JOURNAL OF PALLIATIVE MEDICINE
Volume 25, Number 3, 2022
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2021.0502

Top Ten Tips Palliative Care Clinicians Should Know About Delivering Antiracist Care to Black Americans

Katie Fitzgerald Jones, MSN, APRN,[1,i] Esther Laury, PhD, RN,[2] Justin J. Sanders, MD, MSc,[3]
Lauren T. Starr, PhD, MBE, RN,[4] William E. Rosa, PhD, MBE, APRN,[5,ii] Staja Q. Booker, PhD, RN,[6]
Melissa Wachterman, MD, MPH,[7] Christopher A. Jones, MD, MBA,[8] Susan Hickman, PhD,[9]
Jessica S. Merlin, MD, PhD, MBA,[10] and Salimah H. Meghani, PhD, RN, MBE[11–13]

Abstract

Racial disparities, including decreased hospice utilization, lower quality symptom management, and poor-quality end-of-life care have been well documented in Black Americans. Improving health equity and access to high-quality serious illness care is a national palliative care (PC) priority. Accomplishing these goals requires clinician reflection, engagement, and large-scale change in clinical practice and health-related policies. In this article, we provide an overview of key concepts that underpin racism in health care, discuss common serious illness disparities in Black Americans, and propose steps to promote the delivery of antiracist PC.

Keywords: advance care planning; health inequities; implicit bias; racial inequities, serious illness; structural racism

Palliative care (PC) clinicians, like others socialized within the American health care system, participate in an industry that historically and systematically disenfranchises racial and ethnic minority populations, including Black Americans. This disenfranchisement results in lower quality care (e.g., poor patient/provider communication) and worse health outcomes (e.g., higher cancer mortality) across the lifespan relative to White Americans.[1] To improve the quality of care for persons with serious illness from Black communities, PC clinicians must recognize racial disparities, understand the policies and practices that cause and reinforce health inequities, and advocate to address inequities in their practices and institutions. National hospice and PC organizations, including the American Academy of Hospice and Palliative Medicine (AAHPM),[2] the National Coalition on Hospice and Palliative Care,[3] and the Hospice and Palliative Nurses Association (HPNA) condemn racism and have called for measures that address inequities in PC delivery.[4]

Nevertheless, racial disparities in PC domains are well documented. When compared with White Americans, Black Americans experience worse pain treatment, less access to

---

[1] William F. Connell School of Nursing, Boston College, Chestnut Hill, Massachusetts, USA.
[2] Louise Fitzpatrick College of Nursing, Villanova University, Villanova, Pennsylvania, USA.
[3] Department of Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute and Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts, USA.
[4] New Courtland Center for Transitions and Health, University of Pennsylvania School of Nursing, Philadelphia, Pennsylvania, USA.
[5] Department of Psychiatry and Behavioral Sciences, Memorial Sloan Kettering Cancer Center, New York, New York, USA.
[6] Department of Biobehavioral Nursing Science, University of Florida College of Nursing, Gainesville, Florida, USA.
[7] Section of General Internal Medicine, VA Boston Healthcare System, Boston, Massachusetts, USA.
[8] Department of Medicine, Duke University School of Medicine, Durham, North Carolina, USA.
[9] Department of Community and Health Systems, Indiana University School of Nursing, Indiana University Center for Aging Research, Regenstrief Institute, Inc., Indianapolis, Indiana, USA.
[10] Section of Palliative Care and Medical Ethics, Division of General Internal Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania, USA.
[11] Department of Biobehavioral Health Sciences, University of Pennsylvania, Philadelphia, Pennsylvania, USA.
[12] New Courtland Center for Transitions and Health, University of Pennsylvania, Philadelphia, Pennsylvania, USA.
[13] Leonard Davis Institute of Health Economics, University of Pennsylvania, Philadelphia, Pennsylvania, USA.
[i] ORCID ID (https://orcid.org/0000-0002-0825-8394).
[ii] ORCID ID (https://orcid.org/0000-0002-0680-8911).
Accepted October 5, 2021.

PC, including hospice, less advance care planning (ACP), and lower quality of communication.[5–8] Although Black Americans are a heterogeneous racial group, the persistence and virulence of anti-Black racism in the United States has led to common health care experiences among those who identify or are seen as Black.[9]

In this article, we synthesize key barriers and misconceptions that hamper PC delivery for seriously ill Black patients. We also highlight historical, sociological, and medical principles that underpin health inequity and propose a foundation for the delivery of antiracist care. As an interdisciplinary team of PC and racial disparity scholars, we have organized important concepts on racism and health disparities into ten evidence-based principles and practices that promote equity in PC. By no means comprehensive, these recommendations aim to dismantle racism and driving equitable outcomes for seriously ill Black patients. The structure of the principles and practices is such that the first three points are general concepts that should be understood by all clinicians, the next three points aim to help readers better understand specific disparities in serious illness care (pain disparities, poor end-of-life outcomes, and ACP), and the final four points promote antiracist care with a summary of key recommendations.

