Power Dynamics Perpetuate DEI Inaction: A Qualitative Study of Community Health Clinic Teams

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ABSTRACT

PURPOSE Despite increased clinician awareness of systemic racism, lack of substantial action toward antiracism exists within health care. Clinical staff perspectives, particularly those of racial-ethnic minorities/persons of color (POC) who disproportionately occupy support staff roles with less power on the team, can yield insights into barriers to progress and can inform future efforts to advance diversity, equity, and inclusion (DEI, also referred to as EDI) within health care settings. This qualitative study explored the perspectives of staff members on race and role power dynamics within community health clinic teams.

METHODS We conducted semistructured 45-minute interviews with staff members working in community health clinics in a large urban health care system from May to July 2021. We implemented purposeful recruitment to oversample POC and support staff and to achieve equal representation from the 13 community health clinics in the system. Interviews were audio recorded, transcribed, and analyzed over 6 months using a critical-ideological paradigm. Themes reflecting experiences related to race and role power dynamics were identified.

RESULTS Our cohort had 60 participants: 42 (70%) were support staff (medical assistants, front desk clerks, care navigators, nurses) and 18 (30%) were clinicians and clinic leaders. The large majority of participants were aged 26 to 40 years (60%), were female (83%), and were POC (68%). Five themes emerged: (1) POC face hidden challenges, (2) racial discrimination persists, (3) power dynamics perpetuate inaction, (4) interpersonal actions foster safety and equity, and (5) system-level change is needed for cultural shift.

CONCLUSIONS Understanding the race and role power dynamics within care teams, including experiences of staff members with less power, is critical to advancing DEI in health care.

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INTRODUCTION

Team-based care, established as the gold standard model for providing care more than a decade ago,[1] allows integrated clinical teams with different and complementary skills and perspectives to provide efficient, high-quality health care services to diverse patient populations. Within clinical teams, White individuals typically hold positions with the greatest power in the medical hierarchy (eg, physicians), whereas those of minoritized racial-ethnic identity groups/persons of color (POC) typically occupy positions with the least power (eg, medical assistants), exacerbating societal issues related to discrimination, injustice, and inequity.[2-7] (See Supplemental Appendix 1 for terms used in this article and related terms.) Little is known about experiences of race and role power dynamics within community health clinic teams and how these interactions impact clinic culture. Furthermore, few studies have evaluated the perspectives of staff members in roles with lower power who are disproportionately POC and comprise a majority of the health care team. The aim of our study was to understand the perspectives of clinic staff members across races and roles in order to inform future interventions to improve health care teams with respect to diversity, equity, and inclusion (DEI, also referred to as EDI) and more effectively address race-related issues within health care.

METHODS

Study Design, Participants, and Setting

The study took place in a large urban community health clinic system with 13 clinics (7 family medicine, 3 internal medicine, and 3 pediatric) designated as Federally

Qualified Health Centers (FQHCs). Staff members working at one of the clinics for at least 1 year were eligible to participate. We used a critical-ideological research framework to raise critical consciousness around what it looks like when systemic and institutional racism filter down to clinic-level interpersonal dynamics.[8,9] Purposeful enrollment was conducted to maximize representation of POC and support staff (medical assistants, front desk clerks, care navigators, nurses, and others) with a goal of 70% POC and 70% support staff representation overall. Clinicians and clinic leaders were also included in the study to create a holistic understanding of the ecosystem in which power dynamics occur.

We recruited participants via an e-mail that explained the purpose of the study as aiming to understand staff member experiences with race and ethnicity and role dynamics. Individuals interested in participating completed a screening form documenting demographic information including self-reported race and ethnicity without provision of choices ("How would you describe your race/ethnicity?"). Enrollment was limited to 5 participants per clinic to ensure even distribution across the 13 clinics. The study was reviewed and approved by the Colorado Multiple Institutional Review Board. All participants provided electronic informed consent before participation.

