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Dialogue as Skill: Training a Health Professions Workforce That Can Talk About Race and Racism

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Efforts in the field of multicultural education for the health professions have focused on increasing trainees' knowledge base and awareness of other cultures, and on teaching technical communication skills in cross-cultural encounters. Yet to be adequately addressed in training are profound issues of racial bias and the often awkward challenge of cross-racial dialogue, both of which likely play some part in well-documented racial disparities in health care encounters. We seek to establish the need for the skill of dialoguing explicitly with patients, colleagues, and others about race and racism and its implications for patient well-being, for clinical practice, and for the ongoing personal and professional development of health care professionals. We present evidence establishing the need to go beyond training in interview skills that efficiently "extract" relevant cultural and clinical information from patients. This evidence includes concepts from social psychology that include implicit bias, explicit bias, and aversive racism. Aiming to connect the dots of diverse literatures, we believe health professions educators and institutional leaders can play a pivotal role in reducing racial disparities in health care encounters by actively promoting, nurturing, and participating in this dialogue, modeling its value as an indispensable skill and institutional priority.

In a San Francisco Bay Area hospital, an African American physician intern was participating in walk-rounds during an internal medicine ward rotation. A White American surgery resident suddenly pulled him away from the group, exasperated, saying, "Hey, man. I need you to translate [sic] for me." The surgery resident explained that his patient required a chest tube, but the patient repeatedly refused this intervention, no matter how the resident explained its clinical necessity. In speaking with the patient, who was an *English-speaking* African American, the intern gathered that the patient felt disrespected by the surgery resident. The patient confided that he simply did not trust the surgeon, who did not seem sincerely concerned for his best interests. Referring to the surgeon, the patient added, "That guy treats me like I'm stupid."

In multicultural education in the health professions, when we refer to cross-cultural interviewing skills or patient–provider communication with diverse populations, we usually are referring to the technical aspects of how to efficiently elicit accurate clinical and culturally relevant information from patients (Abrams & Moio, 2009; Hawala-Druy & Hill, 2012; Kleinman, 1980; Pilcher, Charles, & Lancaster, 2008; Teal & Street, 2009). Rarely do health professions educators (HPEs) discuss, in a fundamental sense, how difficult it can be for Americans to converse with someone of another race, especially regarding perceptions of racism or exclusion in the clinical encounter (Hall & Fields, 2013; Murray-García et al., 2005; Sue, 2008; Tyson, 2007). Certainly, the surgery resident in the *true* vignette discussed earlier, in his desperate search for an African American "translator," understood that the racial overtones in the interface with this English-speaking patient had something to do with his inability to communicate effectively.

In the 1990s and early 2000s, the field of multicultural physician education saw much progress (Betancourt, 2003; Carrillo, Green,

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& Betancourt, 1999; Culhane-Pera, Reif, Egil, Baker, & Kassekert, 1997; Rankin & Kappy, 1993). However, the fields of social work, nursing, and counseling psychology were way ahead of medical educators, with especially psychology scholars such as Derald Wing Sue, Stanley Sue, and Janet Helms laying important groundwork for what other HPEs have come to operationalize. Accreditation bodies for health professions schools and training programs increasingly provide detailed training guidelines. (Accreditation Council for Graduate Medical Education, 2013; American Academy of Pediatrics, Committee on Pediatric Workforce, 2013; Aponte, 2012; Liaison Committee on Medical Education, 2013; Sue et al., 1998).

Across health professions, early efforts focused on and continue to emphasize increasing trainees' knowledge base and awareness of other cultures, and on teaching technical communication skills in cross-cultural encounters (Aponte, 2012; Berlin & Fowkes, 1983; Betancourt, 2003; Kleinman, 1980). Such skill sets make use of helpful acronyms or approaches designed to elicit relevant cultural information from patients and to build therapeutic partnerships with them (Berlin & Fowkes, 1983; Kleinman, 1980). Additional efforts focused on other important cross-cultural communication skills, such as the optimal use of interpreter services (Putsch, 1985).

