

Medical Trainee Perspectives Around Racism Experienced by Black Adults Near the End of Life

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OBJECTIVE

- To understand medical trainees’ experiences and observations around structural racism and end-of-life care for Black patients.

BACKGROUND

- Black Americans are less likely to receive goal-concordant end-of-life care, in part due to racial disparities such as inadequate pain treatment and reduced access to palliative care.
- Medical trainees spend a significant time with patients, families, and in clinical environments. They may provide a unique perspective that informs efforts to address structural racism.

METHODS

- Semi-structured, in-depth interviews were conducted with 15 UCSF medical trainees with experience caring for Black patients near the end of life.
- Participants included medical students and residents from the UCSF Internal Medicine and Neurology programs.
- Interviews were audio-recorded, transcribed, and anonymized to protect trainees’ identities.
- Thematic analysis was conducted, group coding with 3-4 coders was done for three (20%) of the interviews, and the rest of the interviews were single coded.



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Participant Demographics	
Stage in Training	Medical Student (MS), 67% (n=10)
	Medical Resident (PGY), 33% (n=5)
Gender	Female, 80% (n=12)
	Male, 20% (n=3)
Race, self-identified	AAPI*, 40% (n=6); Black, 20% (n=3), White, 13% (n=2), Multiple races, 7% (n=1) ; Other, 7% (n=1); Declined to state, 7% (n=1)
Ethnicity	Non-Hispanic, 87% (n=13)
	Hispanic/Latinx, 13% (n=2)

* AAPI – Asian American and Pacific Islander

RESULTS

Respondents described **poorer medical care** given to Black patients at the end of life.

“We asked [the nurse]... ‘Have you gone to see this patient this morning?’ The response was, ‘Oh, well that patient’s end of life. I didn’t think I needed to see them’... that pretty much never came up with any... non-Black [patients]; Other times... we [also] had nursing staff essentially not pay attention to [Black end-of-life] patients.”

[Participant 11, MS4]

“The patient’s troponin had been crazy elevated and [rising], but they hadn’t intervened overnight... at all, which is... against evidence-based therapy. And they didn’t call her family... if this was a white patient, would this have happened? I don’t think so.”

[Participant 1, MS3]

The public safety net hospital, which serves a higher proportion of Black patients, was described as having **fewer resources and no palliative care service.**

*“This year we lost palliative care at [public safety-net hospital]... people who aren’t used to leading these family conversations are now the [primary] provider **and** the palliative care doc.”*

“We have hour long appointment blocks at [private academic hospital]; at [public safety-net hospital]... we have often double scheduled patients for every 30 minutes. So only 15 minutes [each]... And it’s often much harder for these patients to get there... to reschedule... and they’re waiting for hours. And so it creates a worse experience... which then feeds into, ‘Do I trust my doctor?... Did I understand what we talked about?’”

[Participant 9, PGY1]

Staff perceived Black patients as disproportionately **aggressive and threatening.**

“And the nurse goes... ‘if you’re not going to put him on a [psychiatric] hold, I won’t go in that room... he is violent, this and that.’ [I asked], ‘Has he done anything violent?’ [The nurse said,] ‘No. But the way he is talking to me makes me feel like he is violent.’”

[Participant 14, PGY2]

[There were] events where [the patient] got very verbally angry and abusive... [But] many other patients at this hospital are... angry, and yelling, and don’t have those behavioral flags.

[Participant 5, MS4]

Respondents described **EMR documentation** potentially negatively affecting care.

“The attending was getting upset... [saying], ‘Now... she’s labeled as a difficult patient, and this may contribute to which [rehabilitation] facility she can get into... If this patient were of a different [racial] identity, [the nurses] would not be writing [such] detailed notes.”

[Participant 12, MS3]

“There was discussion that maybe the team shouldn’t see this patient [because of the behavioral flag]... there was a palpable disparity in how much time was spent with him.”

[Participant 5, MS4]

Racial concordance was noted to be to be important for patients and families.

“[The patient’s sister said] ‘Well, a Black doctor told me this...but you’re telling me [something else]’.”

[Participant 10, PGY2]

“[The patient’s daughter] gave me... a look; [and said] ‘People who look like us don’t get [quality] care.’ I wonder how my presence [as a Black healthcare provider] could have empowered her to speak...she didn’t mention race... except in private... with me.”

[Participant 12, MS3]

CONCLUSION

- Respondents described Black patients near the end of life receiving poorer medical care or otherwise having negative care experiences.
- While it may not be possible to determine the exact causal mechanisms for each individual situation, the literature suggests patterns of poor treatment are caused by both individual racial bias and structural racism.
- More research with medical trainees and other stakeholders is needed to guide interventions addressing racism’s effect on end-of-life care.