Race, Racism and Health
Providence Medicine Grand Rounds
October 29, 2020

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Christina Harris, MD
Teresa Seeman, PhD
Keith Norris, MD, PhD
UCLA Department of Medicine Office for Equity, Diversity and Inclusion

“Few people are capable of expressing with equanimity opinions which differ from the prejudices of their social environment.”
- Albert Einstein
Speakers and Conflicts of Interest*

• Presenters

• Christina Harris, MD
  - Associate Vice Chair, Dept of Medicine for Equity, Diversity, & Inclusion
  - Associate Professor of Medicine, Division of General Internal Medicine
  - Associate Program Director of Internal Medicine Residency

• Teresa Seeman PhD
  - Associate Vice Chair, Dept of Medicine for Equity, Diversity, & Inclusion
  - Professor of Medicine & Epidemiology, UCLA

• Keith Norris MD, PhD
  - Executive Vice Chair, Dept of Medicine for Equity, Diversity, & Inclusion
  - Professor of Medicine, Division of Nephrology

*Our Biases: We believe in a society grounded in Equity & Justice
Overview

- COVID-19 Pandemic and the Unmasking of Racial/Ethnic Disparities
- Race and Racism
- The Biology of Racism
- The Endemic: Police Brutality and Racism
- A Way Forward

“Every system is perfectly designed to achieve the results it gets.” - Don Berwick

From UCLA Health Care Workers rally for Black Lives Matter – June 2020
Realities of the Pandemic

U.S. CORRECTIONAL FACILITIES REPORT STEEP RISE IN CORONAVIRUS INFECTION RATE

BY MEGHAN ROOS ON 4/16/20 AT 6:33 PM EDT

‘They’re Death Pits’: Virus Claims at Least 7,000 Lives in U.S. Nursing Homes

More than six weeks after the first coronavirus deaths in a nursing home, outbreaks unfold across the country. About a fifth of U.S. virus deaths are linked to nursing facilities.

Native American Deaths Rising at Alarming Rate from COVID-19

Covid-19’s devastating toll on black and Latino Americans, in one chart

The US health system has failed black and Latino populations for decades. Now they're paying the price.

By Dylan Scott | @dylanascott | dylan.scott@vox.com | Apr 17, 2020, 4:10pm EDT
Race Gaps in Covid-19 Deaths

**Figure 2.** Huge race gaps in COVID-19 death rates, especially in middle age

Ratio of death rates

- **White : White**
- **Black : White**
- **Hispanic/Latino : White**

8-10 X higher ratio of death

**Race gaps in COVID-19 deaths are even bigger than they appear**

Tiffany Funk, Sarah Behar, and Richard V. Hernandez - Tuesday, June 16, 2020
<table>
<thead>
<tr>
<th>Structural Racism*</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g. residential segregation, underfunded school systems, poverty, chronic discrimination)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Increase Risk of Exposure</th>
<th>Service Jobs</th>
<th>Poor housing conditions</th>
<th>Public Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Chronic Disease Burden</td>
<td>DM/CKD</td>
<td>HTN/CVD</td>
<td>Asthma/COPD</td>
</tr>
<tr>
<td>Lack of Access to Quality Care</td>
<td>Early testing shortage</td>
<td>Poor preventative care</td>
<td>Low quality hospitals</td>
</tr>
</tbody>
</table>
The Making of Race

The “Scientific” Foundation for Racism

1735 - Carl Linnaeus, father of modern taxonomy: Socially-constructed, hierarchal groupings with specific personal attributes establishing the foundation for racism (“Systema Naturae”).

Americanus (American Indian): obstinate, merry, free, regulated by customs
Asiaticus (Asian): melancholy, avaricious, ruled by opinions
Africanus (Black): relaxed, crafty, negligent, governed by caprice
European (White): muscular, gentle, inventive, governed by laws

Leading Universities taught this through the 1970s

Blumenbach- 1795

Caucasian - “to describe the variety of mankind in south of Mount Caucasus”; He claimed it was the “original” race and therefore the most “beautiful”.

David Geffen
School of Medicine
The Making of Race

- Race is a modern idea.
- Race is not based on biologic or scientific fact.
- Race and American freedom were born together.
- Race is a political construction which shifted over time.