Data Collection

Two authors who are licensed psychologists (L.M.R. and S.P.M.) and 2 research assistants (H.W-I.C. and R.R.) conducted 60 one-to-one virtual interviews over a 3-month period. The interview guide (Supplemental Appendix 2) was based on a literature review of race and role power dynamics within the workplace and investigator expertise. To create safety around vulnerable content, participants who identified as POC were offered the opportunity to interview with a POC interviewer (L.M.R. or H.W-I.C.); all POC participants opted for a POC interviewer. Participants who identified as White interviewed with a White interviewer (S.P.M. or R.R.). Interviews were audio recorded, transcribed, and conducted until representation across race and role was achieved throughout the 13 clinic sites, which was accomplished at 60 participants. Thematic saturation was reached at approximately 40 participants across roughly 8 clinics.

Data Analysis

Transcripts were imported into Atlas.ti, version 8.0.27.0 (Scientific Software Development). Total analysis spanned 6 months; interrater reliability was assessed for the first 2 months during codebook development, and data triangulation occurred throughout the duration of analysis. Data analysis included coding, thematic analysis, and thematic building. Line-by-line coding was done by 2 coauthors (L.M.R. and S.P.M.). Each transcript was reviewed throughout this process (1) to enrich analysts' interpretation of the transcripts and (2) to acknowledge researcher values and allow them to inform analysis.[8] Code words that appeared to capture participants' thoughts, patterns of behaviors, and phrases were cataloged into the codebook. We used constant comparison and analytic induction to support or modify emerging themes and build consensus.[10,11] A family medicine resident (B.H.) and a psychology resident (H.W-I.C.) assisted in the ongoing analysis to triangulate, confirm interrater reliability, and resolve discordance issues. The analysis team (L.M.R., S.P.M., B.H., and H.W-I.C.) performed a final distillation of themes with illustrative quotes and shared them with participants via e-mail before wide dissemination to ensure comfort with the quotes and verify findings, consistent with the critical ideological paradigm.[10,11]

RESULTS

Participant Characteristics

Among the 60 individuals who participated, the large majority identified as female (83%), POC (68%), and support staff members (70%) (Supplemental Table 1). More than three-quarters of POC participants (76%) were in support staff roles, illustrating the fact that support staff members are disproportionately POC, and mirroring the racial and ethnic distribution in the community clinic workforce.

Themes and Subthemes

Five overarching themes emerged: (1) POC face hidden challenges, (2) racial discrimination persists, (3) power dynamics perpetuate inaction, (4) interpersonal actions foster safety and equity, and (5) system-level change is needed for cultural shift. These themes and the corresponding subthemes (italicized) and illustrative quotations are highlighted below and detailed in Supplemental Table 2.

POC Face Hidden Challenges

People of color participants across roles described experiencing constant internal negotiation around expressing thoughts, ideas, and needs while maintaining relationships and avoiding reinforcement of stereotypes associated with their identities. POC participants expressed that *emotional labor is constantly demanded*, including the need to regularly assess the trustworthiness and psychological safety of relationships with coworkers and management; weighing the energy needed and risk of responding to a race-related event in a fast-paced environment; and second-guessing their own and others' interpretation of and response to a race-related incident.

> "I can't lie to you and [say], 'Oh I'm happy, that didn't affect me.' Yes, I'm upset, but I'm going to keep going ... but on the inside, we're not okay." – POC support staff

Some POC participants reported becoming tearful as repressed feelings resurfaced; at times, POC participants were tearful during the interview as they recounted such events. White participants made no comment on emotional workload associated with race dynamics, either their own or that of their colleagues.

"I feel like people are very heard ... I don't think I have heard or witnessed anything within the team that would be concerning." – White clinician

Racial Discrimination Persists

Participants across races and roles reported witnessing or experiencing race-related incidents. POC participants additionally reported being negatively affected by inequitable policies and/or inequitable enforcement of policies, whereas White participants did not report experiencing negative policy-related impacts or inequitable treatment. Participants explained that although policies are not explicitly written to be inequitable across racial and ethnic lines, some policies differ across job roles that are racially disparate.

"There is marginalization built into the system that minorities will experience based on the level of where they are in the hierarchy…" – POC clinician

Power Dynamics Perpetuate Inaction

Participants reported that *positional privilege suppresses roles with less power*, and perceived the current hierarchical structure as a barrier to an inclusive work environment. Support staff, particularly those who are POC, recognized that they have less agency in the system, and that *systemic protection excludes POC support staff;* specifically, reporting race-related incidents did not feel safe or productive, and their jobs did not feel secure. Support staff expressed concerns that they would be labeled as a "problem" and targeted in the future, or that their words would be communicated to other staff members or management without their knowledge or permission. Clinic leaders, however, reported experiencing the opposite: in addition to not often recognizing race-related incidents, they felt safe escalating workplace issues without concern for job security.