The 21st century has thus far seen a more direct and open acknowledgment of racial bias as a potential contributor to the persistence of racial and ethnic disparities in health care service allocation and quality. (Burgess, van Ryn, Dovidio, & Saha, 2007; Constantine, 2007; Dovidio & Fiske, 2012; Dovidio et al., 2008; Hall & Fields, 2013; Sorkin, Ngo-Metzer, & De Alba, 2010; van Ryn & Saha, 2011). The impact of these biases is reflected in the voluminous literature on racial disparities in health care, including perhaps most widely publicized, the Institute of Medicine's (2003) groundbreaking and influential report, *Unequal Treatment*. We have yet to adequately address these profound issues of racial bias in health professions education, biases which spring from providers' conscious or subconscious perceptions of the differential value and deservedness of patients. As clinicians in America, these are perceptions that we all hold to some extent by virtue of the insidious nature of our nation's racially stratified social hierarchy (Pinderhughes, 1989; Ridley, 1995; Tatum, 1997; Tervalon & Murray-García, 1998).

We are not suggesting that race and racism in health care have not been talked or written about previously. However, we perceive the need to continuously and progressively move from the general to the specific. Furthermore, it is essential that at least some discussions of race in health professions education not be diluted by the other very important dimensions of difference that multicultural education must address. Other discussions include the topics of literacy, English language proficiency, economic class issues, gender, sexual orientation, body habitus, and so on (Aponte, 2012; Carrillo et al., 1999; Feinberg, 2001; Hitchcock & Wilson, 1992; Tervalon, 2003) Indeed, we use the terms cross-racial and cross-cultural interchangeably in this discussion in part to respect the intersectionalities of these dimensions of identity, while not losing this discussion's focus on race.

This era in American health care reform and increased accountability for quality, cost containment, and population health, represents an incredible opportunity for HPEs to renew their efforts to eliminate inequality in health care delivery, inequality costly in both human and financial terms (Joint Center for Political and Economic Studies, 2010; Kaiser Family Foundation, 2010). HPEs can play a pivotal role in reducing or eliminating racial disparities in the health care encounter by actively identifying, promoting, and nurturing these dialogue skills for trainees, modeling the value of constructive cross-cultural and cross-racial interplay as an indispensable clinical skill.

Racial Dialogue Skills Needed

Models such as Kleinman's (1980) classic "explanatory models" and Berlin and Fowkes' (1983) "L-E-A-R-N" (Listen, Explain, Acknowledge, Recommend, Negotiate) acronym are useful, practical, and accessible aids in the patient interview. Still, abundant evidence suggests that we simply need to be better at talking with people from other races and cultures. This interface can be complicated by differing cultural styles, conflicting expectations, mistrust, and racist, classist, stereotypes on both sides of the communication dynamic (Dovidio & Fiske, 2012; Hall & Fields, 2013; Sorkin et al., 2010; Tervalon & Murray-García, 1998). This potentially problematic dynamic can underlie and sabotage a cross-racial interaction long before we reach the social history or have the opportunity to ask, "How has this illness impacted your life?"