Tip 1: Race Is a Sociocultural Construct, Not a Biological Factor

> *Race is the child of racism, not the father.—Ta-Nehisi Coates, Between the World and Me*[10]

Race is a sociocultural construct. It does not correspond with degrees or qualities of genetic variability and cannot, therefore, explain differences in health care outcomes.[11] Historians and sociologists have highlighted that racial boundaries shift through time to perpetuate existing power structures, permitting or denying rights to one group or another. Clinical medicine's use of race-based risk factors and algorithms inaccurately conceptualize race as a biologic indice and serve to perpetuate differences by race that can negatively impact clinical care.[12,13] Several common decision-making tools shape the diagnosis and trajectory of serious illness.[14] This includes mortality risk assessments that guide decision making, such as the ''American Heart Association Get with the Guidelines,'' Glomerular Filtration Rates, Renal Cancer Survival Calculator, the National Cancer Institute for Breast Cancer Risk Assessment tool, and pulmonary function testing.[12] In general, treatment algorithms have embedded biases.[14] Therefore, algorithms that contain race as a risk factor, rather than key individual and social indicators of health, are particularly harmful because they compound inequity in the prevention, diagnosis, and treatment of disease.[12,14,15]

Tip 2: Racism and Other Explicit Biases Drive Health Inequities

> *To be antiracist is to deracialize behavior, to remove the tattooed stereotype from every racialized body. Behavior is something humans do, not races do.—Ibram X. Kendi*[16]

Racism is discrimination based on beliefs of racial superiority or differences in attributes and abilities based on race.[17] Racism exists in many forms, including cultural, interpersonal, systematic, and structural racism. For example, the most common form of cultural racism in the United States is White supremacy, which is the valuation of whiteness over and degradation of other racial and minority groups.[18] At times, racist ideas and behaviors that promote White supremacy can be unconscious, often referred to as implicit bias, which is further discussed in tip number three.

Interpersonal racism is the use of explicitly racist words, biases, or actions. Systemic, institutional, and structural racism occurs when policies, institutional practices, and systems either intentionally or unintentionally result in an advantage to one group (e.g., White Americans) or disadvantage of another (e.g., Black Americans).[2,17] Structural racism often reinforces and perpetuates race inequalities. Structural racism can be seen in the criminal justice system, education system, and social and structural determinants of health, including employment/financial structures, education, poverty, and inadequate health care access.[7,19]

Racism must be named as a critical driver of health inequities.[11] Antiracist action involves actively confronting racism by making deliberate and consistent equitable decisions.[20] This requires constant self-reflection and awareness.[21] Racism is not a matter of moral character (such as naming someone as racist or not racist) but rather is about racist or antiracist behaviors.[16] To bring about antiracist action requires acknowledgment of racism within our systems and ourselves. In doing so, racism becomes everyone's problem and we can be intentional and vigilant about working to fix it.[22]

Tip 3: Implicit Stereotypes and Biases Contribute to Racial Inequities

Research shows that almost half of White Americans and nearly one-third of Black Americans hold pro-White bias and a negative bias toward Black Americans.[23] Implicit or unconscious biases inform our thinking, behaviors, and interactions; and may or may not result in explicitly racist behaviors or beliefs.[11] Implicit bias informs misattribution of disease etiology or illness behavior to an individual or community because of their race and has been linked to relatively lower quality care for chronic conditions that may benefit from PC, such as heart disease, renal disease, and cancer.[12,24] Moreover, race inequities persist across multiple health care settings, including emergency, preventative, mental health, and pediatric care settings.[25] So it stands to reason that serious illness care would be no different than other health care specialties and settings.

Although many health care workers do not view themselves as racially biased, implicit biases are pervasive in U.S. culture and health care.[26–28] Regardless of whether biases derive from benign distinctions between groups or more racist beliefs, they can have profoundly negative health consequences when they inform clinician behaviors and decision making.[25] Since a majority of Americans hold a pro-White/anti-Black bias, it is safe to assume that we hold implicit biases. To become aware of any race-based implicit biases that you may hold, an implicit assessment test may be helpful (https://implicit.harvard.edu/implicit/takeatest.html). Moreover, clinicians should periodically assess if their treatment recommendations and outcomes vary by irrelevant characteristics such as race.

Tip 4: Provider Implicit and Explicit Biases, Rather Than Biological Differences, Result in Observed Racial Disparities in Pain Management

Substantial evidence describes pervasive disparities in pain assessment and pain undertreatment among Black Americans.[19,29–38] Black patients often feel that their pain complaints are not believed and data support this notion.[39–42] A meta-analysis synthesizing evidence from 20 years of published studies on pain treatment disparities in the United States found that Black Americans were less likely than any other group in the analysis to receive analgesics.[30] Specifically, Black Americans were less likely to receive opioid medications for pain, and these differences persisted even for traumatic or surgical indications where there is a verifiable cause of pain.[30] This is likely due to the discriminatory idea that Black Americans' opioid misuse behaviors are driven by an increased risk to develop addiction.[43] A recent study in a racially diverse group of cancer patients explored opioid misuse, finding that behaviors were primarily related to lack of education on correct use of opioids, patients' desires to avoid opioid harms, insufficient access to alternatives to analgesics, and attempts to spare opioids overall.[44]

Likewise, Black patients with cancer pain are also more likely to report a negative Pain Management Index (i.e., pain levels relative to prescribed analgesics) compared with White patients with cancer and are less likely than Whites to have a prescription of long-acting opioids for around-the-clock pain coverage.[45] The observed clinical disparities in pain management occur despite accounting for insurance type and clinical risks.[32] Black Americans with cancer pain were more likely to receive an analgesic with toxic metabolites, even after controlling for private insurance type, and despite the presence of clinical risks.[31] It is essential in clinical practice and research to find the driver of the specific gap. Such variables can be broadly termed social determinants of health and include factors such as poverty and socioeconomic position, education, health literacy, primary language, racial discrimination experiences, poor communication, and institutional racism.[5,46]