People of color participants across roles reported that, *white fragility closes conversation*:

"I've tried to address [a race-related incident] with [White coworker] … [they] get defensive and don't hear what I'm trying to say." – POC clinic leader

These reactions led POC participants across roles to experience discomfort and powerlessness when attempting to discuss race-related incidents with their White colleagues. White participants also expressed discomfort:

"I don't know how to fix [racism]. But I think we could just all be supportive of everyone, and that includes White people ... the world may hate us right now, but I don't think we're bad people." – White support staff

Suppression of support staff voices, systemic protection for clinicians/leaders, and defensiveness and unrecognized shortcomings were summed up by the subtheme that *helplessness paralyzes everyone*.

Interpersonal Actions Foster Safety and Equity

Participants identified interpersonal actions as effective steps in repairing race-related damage and harm.

"[The clinic leader] came out and pulled the patient aside and addressed [the race-related incident]. She completely had my back." – POC support staff

People of color participants explained that fairness and trust are established through action. Demonstrating action may mean intervening in the moment to address the race-related incident or circling back with the person who was harmed to demonstrate they are seen and are of value (ie, upstander behaviors). Support staff reported that intentional inclusion and recognition make a difference. Leadership staff who demonstrated active listening, avoided favoritism, and ensured accountability successfully earned trust and created a sense of belonging. Support staff additionally shared that recognition for a job well done is an important inclusion practice that contributes to resilience. Further, support staff reflected that seeing a quick response to patient aggression helped establish safety. Action in response to patient-perpetrated race-related events (eg, when a patient showed aggression toward support staff) inherently demonstrated the potential for such a response to extend to race-related events perpetrated by support staff members.

System-Level Change Is Needed for Cultural Shift

Participants indicated that existing race-related gaps can be closed only by the larger system and its leadership.

"Actions always speak louder than words … there's been a lot of talk … I think it would be nice to actually see some [DEI-related changes] happening for our staff for support." – White clinic leader

Participants explained that one-time opportunities, such as annual trainings, presentations, or workshops, are insufficient to address race-related issues. Instead, time and safe space cultivate community building. Further, participants across race and role emphasized that those with DEI expertise must handle incidents to repair damage and proactively create a sense of safety for future interactions. Leadership participants, however, reported feeling unprepared to handle race-related incidents within their teams. POC participants also expressed that the existing reporting system was untrustworthy, and that human resources often missed the severity or nuance of race-related incidents, leaving victims feeling isolated when these incidents occurred and remained unresolved. Participants considered a new DEI incident reporting mechanism essential for trust. Participants across races and roles expressed frustration with the imbalance between talk and tangible change and made a plea for more action demonstrating antiracism. Their ideas included protecting time for staff members to engage in ongoing and meaningful work and providing safe and effective outlets to handle race-related incidents when they occur.

Challenges and Opportunities

Each of the themes we identified poses a challenge to overcome, but at the same time presents an opportunity for improving workplace DEI and power dynamics (Supplemental Table 3). The opportunities entail taking concerted steps at the individual, clinic, and system levels, and are discussed further below.

DISCUSSION

Using a critical-ideological approach, we set out to understand the race-related experiences of community health clinic team members, focusing on those with the least amount of power in the clinic. Overall, we identified 3 key findings: (1) POC team members experience hidden challenges related to managing an emotional burden that White team members are not aware of; (2) those with the least amount of power in the clinic (ie, support staff who identify as POC) bear the brunt of the burden and paradoxically have the least amount of power to bring about change, resulting in DEI inaction; and (3) relationship building provides a buffer to race-related experiences and is, to some extent, reparative and protective for POC team members.

Our first key finding was that POC team members across clinic roles face hidden challenges regarding the time and effort needed to internally manage discriminatory experiences and to accommodate and thereby continue operating day-to-day in the workplace. These findings align with scholarly work examining the emotional outcomes and psychological damage of race-related events,[12-15] and work examining race and role power dynamics in the workplace[16,17] wherein POCs mask emotions of anger, disbelief, and frustration to ensure a task or process continues to run smoothly in the moment.[18] Further, in response to being dismissed or devalued when reporting discriminatory incidents, racial-ethnic minorities bury triggering incidents as a means of protection from further internal damage.[13,19] Finally, findings illustrate that clinic members with greater race-based and role-based power (ie, White clinicians and clinic leaders) remain largely unaware of the energy expended by POC.