Substantial evidence bolsters the notion that health care professionals' communicating with patients of color are dysfunctional and have shortcomings apart from a failure to obtain or "extract" relevant cultural information (Burgess et al., 2007; Carter & Helms, 1992; Constantine, 2007; Dovidio & Fiske, 2012; Dovidio et al., 2008; Ngo-Metzger et al., 2003; Sue, 2008; Tyson, 2007; van Ryn & Burke, 2000; van Ryn & Saha, 2011). In the medical literature, for example, compared with care rendered to White patients, data suggest physicians show less empathy and offer less reassurance to non-White patients (Johnson, Roter, Powe, & Cooper, 2004), present barriers to discussion of non-Western medical approaches (Ngo-Metzger et al., 2003), are less attentive to non-White patients in their interactions (Basáñez, Blanco, Collazo, Berger, & Crano, 2013), and give non-White patients less control over treatment decisions. (DeVoe, Wallace, Pandhi, Solotaroff, & Freyer, 2008) More generally, non-White patients rate their care lower, across a variety of age groups, care settings, and insurance statuses (Haussman, Shasha, Mor, Schaefer, & Fine, 2013; Haviland, Morales, Dial, & Pincus, 2007; Johnson, Saha, Arbeleaz, Beach, & Cooper, 2004; Murray-García, Selby, Schmittdiel, Grumbach, & Queseberry, 2000; Sorkin, Ngo-Metzger, & De Alba, 2010; Weech-Maldonado, Hall, Bryant, Jenkins, & Elliott, 2012; Wilkins, Elliott, Richardson, Lozano, & Mangione-Smith, 2011). In addition, non-White patients are more likely than White patients to believe that if they had been a different race or ethnicity, they would have been treated better by their provider (Johnson et al., 2004).

We still have much to learn about the skill of cross-racial dialogue and its facilitation of the patient–provider interface. Insight into the nature of the dysfunction of the patient–provider dynamic as a source of disparate care comes from the relatively new application of social psychology to the study of disparities in patient–provider communication. The concepts of explicit and implicit bias are informed by decades of research findings in psychology, although most of the research in patient–provider communication has been thus far limited to White and Black physicians and patients (Dovidio & Fiske, 2012; Dovidio et al., 2008). *Explicit bias* is defined by the conscious, overt actions or

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attitudes that we generally associate with times gone by in the United States, with intent to harm or exclude, or a belief in the superiority of one race over another. Measured by subjects' self-reports, explicit bias and reports of blatant racism have continually decreased over time in the U.S. population in both Whites and non-Whites (Dovidio & Fiske, 2012; Dovidio et al., 2008).

Implicit bias describes a constellation of attitudes toward a targeted person or group, set in motion subconsciously, and remaining beneath the subject's awareness or conscious intention, that nonetheless produces discriminatory behavior and decision-making. The communicative nature of explicit bias is conscious, intentional, deliberated (self-reports of egalitarian principles), whereas the manifestation of implicit bias is "spontaneous and uncensored" behavior (Dovidio et al., 2008; Moskowitz, 2010), including telltale nonverbal behavior reflecting discomfort, fear, disdain, or avoidance behaviors, again, operating beneath the subject's conscious awareness.(Dovidio & Fiske, 2012; Dovidio, Kawakami, & Gaertner, 2002; Dovidio et al., 2008).

Like other research subjects, most providers explicitly espouse egalitarian values, while often demonstrating pro-White biases on tests that measure implicit bias, most recently the Implicit Association Test (IAT; Burgess et al., 2007; Chapman, Kaatz, & Carnes, 2013; Dovidio & Fiske, 2012; Dovidio, Kawakami, Johnson, Johnson, & Howard, 1997; Dovidio et al., 2008). Clinical decision making is associated more strongly with physicians' level of implicit bias. For example, among a sample of 86 pediatricians, pro-White implicit bias resulted in appropriate prescription of postoperative opioid medication for White patients, and inappropriate nonprescription of postoperative opioid medication for African Americans in a case vignette (Sabin & Greenwald, 2012). Sabin and Greenwald report, "As pediatricians' implicit pro-White bias increased, prescribing narcotic medication decreased for African American patients but not for White patients" (Sabin & Greenwald, 2012, p. 958).

Another Web-based, vignette study of 287 internal medicine and emergency residents at four academic medical centers in Boston and Atlanta showed that as residents' levels of pro-White implicit bias increased, their likelihood of appropriately treating White patients who presented with chest pain and an electrocardiogram (EKG) suggesting myocardial infarction with referral for thrombolytic therapy increased, whereas their likelihood of appropriately referring Black patients with chest pain and the same EKG for thrombolytic referral decreased. Measures of explicit bias were not associated with the likelihood of referral for thrombolytics (Green et al., 2007).