Tip 5: Black Americans Receive Poorer Quality Serious Illness Care

Black Americans face a higher risk of developing and suffering from serious illness. Social determinants of health, including poverty, low educational attainment, low health literacy, and poor access to care, contribute to higher incidence and prevalence of chronic conditions, lower uptake of prevention and screening, later diagnosis, and insufficient treatment.[47–51] Consequently, compared with White Americans, Black Americans die earlier, at higher rates, and suffer more complications of cardiovascular disease, renal disease, lung disease, cancer, and infectious diseases, including HIV/AIDS and COVID-19.[5,52] These disparities persist through the course of serious illness. Black Americans experience higher rates of hospital readmission,[53] more intensive care and late care transitions,[6,24,54,55] and are less likely to enroll in or stay enrolled in hospice.[56,57] These disparities contribute to lower quality EOL care and self-reported outcomes.[5,51,58–62]

Black Americans, like their White peers, express a desire to participate in serious illness discussions,[63,64] but are less likely to experience high-quality communication.[64–66] High-quality communication is patient- and family-centered, honest, sensitive, reciprocal, and occurs when patients and family members are ready to discuss and engage in informed decision making.[67–71] High-quality communication is a low-risk, high-value intervention that improves serious illness metrics, including quality of life, length of hospital stays, lower intensive care costs and mortality rates, adoption of comfort-focused care, and greater family members' acceptance of EOL decisions.[67,70,72,73]

Tip 6: Racial Disparities in ACP Result from Myriad Factors, Including Access and High-Quality Communication

Black Americans are less likely to engage in ACP.[74] ACP and communication have been shown to improve patient and family outcomes,[75] such as receiving care aligned with their preferences, more satisfaction with care, and improved quality of life.[76–78] ACP has the potential to improve Black Americans' EOL care outcomes when accompanied by high-quality communication.

Lower relative engagement in ACP among Black Americans is due, in part, to clinicians' failure to engage Black American patients in high-quality communication.[79] The quality of patient/provider communication experienced by Black Americans has a cumulative impact on their EOL care decision making and outcomes.[8] Given the magnitude of this impact, it is essential that clinicians proactively integrate ACP early in the disease trajectory of Black American patients,[70] as well as engage them in high-quality communication and shared, family-oriented decision making.

Tip 7: Blaming Health Disparities on Issues of Distrust Masks the Role of Structural Racism

The role of distrust is overstated in explaining disparities and serves as a scapegoat that masks the fundamental realities of structural racism.[80] Furthermore, centralizing trust as key to health disparities places the blame on Black Americans for their mistreatment rather than attributing it to racism.[11] A disproportionate focus on trust also ignores the pertinent history of inhumane and inequitable care that has consistently occurred in the care of Black Americans.[81] Indeed, some Black Americans worry that their race or other marginalized status may make them more ''disposable'' at EOL.[82]

In serious illness care, lack of trust is an overimplicated explanatory variable for disparities in EOL care among Black Americans.[83] Research that has attempted to quantify distrust does not support the notion that Black Americans choose life-sustaining treatments because they distrust the health care system[83]; despite the many ways in which the health care system systemically falls short in delivering equitable care to Black Americans.[84] Instead, evidence suggests there are no notable differences in trust among Black Americans compared with White Americans. In most empirical studies, trust has not been found to be associated with Black Americans' ACP outcomes.[63,83,85–90]

Distrust continues to be commonly cited as a factor for disparities, as recently noted in the COVID-19 vaccine debate.[91] Although distrust is associated with poor-quality patient/provider communication among Black Americans,[8,81,92] rapport building, respectful communication and information sharing, and appreciation for cultural values and faith build trust with Black American patients and their families.[8,40,70,93] Rather than focus on patients' potential for distrust, providers must acknowledge and address systemic racism and structural barriers that have resulted in the disproportionate distribution of opportunities and mistreatment of Black American patients. Beyond acknowledgment, providers must also actively engage in high-quality interpersonal interactions that foster trust and build strong relationships with Black American patients and their families.

Tip 8: PC Consultation Can Improve Equity in Serious Illness Care for Black Americans

PC consultation has been shown to improve EOL care outcomes in a variety of ways. Specialty PC skills can fill many clinical gaps discussed above through expert communication, ACP, and improved access to hospice.[56,57] As such, evidence suggests that Black Americans benefit from PC consultation. One recent study found that seriously ill Black Americans who engaged in PC consultation to discuss goals of care were 15 times more likely to enroll in hospice than clinically similar Black Americans who did not receive a PC consultation.[94] Likewise, another study found PC consultation was associated with four times higher likelihood of discharge to hospice among a diverse set of seriously ill patients.[79] Among a diverse group of seriously ill patients who received PC consultation, only Medicaid use (and not Black race or any racial or ethnic group) was found to be an independent predictor of discharge to hospice, with Medicaid patients less likely to enroll in hospice, further pointing to the role social determinants of health play in hospice use.[113]

Evidence also suggests patient/clinician communication, health literacy, and understanding prognosis and care options influence Black Americans' decision making. Additionally, knowledge of and access to services play roles in the EOL care decisions among Black Americans.[94–99] Taken together, seriously ill patients across racial groups may demonstrate similar preferences for comfort-focused care when given the opportunity to discuss their care with a clinician trained to engage in high-quality communication.