Perhaps the most compelling finding of the current study, our second key finding, is that the intersectionality between race and role perpetuates discrimination and DEI inaction in the clinic space. Given that support staff roles are often occupied by POC, the additive effect of race-based and role-based power dynamics produces a workplace environment primed for biases to exist without acknowledgment, as those with greater power are often unaware of the negative experiences of those with less power.[20] This finding is consistent with conclusions from recent literature exploring and determining why race-related issues persist in workplace settings, including health care.[19-23] Those injured also have little power to bring about systemic change because of the deeply embedded hierarchy in health care, meaning that these dynamics continue largely unchecked. Further, when POC staff members take a risk and put themselves in a vulnerable place to raise concerns, White staff members tend to close the conversation, which prevents any opportunity for repair.[19,24] Given that these dynamics perpetuate inaction, deliberate rebalancing of power will have to be done by those who are currently in positions of power.

Our third key finding is that both interpersonal actions and system-level changes are necessary for cultural shift. Previous work exploring elements contributing to healthy workplace cultures aligns with this finding[25-27] and shows that without a sense of belonging and value, diversity and equity efforts are not lasting in the workplace.[21] Given the efficiency expected in health care and that the medical hierarchy does not lend itself to equal valuation across roles, relationships often default to being transactional with minimal positive feedback for team members, especially support staff. Meaningful demonstrations of antiracism require an investment of time and effort that show genuine commitment amid competing demands by leadership.[26] On the basis of our finding that time invested in developing relationships within teams, active recognition of staff members' contributions, and tangible antiracism action steps demonstrated by leadership foster safety and equity, we recommend that leadership take on the onus of identifying and offering repeated, experiential, and interactive trainings grounded in improving relationships among team members as alternatives to ineffective one-time DEI trainings.

This study has both limitations and strengths. First, although researcher bias is inevitable as acknowledged in our critical-ideological paradigm,[8,9] investigators attempted to mitigate this bias by using a standardized interview tool, involving trained graduate-level research assistants, and offering participants the choice of interviewer based on shared racial-ethnic identity.[28] Several staff members commented, without being prompted, that they felt comfortable sharing explicit thoughts with a POC interviewer and that they would have not been as open or would have declined to share these experiences if interviews had been conducted solely by White interviewers. Second, the use of a virtual platform may have limited connectedness and sense of safety during the interviews because of minor sound quality issues and reduced ability to communicate nonverbally.[29] POC participants, however, often expressed gratitude at the end of their interview for being intentionally recruited and having dedicated time and space to reflect on and share their race-, ethnicity-, and role-related experiences. Lastly, we ensured strong ecological validity through a robust and diverse sample across clinic location, participant role within the medical hierarchy, and individual identity. The current study focused on race as a foundation rather than on other marginalized identities (eg, gender, socioeconomic status, ability); therefore, addressing intersectionality is outside the scope of this study, and would be a good direction for future research. Another future research direction includes evaluation of impact of system DEI initiatives on diverse staff. Two coauthors (L.M.R. and S.P.M.) conducted this inquiry into existing and subsequently

implemented DEI initiatives in the same FQHC system (eg, workshop in trauma and resilience including from racism and bias, appointment of executive sponsors to DEI work groups, and required online education modules); a manuscript describing that undertaking is in preparation.

CONCLUSIONS

Although it is important to address health disparities for POC patients, it is equally important to "look in-house" by examining the racial-ethnic dynamics within health care teams. The fact that staff occupying positions with less power are also disproportionately POC is both an explanation for why race and role dynamics persist within clinics, and also a complicating factor for effectively addressing these dynamics. By attending to this group through opportunities to report issues and work through complex dynamics as a team, there is healing for all—the individuals themselves, as well as those with more power—even as solutions are in progress.

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Key words: community health clinic; primary care; patient care team; diversity, equity, inclusion; group dynamics; power dynamics; racial-ethnic minorities; healthcare staff; racism; antiracism; race relations; organizational change; practice-based research; working conditions

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Supplemental materials

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