Cooper and colleagues (2012) used tests of explicit and implicit bias of 40 primary care physicians practicing in urban community settings, along with postvisit patient surveys and analyses of audiotaped patient visits. Controlling for patient income, insurance status, education, health status, and how well a patient knew his physician, they found that, among African American patients, physicians' pro-White implicit bias was associated with lower patient ratings of perceived respect, confidence in the clinician, and likelihood of recommending the clinician to other patients. Furthermore, audiotaped analysis documented that physicians' pro-White bias was associated with more patient-centered dialogue with Whites and less patient-centered dialogue with Blacks. Finally, physicians' pro-White implicit bias was also associated with lower patient responsiveness to their physicians in Blacks but not in Whites.

Although Cooper's study (2012) was cross-sectional, this latter finding suggests that patients detect and respond to clinicians' pro-White implicit bias and the unconscious, often awkward, nonverbal behavior that follows. Psychology studies of race-discordant interactions in nonhealth care settings confirm that a White subject's pro-White implicit bias and nonverbal behavior can have a profound, negative, distancing effect on the behavior of those non-White participants with whom they are interacting (Dovidio et al., 2002; Dovidio et al., 2008). The resultant, increased avoidance behavior of the White clinician in response to the non-White person can then set in motion parallel, self-reinforcing cycles between patients and providers, including distancing or disconnecting both from the investment needed to make any long-term relationship or short-term communication dynamic work.

Furthermore, the stark contrast of simultaneous high implicit bias (subconscious, nonverbal) and low explicit bias (professed liberalism) in the clinician can have a deleterious impact on the provider–patient interface. In a study of 150 Black patients in an inner-city primary care clinic, Penner et al. (2010) found that physicians low in pro-White explicit bias (self-report) and high in pro-White implicit bias (IAT scores) received significantly worse patient ratings than physicians who were either high in both explicit and implicit pro-White bias, or low in both explicit and implicit pro-White bias. According to Dovidio and Fiske (2012), "The ambivalent nature of contemporary racial prejudice may create a mismatch between a physician's positive verbal behavior (as a function of conscious egalitarian values) and negative nonverbal behavior (indicating implicit bias); *this is likely to make a physician seem especially untrustworthy and duplicitous to those who are vigilant for cues of bias*" (Dovidio & Fiske, 2012, p. 949, our emphasis).

Not enough attention has been paid to the potential emotional pain and turmoil this dissonant conundrum presents for well-meaning clinicians and trainees, the result of powerful historical, divergent scripts and expectations between race discordant patients and providers, as well as in some race concordant dyads (Carter & Helms, 1992; van Ryn & Burke, 2000). The unintentional and subconscious nature of implicit bias and its behavioral consequences would be rejected by and abhorrent to most providers and others in the "helping professions," who espouse fairness, justice, and equality in clinical encounters (explicit bias); hence, Dovidio and others have termed this contemporary but potent form of racism, represented by low pro-White explicit bias and high pro-White implicit bias, as *aversive racism*. According to Dovidio and others, aversive racism is demonstrated by

> . . . a fundamental discrepancy between their explicit egalitarian attitudes, which they consciously endorse, and their implicit negative racial attitudes, which they do not recognize. . . Because of their explicit egalitarian orientation, *the feelings that aversive racists experience toward other groups are not of hatred or open contempt, which motivate direct harm, but are rather anxiety and discomfort, which lead to avoidance.* Moreover, the negative feelings and implicit attitudes of aversive racists produce systematic discrimination, but in subtle and indirect ways that do not threaten an aversive racist's nonprejudiced image. This contemporary form of racism is termed "aversive" because these "well-intentioned" people would find aversive any suggestion that they are racially biased. (Dovidio et al., 2008, p. 2, our emphasis).

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The principal issues this scholarship of bias raise for us concern providers' subconscious perception of (a) the differential value they place on their time with patients, (b) the differential comfort providers and trainees feel they have in interacting with "The Other," (c) the differential worthiness of the investment of health care resources on patients, (d) the differential potential of patients to act as capable partners in the health care alliance, and (e) more bluntly and painfully, the differential deservedness of patients to receive scarce, expensive, and technologically advanced resources.