Tip 9: Culturally Humble, Person-Centered Care Is Crucial to Providing Antiracist PC

Cultural humility is a process of openness, humility, and self-awareness that is necessary in a multicultural world where power imbalances exist.[100] Cultural humility strives for mutual empowerment, respect, and life-long learning.[100] The approach of cultural humility moves away from cultural competence, which can promote stereotypical thinking and ''othering'' of minority groups.[101,102] Cultural competence suggests the false belief that you can be competent in someone else's culture and implies learning is finite.[102] Conversely, cultural humility is a *process*, wherein learning is infinite and centered on an iterative approach of self-reflection and self-evaluation.[100] Cultural humility takes into account who you are, your experiences, how you live, and how you view the world.[100]

Cultural humility seeks to challenge power dynamics and prioritizes viewing individuals as complex, and frequently evolving as result of life experiences, relationships, and interactions.[103] For example, as clinicians, we exist in and view the world through the lenses of multiple cultures, simultaneously.[104] We see the world through our discipline, our race, ethnic background(s), religion, self- identified gender, sexual identity, clinical experiences, and educational background(s). Similarly, those who we serve, view the world through their own multidimensional, unique cultural and personal lenses, which inform how they approach serious illness care and decisions.[105]

Providing culturally humble, person-centered care to Black Americans begins with the awareness of the power dynamics that are ubiquitous in clinical interactions and how clinicians' own cultural framing influences these interactions.[104] Indeed, Robinson-Lane and Booker have advocated for culturally humble and responsive pain care practices for older Black Americans.[106] A common source of power in U.S. society and health care is White privilege, which is defined as the relative advantages that racism afford people who identify as or are perceived as White.[107] Because White privilege and racism are the basis for many health inequities among Black Americans, providing person-centered and culturally humble care requires internal reflective work and constant evaluation of daily practices and beliefs to avoid oppressing marginalized groups.[107]

This reflective work requires examining the subtle assumptions that we make about people based on race, which is that Black Americans choose aggressive care at the EOL because of their racial identity, and can lead to microaggressions and fragmented relationships.[108] A more accurate and culturally humble manner to interpret EOL decisions among Black Americans should take into account that a complex set of variables interact to influence decision making along the continuum of serious illness. This manner includes not attributing care preferences to racial identity but more accurately recognize racism, systemic barriers that may shape access, and individual preferences.[94,109] Providing culturally humble and antiracist care is a way of being and seeks to understand each individual's life experiences, goals, and values, and how they influence decisions, access, and care.[100]

Tip 10: PC Teams Can Reduce Racial Disparities by Advocating for Policy Change and Cultivating Antiracist Environments

PC clinicians must create antiracist environments at all levels: on our clinical teams, within our institutions, in research, and within the broader health care system. Becoming an antiracist involves changing the ways we think, behave, and advocate for equity.[110] Almost every aspect of American culture has been shaped by racism and, therefore, requires a close examination of policies and racist ideas that propagate inequities.[11] Antiracist actions benefit from and are amplified by collective action and energy.[16] Examples of antiracist activities include (1) acknowledging that racism exists and is detrimental to societal health, (2) seeking education on the history of racism in the United States, and (3) avoiding perpetuating it through intentional beneficence. As a first step, PC clinicians can acknowledge their own racism, allow themselves time to recognize and confront racism to shift to providing antiracist care, and oppose racism in all domains (individual, institutional, and political).[21]

Table 1. Recommendations to Promote the Delivery of Antiracist Palliative Care

PC teams should respectfully and empathically treat each patient as a person with individual preferences and needs, not as someone part of a racial group.
PC teams should reject the use of race as a biological variable in clinical practice and scholarship. Antiracist actions includes self-reflection and critique of tools and studies that frames race as a biological variable rather than a sociopolitical construct.
PC teams should recognize racially biased care that reinforces health disparities and identify policies and structures that underpin racial inequities, thereby acknowledging social and structural determinants of health that directly result from racism and account for differences in serious illness care.
PC teams should periodically assess (and work to correct) if their treatment recommendations and outcomes differ by irrelevant characteristics such as race and other at-risk identities.
PC teams should hold regular forums to exchange feedback and evaluate any practices that may be inadvertently racist. Providing antiracist PC includes receptiveness to feedback on your own biases and beliefs. It is important to avoid thinking of people as racist or not racist. Instead, think of people as committing racist or antiracist acts.
PC teams should integrate perspectives of individuals, patients, and caregivers with lived experiences of racism in designing antiracist clinical care and policies. This may include community liaisons, patient champions, faith leaders, health care providers, and ethics experts.
PC teams should advocate for and participate in informing an agenda to ameliorate disparities in serious illness care by working with institutional, organizational, and public policymakers.
PC teams should hold each other accountable for attaining the common goal of achieving equity in serious illness care.

PC, palliative care.

Moreover, for PC clinicians, a close examination of power structures, systems of care, and payment policies that promote inequities in serious illness care is needed. Systems that encourage inequities include, but are not limited to, lack of diversity in the PC field, poor representation of Black clinicians in leadership positions, and less availability of PC services and training opportunities in minority-serving hospitals.[42,111] In addition, Medicaid, the country's state-based safety-net insurance program, is a poignant exemplar of payment policy steeped in structural racism. The federal government gives states significant discretion over the health services for which Medicaid reimburses. Hospice and PC are not classified as essential benefits under Medicaid.[112,113] Medicaid programs have also underfunded care in nursing homes, where a higher proportion of Black Americans than White Americans die.[114]

Access to PC and hospice must improve for Black Americans by requiring federal and state-level policy changes as well as correct attribution of factors related to lack of hospice use among Black Americans.[83,115] PC interventions must directly target underserved hospitals and communities of color. Antiracist health care policies should be designed with a purview that encompasses health equity along the complete health care continuum, including disease prevention, treatment, and quality EOL care.[116,117]

Conclusion

Dismantling racism is a continuous reflective process, which demands that clinicians understand how explicit and implicit biases and disparities are generated. It also requires vigilance and constant reevaluation of practices, policies, and systems that perpetuate or exacerbate these racial inequities. This article is strengthened by our author group, which includes a range of racial, cultural, and other under-represented identities, but we recognize inherent limitations may prevent us from seeing and addressing all levels of race-based implications. Black Americans face significantly greater barriers to high-quality serious illness care. The information in this article highlights several important drivers of race disparities and provides guidance to improve the delivery of PC to Black Americans.