Race was created via pseudoscience as a classification to give power to whites, to legitimize dominance, and to justify slavery.

“No one was white before he/she came to America. It took generations and a vast amount of coercion, before this became a white country.” - James Baldwin
1845
“Manifest Destiny”
To justify colonization and dominance

1899
“The White Man’s Burden”
The moral imperative to govern inferior people

WHITE SUPREMACY:
A historically based, institutionally perpetuated system of exploitation and oppression of continents, nations and peoples of color by white peoples; for the purpose of maintaining and defending a system of wealth, power and privilege.
**Individual Racism** -
Bigotry or discrimination by an individual based on race.

**Institutional Racism** -
Discriminatory treatment, unfair policies and inequitable opportunities and impacts, based on race, produced and perpetuated by institutions.

- Health Care
- Education
- Employment
- Criminal Justice
- Housing
Structural Racism

The System which perpetuates Racial Inequities

- White Supremacy
- Education
- Health Care
- Criminal Justice
- Employment
- Housing
- Exclusion
- Marginalization
- Exploitation

It’s as ubiquitous as the air we breathe, for those allowed to breathe.
It’s as ubiquitous as the air we breathe, for those allowed to breathe.
FDR New Deal created Homeowners’ Loan Act in 1933: Billions of dollars in low-interest loans for home ownership

- Black Americans were systematically excluded because of redlining practices

FHA Underwriting Manual 1935:
“Important among adverse influences are the following: infiltration of inharmonious racial or nationality groups; the presence of smoke, odor, fog, etc.”

Redlining in Los Angeles

Source: Philip J. Jacob, “Race, Finance, and Inequality.”
Structural Racism in Action - Health Care

[Map of Los Angeles County with various cities and neighborhoods marked, highlighting the structural racism in health care across different regions.]
Structural Racism in Action - Health Care
The Biology of Racism

Society ↔ Structural Racism
Inequity in resources and opportunities
Personal Experiences with discrimination and racism
Health inequities and subsequent impact
Weathering

“Blacks experience early health deterioration as a consequence of the cumulative impact of repeated experience with social and/or economic adversity and political marginalization. On a physiological level, persistent, high-effort coping with acute and chronic stressors has a profound impact on health”

Arline Geronimus
Black vs White Differences in Childhood Adversity

- Family received public assistance
- Parental education < high school (ed<HS)
- Low status parental occupation
- Parental death
- Sibling death

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Family received public assistance</td>
<td></td>
</tr>
<tr>
<td>Parental education &lt; HS</td>
<td></td>
</tr>
<tr>
<td>Low status parental occupation</td>
<td></td>
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<tr>
<td>Parental death</td>
<td></td>
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- Blacks (N=228)
- Whites (N=942)
Black vs White Differences in Adult Adversity

- **Major discrimination events**: 2.9% (Blacks) vs 0% (Whites)
- **Everyday discrimination**: 14.8% (Blacks) vs 0% (Whites)
- **Major Life events**: 3.2% (Blacks) vs 0% (Whites)
- **SES Adversity**: 4.1% (Blacks) vs 0% (Whites)

Blacks (N=228) vs Whites (N=942)
<table>
<thead>
<tr>
<th></th>
<th>Blacks (n=228; avg age=53)</th>
<th>Whites (n=942; avg age=58)</th>
<th>Race Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting glucose (mg/dL)</td>
<td>111.1±42.3</td>
<td>99.9±23.4</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>HOMA-IR</td>
<td>1.5±0.64</td>
<td>1.3±0.55</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>CRP (ug/dL)</td>
<td>1.34±0.80</td>
<td>1.0±0.68</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>IL-6 (pg/mL)</td>
<td>1.5±0.54</td>
<td>1.2±0.51</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>E-selectin (ng/mL)</td>
<td>52.1±28.9</td>
<td>41.3±20.6</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Waist</td>
<td>101.4±18.1</td>
<td>96.5±15.7</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>BMI</td>
<td>32.8±8.6</td>
<td>29.0±5.9</td>
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Allostatic Load = a cumulative index of dysregulation across multiple of the body’s regulatory systems
- Reflecting “wear and tear on the body” / biological aging – i.e. Weathering
- Cumulative effects on multiple biological regulatory systems of living in and adapting to one’s environment.