Health professions trainees and seasoned providers might subconsciously ask themselves a wide array of questions: "Is my time well-spent with *this* patient? Will my time yield the same results as with other patients? Will I receive the positive feedback and affirmation of a job well-done from this patient, or will this once again be an unpleasant, unfulfilling experience of not connecting and of suspicion of my motives? Can this 'unsophisticated' patient be a capable partner with me in the health care encounter and in an ongoing therapeutic alliance? In an era of scarce resources, in which my teachers, peers, utilization review boards, and so forth judge my performance, does this patient deserve my scarce time or expensive therapy or intervention? Will the patient appreciate it? Will s/he follow up? Does s/he value her/his life to the same extent as I value mine? Is her/his life worth prolonging or enriching? Will s/he appreciate and do as much with the investment I am going to make as would other patients?"

Identifying Tasks for Educators

In light of this discussion, HPEs might be tempted to concoct a flurry of training activities that simply provide students with technical upgrades to their interviewing and interpersonal communication skills. Yet, there is something more in our educational leadership and proposed pedagogies that we feel needs emphasis, especially as our overarching goals include setting students on developmental trajectories of lifelong learning and commitments to equity and professionalism (Accreditation Council for Graduate Medical Education, 2013; Liaison Committee on Medical Education, 2013; Sue, 2008; Tervalon & Murray-García, 1998). We suggest that this "something more," beyond mechanizing the patient–provider dynamic, is at least twofold: First, we cannot ignore the guilt, sadness, frustration, anger, and pain that come with the sense of self-betrayal almost inevitably inherent in the realization of aversive racism as a force present in all of us, and between us and our patients. Coming to realize the duplicity of explicit bias (expressing and consciously trying to treat patients equitably), with the coexistence and undermining effects of implicit bias (unintentional, spontaneous, and operating below the conscious) can be understandably discombobulating and discouraging (Abernethy, 1995; Murray-García et al., 2005; Pinderhughes, 1989; Tatum, 1992). We can confidently predict that when given a choice, many trainees will not enter into this journey of self-discovery voluntarily. If required, especially in once-a-quarter or annual sessions, students often react with resistance and avoidance, downplaying the material as political correctness or "soft" skills that won't help them pass the Boards or get into a highly valued residency (Accapadi, 2007; Gonzalez & Bussey-Jones, 2010; Murray-García et al., 2005). We can now understand this avoidance behavior with some compassion and begin to create and evaluate educational activities that will diffuse the anxiety and fear of cross-cultural relationships and cross-racial dialogue, activities that lower the emotional and social stakes of these common interactions.

Even though we might sincerely envision that this information can be delivered in a nonthreatening way, even if the material and process is compassionately and skillfully presented and facilitated, a truly effective pedagogy will and should appropriately threaten trainees' duplicitous sense of self. How could it not, if it is to be effective in changing behavior by addressing such deep-seated biases and thought patterns in the context of such conflicting psychic realities (implicit vs. explicit bias)? The very complex and subtle nature of aversive racism is such that trainees will always label it as something they are averse to, or don't need or want. Our goal, therefore, should not be to avoid the skillfully facilitated confrontation of self, but rather the provision of an emotionally safe, supportive, nonjudgmental environment for trainees to be inspired and enabled to sustain the continual self-exploration and self-critique this ongoing development requires.