We also acknowledge that while Black Americans represent a heterogeneous group, they largely have a shared experience of racism in the U.S. health care and social system. To erode the impact of racism in PC, Black Americans deserve and we all should demand high-quality, tailored care that aligns with individual patients' goals and values not race-based ideas or factors. To improve equitable delivery of serious illness care, we must also promote diversity in our field and honor and support scholars, clinicians, and researchers working to advance a national agenda to address and eradicate disparities in the delivery of PC.

Funding Information

K.F.J. is funded by the National Institute of Nursing Research Ruth L. Kirschstein National Service Award (F31NR019929-01) and is a Jonas Mental Health Scholar 2021–2023. L.T.S. is supported by the Ruth L. Kirschstein National Research Service Award training program in Individualized Care for at Risk Older Adults at the University of Pennsylvania, National Institute of Nursing Research of the National Institutes of Health (T32NR009356). W.E.R. is funded by the NIH/NCI Cancer Center Support Grant P30 CA008748 and the NCI award number T32 CA009461. S.Q.B. is funded by the National Institute of Arthritis and Musculoskeletal and Skin Diseases (K23AR076463).

Author Disclosure Statement

No competing financial interests exist.

References

1. Alexander MJ, Kiang MV, Barbieri M: Trends in black and white opioid mortality in the United States, 1979–2015. Epidemiology (Cambridge, Mass) 2018;29:707.
2. American Academy of Hospice and Palliative Medicine: AAHPM Statement on Racism in Healthcare. 2020. http://aahpmblog.org/articles/aahpm-statement-on-racism-in-healthcare (Last accessed July 15, 2020).

3. National Hospice and Palliative Care Organization: Statement on Institutional Racism. 2020. https://www.nhpco.org/nhpco-statement-in-response-to-acts-of-racism-and-violence-and-need-to-address-structural-racism-and-health-inequities-in-the-u-s (Last accessed August 18, 2020).
4. Hospice and Palliative Care Nurse Association: HPNA Promotes Resources for Collaboration with the Public in the Protection of Human Rights. 2020. https://advancingexpertcare.org/HPNAweb/Protection_of_Human_Rights.aspx (Last accessed August 2, 2021).
5. Starr LT, O'Connor NR, Meghani SH: Improved serious illness communication may help mitigate racial disparities in care among Black Americans with COVID-19. J Gen Intern Med 2021;36:1071–1076.
6. Brown CE, Engelberg RA, Sharma R, et al.: Race/ethnicity, socioeconomic status, and healthcare intensity at the end of life. J Palliat Med 2018;21:1308–1316.
7. Gee GC, Ford CL: Structural racism and health inequities: Old issues, new directions. Du Bois Rev 2011; 8:115–132.
8. Sanders JJ, Robinson MT, Block SD: Factors impacting advance care planning among African Americans: Results of a systematic integrated review. J Palliat Med 2016;19:202–227.
9. Williams DR, Lawrence JA, Davis BA: Racism and health: Evidence and needed research. Annu Rev Public Health 2019;40:105–125.
10. Coates T-N: *Between the World and Me*. New York: Penguin Random House, 2015.
11. On Racism: A New Standard for Publishing on Racial Health Inequities. *Health Affairs Blog*. Vol July 2, 2020. [Epub ahead of print]; DOI: 10.1377/hblog20200630.939347/full/2020.
12. Vyas DA, Eisenstein LG, Jones DS: Hidden in plain sight—Reconsidering the use of race correction in clinical algorithms. N Engl J Med 2020;383:874–882.
13. DeCamp M, Lindvall C: Latent bias and the implementation of artificial intelligence in medicine. J Am Med Inform Assoc 2020;27:2020–2023.
14. Park, M., Alson A, Washington-Brown L: Toward rational conversation about race, health risk, and nursing. Am Nurse J 2021;16:55–58.
15. Meghani SH, Hinds PS: Policy brief: The Institute of Medicine report Dying in America: Improving quality and honoring individual preferences near the end of life. Nurs Outlook 2015;63:51–59.
16. Kendi IX: *How to Be an Antiracist*. New York: Penguin Random House LLC, 2019.
17. Churchwell K, Elkind Mitchell SV, Benjamin Regina M, et al.: Call to action: Structural racism as a fundamental driver of health disparities: A Presidential Advisory from the American Heart Association. Circulation 2020;142: e454–e468.
18. Salter PS, Adams G, Perez MJ: Racism in the structure of everyday worlds: A cultural-psychological perspective. Curr Dir Psychol Sci 2017;27:150–155.
19. Meghani SH, Chittams J: Controlling for socioeconomic status in pain disparities research: All-else-equal analysis when ''All Else'' is not equal. Pain Med 2015;16:2222–2225.
20. Talking About Race: National Museum of African American History and Culture. https://nmaahc.si.edu/learn/talking-about-race (Last accessed July 6, 2021).
21. Getting Our Knees Off Black People's Neck: An Anti-racist approach to Medical Care. *Health Affaird Blog*, November 4, 2020. [Epub ahead of print]; DOI: 10.1377/hblog20201029.167296.
22. Singh A: *The Racial Healing Handbook: Practical Activities to Help You Challenge Privelege, Confront, Systemic Racism, and Engage in Collective Healing*. Oakland, CA: New Harbinger Publications, 2019.
23. Morin R: Exploring Racial Bias Among Biracial and Single-Race Adults: The IAT. *Pew Research Center Social & Demographic Trends*. August 19, 2015. https://www.pewresearch.org/social-trends/2015/08/19/exploring-racial-bias-among-biracial-and-single-race-adults-the-iat (Last accessed March 3, 2021).
24. Perry LM, Walsh LE, Horswell R, et al.: Racial disparities in end-of-life care between Black and White adults with metastatic cancer. J Pain Symptom Manage 2021;61:342–349.e1.
25. Mathew DB: *Just Medicine: A Cure for Racial Inequality in American Health Care*. New York: New York University Press, 2015.
26. It's Time to Address the Role of Implicit Bias Within Health Care Delivery. *Health Affairs Blog*, January 15, 2020. [Epub ahead of print]; DOI: 10.1377/hblog30300108.34515.
27. Phelan JC, Link BG: Is racism a fundamental cause of inequalities in health? In: Cook KS, Massey DS (eds): *Annual Review of Sociology,* vol. 41. Annual Reviews Inc. 2015, pp. 311–330.
28. Fitzgerald C, Hurst S: Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics 2017;18:19.
29. Meghani SH: Corporatization of pain medicine: Implications for widening pain care disparities. Pain Med 2011; 12:634–644.
30. Meghani SH, Byun E, Gallagher RM: Time to take stock: A meta-analysis and systematic review of analgesic treatment disparities for pain in the United States. Pain Med 2012;13:150–174.
31. Meghani SH, Kang Y, Chittams J, et al.: African Americans with cancer pain are more likely to receive an analgesic with toxic metabolite despite clinical risks: A mediation analysis study. J Clin Oncol 2014;32:2773–2779.
32. Meghani SH, Rosa WE, Chittams J, et al.: Both race and insurance type independently predict the selection of oral opioids prescribed to cancer outpatients. Pain Manag Nurs 2020;21:65–71.
33. Anderson KO, Green CR, Payne R: Racial and ethnic disparities in pain: Causes and consequences of unequal care. J Pain 2009;10:1187–1204.
34. Cintron A, Morrison RS: Pain and ethnicity in the United States: A systematic review. J Palliat Med 2006;9:1454–1473.
35. Institute of Medicine: *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington, D.C.: National Academies Press, 2011.
36. Mack DS, Hunnicutt JN, Jesdale BM, Lapane KL: Non-Hispanic Black-White disparities in pain and pain management among newly admitted nursing home residents with cancer. J Pain Res 2018;11:753–761.
37. Morrison R, Jesdale B, Dube C, et al.: Racial/ethnic differences in staff-assessed pain behaviors among newly admitted nursing home residents. J Pain Symptom Manage 2021;61:438–448 e433.