Consequences = shorter life spans, earlier onset of chronic disease

Predictors = lives characterized by greater stress in the face of fewer resources
# Black vs. White differences in Allostatic Load Over the Life-Course

**Allostatic Load** = count of parameters with values in highest quartile of risk.

- Systolic BP (>127 mmHG)
- Diastolic BP (>80 mmHG)
- BMI (>30.9)
- Glycated hemoglobin (HgA1c > 5.4%)
- Albumin (<4.2 g/dL) *
- Creatinine clearance (<66 mg/dL) *

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Values</th>
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<tbody>
<tr>
<td>Triglycerides</td>
<td>(&gt;168 mg/dL)</td>
</tr>
<tr>
<td>C-Reactive Protein</td>
<td>(&gt;0.41 mg/dL)</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>(&gt;225 mg/dL)</td>
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*bottom 25% for albumin & creatinine clearance|
Early Age Differences and Allosteric Load


**FIGURE 1**—Probability of having an allostatic load of 4 or higher, as predicted by race (a)
Poverty and Allostatic Load


*Note.* PIR = poverty income ratio.

**FIGURE 2**—Probability of having an allostatic load of 4 or higher, as predicted by poverty income ratio (a) and poverty income ratio and race (b).
Figure 3. Predicted diastolic blood pressure (DBP) by PERCEIVED DISCRIMINATION scores in older African Americans and whites.
Differential Weathering in the MIDUS Cohort (ages 35-85)

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Lifetime Discrimination & Inflammation Burden* in Adults: Mid-Life in the US (MIDUS)

Sum top 25%: CRP, IL-6, fibrinogen, E-selectin, intracellular adhesion molecule-1 (ICAM-1) (Ong et al, 2019)
C-Reactive Protein & COVID-19 Severity

CRP Distributions by Race/Ethnicity: MESA
• Summary of health inequalities:
  • How long people live
  • How health differences during their life-times
    • Earlier deterioration in how body systems function
    • Earlier onset of chronic health problems – hypertension, diabetes
    • Worse outcomes from diseases – e.g. COVID-19

• How We Address Health Inequalities – Addressing Structural Racism
Police Brutality & Racism in America: View from the lens of a Black American Faculty

The criminal justice, education and health systems and the laws that support them are key barometers of the level of racism in America.

"That's not a chip on my shoulder. That's your foot on my neck."
Malcolm X
Lynching/Dying in Police Custody

- Many police departments began as slave patrols
- Post slavery/Jim Crow lynching, often led by or supported by police, was the ultimate expression of racism (*fear & oppression*)
- Practice of police sanctioned killing of Blacks is considered a modern-day lynching
  - For White America police = safety
  - For Black America police = fear/oppression
- Over 200 Anti-Lynching Bills since 1918 – still not passed

Message to Black Americans has been and remains clear: Values of White Supremacy & Structural Racism Rule this Nation

- Equal Justice Initiative
Cost of Eliminating Racism vs Keeping Racism

• We do not just have a police, education, employment, or health disparities problem…. **We have a 400-year-old problem of Structural Racism.**
  • It is not a Black American Problem - it is an American Problem –yet its wrath is levied most heavily upon Black Americans

• Racism undermines realization of the full potential of society through the waste of human resources.
  • >$2 Trillion/year lost gross domestic product (GDP)
    • $1-1.5T less revenue generation
    • $200-400B in excess health care costs

Money is there, do we have the will to dismantle Structural Racism?

