not have the power to discriminate— "*whoever from the community presents to our ED or presents to our physicians, they get scheduled for care at [the hospital].*"

To increase awareness of health care disparities, the Equity Team developed dashboards to disaggregate quality data by race, ethnicity, and language. However some believed dashboards were unnecessary because all patients were treated equally and worried that they could even lead to stereotyping. Disaggregating quality data was seen as abandoning, rather than operationalizing, their commitment to equal care. *FGP: We're trying to have people focus to say everybody gets the same care . . . And to then start separating it out… We've tried so hard not to separate people into groupings, so now why are we separating them into groupings? (Senior Nurse Leader, FG 01)*

Even with the dashboards, when racial disparities were discussed, people avoided exploring the "*profound issues,*" as noted by a director-level

employee *(Director, Transcript 18)* and an equity team member who said, *So we talk about "Oh, look at all the differences between the different racial and ethnic groups," but we don't talk about race. It's just like look at the differences …Do we need to change our materials so that it reflects the people who [we] are asking to be screened? (Equity Team Member, Transcript 4)*

Patients' Behaviors and Beliefs Are the Problem

In line with abstract liberalism and meritocracy, participants suggested that certain patients simply do not prioritize their health and engage in problem behaviors such as: making poor dietary choices when they have hypertension or diabetes; failing to arrange adequate child care so that they can attend medical appointments; and spending limited resources on luxury items rather than medication. One unit nurse manager reminded their group about the importance of personal responsibility, "*People have ownership for . . .taking care of themselves*" (FG02). Another felt that members of socially disadvantaged groups take advantage of the system and *"like to come to the hospital [to avoid paying for outpatient care], that's why they keep coming back"* (FG 02). There was some sense that because they treated all patients equally, these patients received more than they deserved.

Semantic Moves: Expressions of Doubt/Denial

At times, the PI was met with skepticism. *FGP: If there's research out that's saying as you're saying, it would be good for us to be aware of that. (Senior Nurse Leader, FG 01)*

Although this speaker expressed a

desire for more information, the "if" statement questions whether there is indeed a body of research that documents racial disparities in care. One FGP cast doubt upon the PI's motivations. *FGP: I'm thinking you want us to say something that we maybe don't feel that we have—that we feel that we're really doing really a pretty good job on… We're not saying what you want to hear. (Unit Nurse Manager, FG 02)*

Similarly, an interviewee recalled White colleagues' discounting experiences of personnel of color. Stories about microaggressions, which described a lack of inclusion or a lack of respect (eg, having one's credentials questioned in a meeting), were met with disbelief. *You walk in an elevator and no one says hello or greets you, [everyone] looks down, or turns the other way…In their mind, 'Are you being too sensitive? People say hi to me when I walk through the hallway. People say hi to me when I'm in the elevator.' (Director, Transcript 19).*

Semantic Moves: Acknowledging Blind-Spots

Statements about blind-spots allowed speakers to take both sides of an issue, ie, to deny the problem and simultaneously allow for its possibility. For example, a senior division leader stated, "*I don't see that [health care disparities] at all. I don't deny it exists but I just don't see it at all*" (Transcript 13). A primary care physician said, "*maybe… I've not seen [race] because of my own issues or background*" (FG 04). Similarly, when asked to identify potential obstacles to equity that may be related to the organization's culture, a White division leader seemed to question the premise underlying the question but then sug-

gested that they may have a blind-spot: *So what would an example of that be? Institutional racism comes to mind. That doesn't exist, so are there more nuanced versions of that that I'm not clever enough to perceive? (Transcript 5).*

Semantic Moves: The Black Friend

One respondent reported that it was not uncommon for colleagues to admit that they "*have never met or talked to a Black person before, or the opposite happens—'I have a lot of Black friends'*" (Director, Transcript 19). The first statement offered an excuse for a lack of knowledge. The second may have been meant to convey racial tolerance or to build credibility. Similarly, a senior administrator (FG 03) described a Black surgeon colleague who "*told me repeatedly that it was [a] socioeconomic and cultural issue not a race issue.*" It was not the participant, but rather the Black surgeon, who said class and culture are the problems.