38. Green CR, Anderson KO, Baker TA, et al.: The unequal burden of pain: Confronting racial and ethnic disparities in pain. Pain Med 2003;4:277–294.
39. Meghani SH, Keane A: Preference for analgesic treatment for cancer pain among African Americans. J Pain Symptom Manage 2007;34:136–147.
40. Booker SQ, Tripp-Reimer T, Herr KA: ''Bearing the Pain'': The experience of aging African Americans with osteoarthritis pain. Global Qual Nurs Res 2020;7: 2333393620925793.
41. Booker SQ, Cousin L, Buck HG: ''Puttin' on'': Expectations versus family responses, the lived experience of older African Americans with chronic pain. J Fam Nurs 2019;25:533–556.
42. Booker S, Herr K: Voices of African American older adults on the implications of social and healthcare-related policies for osteoarthritis pain care. Pain Manage Nurs 2021;22:50–57.
43. Hirsh AT, Anastas TM, Miller MM, et al.: Patient race and opioid misuse history influence provider risk perceptions for future opioid-related problems. Am Psychol 2020;75:784–795.
44. Meghani SH, Wool J, Davis J, et al.: When patients take charge of opioids: Self-management concerns and practices among cancer outpatients in the context of opioid crisis. J Pain Symptom Manage 2020;59:618–625.
45. Meghani SH, Thompson AM, Chittams J, et al.: Adherence to analgesics for cancer pain: A comparative study of African Americans and Whites using an electronic monitoring device. J Pain 2015;16:825–835.
46. Ioannidis JPA, Powe NR, Yancy C: Recalibrating the use of race in medical research. JAMA 2021;325:623–624.
47. Rozenfeld Y, Beam J, Maier H, et al.: A model of disparities: Risk factors associated with COVID-19 infection. Int J Equity Health 2020;19:126.
48. Walker RJ, Smalls BL, Campbell JA, et al.: Impact of social determinants of health on outcomes for type 2 diabetes: A systematic review. Endocrine 2014;47:29–48.
49. Braveman P, Gottlieb L: The social determinants of health: It's time to consider the causes of the causes. Public Health Rep 2014;129 Suppl 2:19–31.
50. Paradies Y, Ben J, Denson N, et al.: Racism as a determinant of health: A systematic review and meta-analysis. PLoS One 2015;10:e0138511.
51. Johnson KS: Racial and ethnic disparities in palliative care. J Palliat Med. 2013;16:1329–1334.
52. Centers for Disease Control and Prevention CDC: Vital Signs: African American Health—creating equal opportunities for health. CDC. 2017. Updated July 3, 2017. https://www.cdc.gov/vitalsigns/aahealth/index.html (Last accessed January 26, 2021).
53. Chen Y, Criss SD, Watson TR, et al.: Cost and utilization of lung cancer end-of-life care among racial-ethnic minority groups in the United States. Oncologist 2020;25: e120–e129.
54. Yang A, Goldin D, Nova J, et al.: Racial disparities in health care utilization at the end of life among New Jersey Medicaid beneficiaries with advanced cancer. JCO Oncol Pract 2020;16:e538–e548.
55. Clark MA, Person SD, Gosline A, et al.: Racial and ethnic differences in advance care planning: Results of a statewide population-based survey. J Palliat Med 2018;21: 1078–1085.
56. Ornstein KA, Roth DL, Huang J, et al.: Evaluation of racial disparities in hospice use and end-of-life treatment intensity in the REGARDS cohort. JAMA Netw Open 2020;3:e2014639.
57. National Hospice and Palliative Care Organization: NHPCO Facts and Figures 2020 Edition. 2020. https://www.nhpco.org/factsfigures (Last accessed November 1, 2020).
58. Fiscella K, Sanders MR: Racial and ethnic disparities in the quality of health care. Annu Rev Public Health 2016; 37:375–394.
59. Kirkendall A, Holland JM, Keene JR, Luna N: Evaluation of hospice care by family members of Hispanic and non-Hispanic patients. Am J Hosp Palliat Care 2015;32:313–321.
60. Rhodes RL, Xuan L, Halm EA: African American bereaved family members' perceptions of hospice quality: Do hospices with high proportions of African Americans do better? J Palliat Med 2012;15:1137–1141.
61. Welch LC, Teno JM, Mor V: End-of-life care in black and white: race matters for medical care of dying patients and their families. J Am Geriatr Soc 2005;53:1145–1153.
62. Rhodes RL, Teno JM, Connor SR: African American bereaved family members' perceptions of the quality of hospice care: Lessened disparities, but opportunities to improve remain. J Pain Symptom Manage 2007;34:472–479.
63. Loggers ET, Maciejewski PK, Paulk E, et al.: Racial differences in predictors of intensive end-of-life care in patients with advanced cancer. J Clin Oncol 2009;27: 5559–5564.
64. Mack JW, Paulk ME, Viswanath K, Prigerson HG: Racial disparities in the outcomes of communication on medical care received near death. Arch Intern Med 2010;170: 1533–1540.
65. Kwak J, Haley WE: Current research findings on end-of-life decision making among racially or ethnically diverse groups. Gerontologist 2005;45:634–641.
66. Love A, Yates P: Advance Care Planning in palliative care: A systematic literature review of the contextual factors influencing its uptake 2008–2012. Palliat Med 2014;28:1026–1035.
67. Smith-Howell ER, Hickman SE, Meghani SH, et al.: End-of-life decision making and communication of bereaved family members of African Americans with serious illness. J Palliat Med 2016;19:174–182.
68. The Joint Commission: The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. Oakbrook Terrace, IL: The Joint Commission, 2010.
69. Williams SW, Hanson LC, Boyd C, et al.: Communication, decision making, and cancer: What African Americans want physicians to know. J Palliat Med 2008;11: 1221–1226.
70. Bernacki RE, Block SD; American College of Physicians High Value Care Task Force. Communication about serious illness care goals: A review and synthesis of best practices. JAMA Intern Med 2014;174:1994–2003.
71. Wenrich MD, Curtis JR, Shannon SE, et al.: Communicating with dying patients within the spectrum of medical care from terminal diagnosis to death. Arch Intern Med 2001;161:868–874.