Second, if our goal stops with providing trainees tools solely to manipulate the interview process, we will have forfeited the opportunity and necessity for the kind of change that transforms individuals, relationships, and institutions (Hall & Fields, 2013; Sue, 2008; Tervalon & Murray-García, 1998). It is not enough for trainees to feel confident and competent in preparing themselves for an upcoming, scheduled appointment or interaction when they know it to be race discordant or cross-cultural. What happens to the quality and outcome of that dialogue when they find themselves in unanticipated, racially charged situations with patients, such as when a patient's suspicions and distrust are borne of numerous past, and even intergenerational, injurious interactions with other social institutions? What happens when racially charged situations are not of our own or the patient's doing, when we are certain that our institution or a colleague has conducted itself or himself or herself in discriminatory ways? What happens when we inevitably fall short and blunder in ways we did not intend, that justify a patient or colleague's suspicion of us? How can we teach trainees to recognize and lean into and not away from those moments as they are and be able to diffuse their anxiety, disappointment, self-betrayal, fear, and anger that can come in that point, emotions common to many cross-racial interactions (Abernethy, 1995; Dovidio & Fiske, 2012; Murray-García et al., 2005; Utsey, Gernant, & Hammar, 2005)? How do we develop trainees' ability to recognize and manage their own spontaneous, unsettling emotions and uncensored reactions, as their implicit bias is activated, as a racially charged situation emerges, or as they seek to share the power of decisionmaking and of giving up their claim to being the sole expert on this patient's condition?

No, the ability to extract clinically relevant information from patients is not the only thing at stake here in cross-cultural relationships that we should equip trainees to negotiate. And although a prerequisite, reducing trainees' bias is not the same as developing skills in racial dialogue. There is a kind of deep, personal transformation that we must find a way to weave into the training of the health professions workforce, a kind of transformation that brings with it relational, self-recovery and dialogue skills that go beyond the mechanics of the clinical interview.

Practicing Cross-Racial Dialogue in Safe Arenas

Health professions students and trainees of all races and cultures need the opportunity to practice substantive, cross-cultural dialogue.

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The revelation and realization of one's implicit bias often comes unexpectedly in the process of racially charged dialogue. Social psychologist John Dovidio points out that students ". . . have full access to their explicit attitudes and are able to monitor and control their more overt and deliberative behaviors. They do not have such full access to their implicit attitudes or to their less monitorable behavior" (Dovidio et al., 2002, page 63). Those of us trained and experienced in compassionately facilitating these often highly charged and unpredictable discussions welcome and even depend on these teachable, albeit often volatile, moments of self-discovery to bring trainees to a place from which they can grow and their patients will benefit. These can be frightening experiences for untrained and unmotivated faculty facilitators, who may quickly leverage their authority to divert these awkward dialogue opportunities to less threatening, more safe ground, role modeling the very avoidance behavior we are trying to identify and transform in trainees.

Indeed, this is a different skill, desire, and set of experiences than many well-meaning, seasoned HPEs and other group facilitators of "doctoring" and introductory interviewing and behavioral science courses possess. These often-intense small and large group racial dialogue sessions should not, for convenience sake, simply be added on to already existing yearlong experiences in less emotionally charged biomedical and behavioral issues, wherein nascent clinical interviewing skills are being developed.

Trainees will want and perhaps already sense the answers to the following important questions: When you first see and hear the awkwardness that informs the anxiety in my dialogue, will you see it as implying ill will or bigoted intent? When you reveal to me the painful and embarrassing duplicity of my aversive racism and how it can subconsciously undermine relationship-building with patients, will you also give me a place where I won't be judged by my peers or evaluated harshly by you, my instructor? Will this be a space wherein I can deal with my self-betrayal, self-disappointment, and guilt, and find nonjudgment, and even healing and absolution, from you and my peers? Who will reassure me that I am not fatally flawed, but rather in an important stage of my racial identity development (Murray-García et al., 2005; Tatum, 1992; Tatum, 1997)? Will you show me how not to consume the energy I need to recover in dialogue, how not to consume that energy on defensiveness, avoidance, and even resentment? Will you protect the often already marginalized non-White students from the colluding, silencing, and retaliatory behaviors of their White peers, behaviors which can predictably spring from my guilt, anger, and need for mastery? Are you skilled enough to make this a constructive rather than a divisive experience for my peers and me? Is there an authority figure in the room who can help me walk out of here—maybe not on this day, but on some day—with the sense of hope, inspiration, investment, and courage it will take to sustain this lifelong path of self-discovery, self-critique, and learning you have asked and implicitly required me to embark on (Tervalon & Murray-García, 1998)?