Note on Outliers

A few respondents explicitly brought attention to race. One physician member of the Equity Team stated that implicit racial bias was a "*big reality*" (Equity Team Member, Transcript 7) and was reinforced by medical education. A primary care physician mentioned patient case presentations, "*We never say Caucasian. We always leave that out,*" while patients of color were routinely identified by race (FG 04). A cancer provider noted that less time was spent with certain patients—"*more of a quiet racism. It's not overt, it's more omission. It's just things [like] we don't necessarily sit and talk as long with someone who maybe you identify more with (FG*

05). This same participant suggested that there might be a problem with the health care system itself because it was designed "*from our perspective, from the mold we want patients to fit*" (FG 05). A senior executive noted, "*one of the challenges…is you have a system that's… largely built by White upper- to middle-class folks…with that lens*"(Transcript 3). One FGP linked socioeconomic status to historical racism, stating that "*it can also be a reflection of resources which also could be long standing discrimination*" (Cancer Clinical Staff, FG 06). Two leaders identified systemic problems linked to organizational values. The first, a division leader, acknowledged that strict adherence to equality may undercut equity, "*We take care of everybody [equally]--now it can be kind of a 'We're not obligated to do anything different. Neutrality can be a little bit of a stiff arm if you really want to make progress*" (Transcript 12). A senior executive commented on system priorities, "*To be frank, if we thought this [equity] was the biggest deal we might say, 'Well, then we should be building clinics in new places'*" (Transcript 2). When made in focus groups, these statements went unchallenged by the other participants. These comments suggest fissures in the dominant narrative. Most were made by people who were not formally part of the Equity Team, which suggests that some personnel are ready to more deeply engage with structural racism.

DISCUSSION

Consistent with the CRT construct of colorblindness, respondents minimized racism and identified other factors—primarily income or insur-

ance status; secondarily patients' behaviors, belief systems, and language barriers—as the main etiologies of unequal outcomes. Assured by colleagues' professionalism and procedures, such as care algorithms, most disavowed differential treatment of patients. Faith in seemingly race-neutral care processes meant that disaggregating outcomes data by race seemed unnecessary. Indeed, thinking about patients in demographic groups rather than as individuals ran counter to professional norms and seemed antithetical to equality. The focus on culture allowed respondents to evade questions of power. Structural racism mostly went unnoticed, though some suggested that there was a "mold" that patients needed to fit to receive optimal care and some practices (eg, case presentations) varied by race. Although respondents spoke about the social determinants of health, they rarely acknowledged their uneven distribution by race. Semantic moves included: commenting about blind-spots; referencing the diversity (or lack thereof) of one's social networks; and microaggressions, such as voicing doubts about the data, the PI's intentions, and colleagues of color's accounts. While these colorblind responses may not be meant as racial slights, they demonstrate limited understandings about the causes of racial disparities and the lived experiences of people of color.

To more robustly address health equity, health care organizations will need to challenge colorblindness. CRT suggests explicitly cultivating race-conscious organizations. This can be done by providing racial equity training. Such training can challenge individualist frameworks, attend to issues of rac-

ism and power that are often neglected in cultural competency curricula, and empower personnel to address the structures that contribute to racial disparities in health.[14] CRT emphasizes the role of story-telling and centering at the margins as vehicles for change. Providers should be trained to explore patients' exposure to racism as a health risk factor and leaders should include patients and employees of color in substantive roles on key committees; their counternarratives (ie, stories that challenge dominant explanations) may stimulate positive change. Methods—such as developing safe systems to report problematic individual or institutional behavior (eg, incident reporting) and evaluating managers on efforts to advance racial equity—can be developed to track progress.[15] Concerns about reporting bias (eg, due to fears of retribution) can be alleviated by partnering with external consultants. There must also be deliberate and explicit internal and external messaging about the organization's commitment to racial equity from the senior-most leaders. Finally, health care personnel must be educated differently. Some residency programs already train physicians to advocate for racial justice and to integrate racial equity into clinical practice.[16]

Limitations

This study is limited to one large health care organization in Minnesota. Social desirability may have influenced results. For example, some quotes indicate an awareness by participants of the researcher. Future research should examine whether discourse on health equity varies depending on health system characteristics (eg, region, personnel characteristics, and the degree of organizational race-consciousness) and whether greater race consciousness improves care processes and outcomes.

CONCLUSION

When discussing health equity, health care professionals may use colorblindness in ways that obscure racism's contribution to disparities in health care. Future research should determine if CRT can guide health care leaders in developing effective strategies to counter personnel's tendency to focus on other axes of inequality, decontextualize patients' health behaviors and choices, and depend heavily on race-neutral care processes to produce equitable outcomes.

CONFLICT OF INTEREST
No conflicts of interest to report.

AUTHOR CONTRIBUTIONS
Research concept and design: Cunningham; Acquisition of data: Cunningham; Data analysis and interpretation: Cunningham, Scarlato; Manuscript draft: Cunningham, Scarlato; Acquisition of funding: Cunningham; Administrative: Cunningham, Scarlato; Supervision: Cunningham

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