72. Ahrens T, Yancey V, Kollef M: Improving family communications at the end of life: Implications for length of stay in the intensive care unit and resource use. Am J Crit Care 2003;12:317–323.
73. Carlson RW, Devich L, Frank RR: DEvelopment of a comprehensive supportive care team for the hopelessly ill on a university hospital medical service. JAMA 1988;259: 378–383.
74. Gerst K, Burr JA: Planning for end-of-life care—Black-White differences in the completion of advance directives. Res Aging 2008;30:428–449.
75. McMahan RD, Tellez I, Sudore RL: Deconstructing the complexities of advance care planning outcomes: What do we know and where do we go? A scoping review. J Am Geriatr Soc 2021;69:234–244.
76. Detering KM, Hancock AD, Reade MC, Silvester W: The impact of advance care planning on end of life care in elderly patients: Randomised controlled trial. BMJ 2010; 340:c1345.
77. Mack JW, Weeks JC, Wright AA, et al.: End-of-life discussions, goal attainment, and distress at the end of life: Predictors and outcomes of receipt of care consistent with preferences. J Clin Oncol 2010;28:1203–1208.
78. Wright AA, Zhang BH, Ray A, et al.: Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. JAMA 2008;300:1665–1673.
79. Johnson T, Walton S, Jr., Levine S, et al.: Racial and ethnic disparity in palliative care and hospice use. Am J Manag Care 2020;26:e36–e40.
80. Corbie-Smith G: Vaccine hesitancy is a scapegoat for structural racism. JAMA Health Forum 2021;2:e210434.
81. Kaiser K, Rauscher GH, Jacobs EA, et al.: The import of trust in regular providers to trust in cancer physicians among white, African American, and Hispanic breast cancer patients. J Gen Intern Med 2011;26:51–57.
82. Payne R: Improving Palliative Care for African-American & Other Minority Patients. Oncology Times 2002;24:2–4.
83. Laury ER, MacKenzie-Greenle M, Meghani S: Advance care planning outcomes in African Americans: An empirical look at the trust variable. J Palliat Med 2019;22: 442–451.
84. Hardeman RR, Medina EM, Boyd RW: Stolen breaths. N Engl J Med 2020;383:197–199.
85. McKinley ED, Garrett JM, Evans AT, Danis M: Differences in end-of-life decision making among black and white ambulatory cancer patients. J Gen Intern Med 1996; 11:651–656.
86. Morrison RS, Meier DE: High rates of advance care planning in New York City's elderly population. Arch Intern Med 2004;164:2421–2426.
87. Morrison RS, Zayas LH, Mulvihill M, et al.: Barriers to completion of health care proxies—An examination of ethnic differences. Arch Intern Med 1998;158:2493–2497.
88. Smith AK, Davis RB, Krakauer EL: Differences in the quality of the patient-physician relationship among terminally ill African-American and white patients: Impact on advance care planning and treatment preferences. J Gen Intern Med 2007;22:1579–1582.
89. Zapka JG, DesHarnais S: Care at the end of life: Focus on communication and race. J Aging Health 2006;18:791–813.
90. Mahaney-Price AF, Hilgeman MM, Davis LL, et al.: Living will status and desire for living will help among rural Alabama Veterans. Res Nurs Health 2014;37:379–390.
91. Opel DJ, Lo B, Peek ME: Addressing mistrust about COVID-19 vaccines among patients of color. Ann Intern Med 2021;174:698–700.
92. Song L, Weaver MA, Chen RC, et al.: Associations between patient-provider communication and socio-cultural factors in prostate cancer patients: A cross-sectional evaluation of racial differences. Patient Educ Couns 2014;97:339–346.
93. Sanders JJ, Johnson KS, Cannady K, et al.: From barriers to assets: Rethinking factors impacting advance care planning for African Americans. Palliat Support Care 2019;17:306–313.
94. Starr LT, Ulrich CM, Junker P, et al.v Goals-of-care consultation associated with increased hospice enrollment among propensity-matched cohorts of seriously ill African American and White patients. J Pain Symptom Manage 2020;60:801–810.
95. Braun UK, Beyth RJ, Ford ME, McCullough LB: Voices of African American, Caucasian, and Hispanic surrogates on the burdens of end-of-life decision making. J Gen Intern Med 2008;23:267–274.
96. Starr LT, Ulrich CM, Appel SM, et al.: Goals-of-care consultations are associated with lower costs and less acute care use among propensity-matched cohorts of African Americans and Whites with serious illness. J Palliat Med 2020;23:1204–1213.
97. Wicher CP, Meeker MA: What influences African American end-of-life preferences? J Health Care Poor Underserved 2012;23:28–58.
98. Melhado L, Bushy A: Exploring uncertainty in advance care planning in African Americans: Does low health literacy influence decision making preference at end of life. Am J Hosp Palliat Care 2011;28:495–500.
99. Johnson KS, Kuchibhatla M, Tulsky JA: Racial differences in self-reported exposure to information about hospice care. J Palliat Med 2009;12:921–927.
100. Foronda C, Baptiste D-L, Reinholdt MM, Ousman K: Cultural humility: A concept analysis. J Transcult Nurs 2015;27:210–217.
101. Tervalon M, Murray-Garcia J: Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved 1998;9:117–125.
102. Yancu C, Farmer D: Product or process: Cultural competence or cultural humility. Palliat Med Hospice Care Open J 2017;3:e1–e4.
103. Metzl JM, Hansen H: Structural competency: Theorizing a new medical engagement with stigma and inequality. Soc Sci Med 2014;103:126–133.
104. Upshaw NC, Lewis Jr DE, Nelson AL: Cultural humility in action: Reflective and process-oriented supervision with Black trainees. Train Educ Prof Psychol 2020;14:277.
105. Fahlberg B, Foronda C, Baptiste D: Cultural humility: The key to patient/family partnerships for making difficult decisions. Nursing2021 2016;46.
106. Robinson-Lane SG, Booker SQ: Culturally responsive pain management for Black older adults. J Gerontol Nurs 2017;43:1–8.
107. Hardeman RR, Medina EM, Kozhimannil KB: Structural racism and supporting Black lives—The role of health professionals. N Engl J Med 2016;375:2113–2115.