Health professions students and trainees also need opportunities to practice listening, *really listening*, free from the urgency to defend themselves and their perspective, to immediately offer a response, or to quickly categorize a piece of clinical material (Burgess et al., 2007; Sue, 2008; Utsey et al., 2005). (They need to see *us* as HPEs do the same.).

Psychologist Alexis Abernethy (1995) contends that an interaction with a patient should not be the first time a clinician is challenged to respond to the often highly charged or even more subtle presentations of racial anger and other issues that emerge in the communication dynamic. However, embracing the vulnerability necessary to engage in substantive dialogue about race, race relations, and difference in America will inevitably mean struggle, even initially with the choice of words.

As we continue to create and evaluate educational activities that nurture effective and respectful cross-cultural dialogue, it is absolutely essential that HPEs keep in mind the following: It can be counterproductive and perhaps even psychologically cruel to open up trainees and physicians' awareness to the reality of racism and its potential impact on clinical practice in a *single* session and not provide the trainee and the collective student community the facilitated follow-up opportunities to explore that reality in an ongoing manner (Murray-García et al., 2005; Pinderhughes, 1989). The practiced dialogue that is a requisite skill for mitigating racial disparities in the health care experience cannot be engendered in a one-time or once-a-quarter educational or training session. Introducing a controversial racial topic once or twice a quarter is only setting up both White and non-White students for miserable experiences, because some will embrace and collude in their defensiveness, often with open hostility to their non-White peers. Especially in the context of the new, exciting literature on aversive racism, we should predict that doing a little something "now and then" can be worse than doing nothing at all (Murray-García et al., 2005; Sue, 2008; Utsey et al., 2005). Creativity is required to determine how we might more integrally and longitudinally incorporate the building of the skill set of cross-racial dialogue and relationship building into an admittedly already packed curriculum.

Conclusion

At the dawn of the full implementation of the Patient Protection and Affordable Care Act (ACA), millions of people are to be extended the ability to access health care. These will be disproportionately people of color (Kaiser Family Foundation, 2010).

We need a health professions workforce that can talk frankly about race and racism, without fear, defensiveness, and avoidance behaviors. Insights from the social psychology literature regarding explicit bias, implicit bias, and aversive racism should give HPEs reason to hope and a theoretical and practical place to look for untapped educational and training strategies to adopt and evaluate strategies that are beyond the scope of this discussion.

The sense of self-betrayal and guilt inherent in the duplicitous nature of aversive racism requires HPEs to create unique learning environments for trainees to practice the skill of cross-racial dialogue. These arenas must diffuse the emotional and social high stakes nature of cross-racial dialogue, and the fear of racially charged interactions, interactions sometimes not of our own making.

By the very nature of aversive racism, it should be predicted that even with strong intellectual and administrative leadership, many health professions students will resist this educational intervention, and even deliberately and subconsciously create hostile environments for trainees of color and others (Murray-García et al., 2005; Sue, 2008; Utsey et al., 2005). Thus, to not take this educational task seriously by offering only token, infrequent, or single sessions, without follow-up and trained facilitators, may be worse than doing nothing.

It is difficult for us to conceptualize a more evidence-based, longstanding need in American medical education than training

health professions students and trainees to minimize racial disparities in health status and health care delivery by developing skills in racial dialogue, leaning into these quintessentially avoided and even terrifying patient-provider encounters. It falls to us to develop effective ways for trainees' to develop the dialogue and self-recovery skills necessary in racially charged or racially nuanced encounters, often unanticipated and beyond the technical aspects of the clinical interview. We hope this discussion helps the conceptualization of this urgent task, as HPEs move from the general closer to the specific in their rationale and strategies to train a health professions workforce that can provide excellent, effective, and equitable health care for America's diverse population.

Keywords: cross-cultural communication; cultural humility; health disparities; implicit bias; racism

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