108. Davis DE, DeBlaere C, Brubaker K, et al.: Microaggressions and perceptions of cultural humility in counseling. J Couns Dev 2016;94:483–493.
109. Johnson KS, Kuchibhatla M, Tulsky JA: What explains racial differences in the use of advance directives and attitudes toward hospice care? J Am Geriatr Soc 2008;56: 1953–1958.
110. Mensah MO: Majority Taxes—Toward antiracist Allyship in medicine. N Engl J Med 2020;383:e23.
111. Bell LF, Livingston J, Arnold RM, et al.: Lack of exposure to palliative care training for black residents: A study of schools with highest and lowest percentages of black enrollment. J Pain Symptom Manage 2021;61:1023–1027.
112. Report to the Congress: Medicare Payment Policy. 2020. www.medpac.gov/-documents-/reports (Last accessed July 8, 2021).
113. Starr LT, Ulrich CM, Perez GA, et al.: Hospice enrollment, future hospitalization, and future costs among racially and ethnically diverse patients who received palliative care consultation. Am J Hosp Palliat Care 2021: 10499091211034383. [Epub ahead of print]; DOI: 10.1177/10499091211034383
114. Wachterman MW, Sommers BD: Dying poor in the US—Disparities in end-of-life care. JAMA 2021;325:423–424.
115. Cole MB, Ellison JE, Trivedi AN: Association between high-deductible health plans and disparities in access to care among cancer survivors. JAMA Netw Open 2020;3: e208965-e208965.
116. Cerdeña JP, Plaisime MV, Tsai J: From race-based to race-conscious medicine: How anti-racist uprisings call us to act. Lancet 2020;396:1125–1128.
117. Hardeman RR, Karbeah JM: Examining racism in health services research: A disciplinary self-critique. Health Serv Res 2020;55(S2):777–780.

Address correspondence to:
Esther Laury, PhD, RN
Merck Sharp & Dohme Corp.
US Outcomes Research
351 N. Sumneytown Pike
North Wales, PA 19454
USA

E-mail: esther.laury@merck.com