From UCLA Health Care Workers rally for Black Lives Matter – June 2020
Equity vs. Equality

1. **EQUALITY** imagines an equal world.
   “I care about all students equally”

2. **But the world ISN’T EQUAL.**
   
   BIPOC, LGBTQ+, women and others - through laws, practices, policies, narratives and even terrorism keep most there

3. **And it has BIAS AND SYSTEMIC RACISM.**
   
   Limited health care
   Poor Schools
   Microaggressions
   Implicit Bias
   Prejudiced

4. **Within this same picture, a DIVERSITY lens focuses only on bringing more students into an unequal pathway.**
   
   Limited data and analysis
   Goal setting and action planning
   Faculty & staff training to be equity agents

5. **In contrast, EQUITY redirects resources to the pathways with greatest need to fix barriers and intentionally provide support.**
   
   More people in the “pipeline” but the underlying issues have not been addressed

Adapted from the USC Center for Urban Education
Race, Racism, Bias & Health Institutions
The Pipeline/Affirmative Action Problem:
A legal memo was drafted by a White and Black 3rd year NYU law associates – went to 60 partners at 22 law firms who agreed to review

- **Memo 1** was rated **4.1 out of 5**
  - Associate was noted to be generally a good writer but could work on...
  - Praised for his potential and good analytical skills.
  - Reviewers found an average of **2.9 of 7 spelling and grammar errors** in the memo

- **Memo 2** was rated **3.2 out of 5**
  - Associate was criticized as average at best and needing a lot of work.
  - Can’t believe he went to NYU, average at best
  - Reviewers found an average of **5.8 of 7 spelling and grammar errors** in the memo

Even though they both got to NYU law, the Black Student was not performing as well as his White peer

We can’t compromise quality for diversity

Memo 1 and 2 were identical with identical names

We can and do compromise quality for Bias every day

Patient-physician gender concordance and increased mortality among female heart attack patients

Gender concordance and patient survival: 90% confidence interval displayed. Estimates include controls and hospital quarter fixed effects. **Comparison group is male doctor, male patient.** $n = 581,797$ for full sample, $n = 134,420$ for matched sample.

Estimates displayed in the absence of the physician fixed effect to allow comparison across physician race. Includes controls, hospital fixed effect, and time fixed effects. The 95% CI is displayed.

Ref - Patient White–Physician White

Brad N. Greenwood et al. PNAS 2020;117:35:21194-21200
Race Implicit Association Test (IAT)
Doctors, Researchers and Lawyers

Cohen’s D: standardized effect size, comparing the mean to M=0 (no bias), D of 0.2 = small effect, D of 0.5 = medium effect, and D of 0.8 = large effect.

Data from Project Implicit®, operated at Harvard University (https://implicit.harvard.edu/)

N = 344,469
N = 2,535
N = 6,144
N = 7,952

Dr. White can only be described as motherly. You know that if you’re going to be on call with her there you won’t be hungry because she will bring lots of snacks. She is a very kind, caring person and it is reflected in how she treats her patients as well as her coworkers.

- Keith Riggs, MD

Dr. Nwogwugwu makes her team feel loved by how she helps us and brings joy to a stressful day. Her small acts of kindness show that she cares and is there for us. She is direct and honest. Not only is she tactful when giving feedback, but she also provides practical solutions and really helps you to believe in yourself. I wish I had more time to learn from her.

- Kelcie Alexander, MD

Dr. Brock is smart, friendly, and caring. He is also efficient and analytical. His work has laid the foundation for large prospective studies that may answer critical questions to predict and prevent complications of monochorionic twins, including death or severe long term disability. He is an exceptional talent with great potential ahead. We are excited to have him join our Fetal Intervention family!

- Dr. Ramesh Papanna, MD, MPH

I learned so much from Dr. Nasab. She is so cool to be with in the OR, always with a new technique or trick. I appreciated the time she took to teach us and make us better. She is a very caring person. Susan is also super funny, and has amazing stories. She is going to be an amazing REI!

- Adeborewale (Wale) Odulate-Williams, MD

Dr. Simpson not only is a rockstar in the OR, but also in the workplace where she jams to music. She is a loveable chef; her easy-going attitude makes her a great person to work with. She is also approachable. Her composure is one of the many qualities I hope to gain. Wish her all the best!

- Aneesh Kothare, DO

Dr. Bergh is a compassionate and brilliant person with a passion for information technology. During his Fetal Intervention fellowship, he has performed >250 procedures, guided by the best - Drs. Ken Moise & Tony Johnson. He has developed multiple novel studies, and continues to do research which will lay the foundation for developmental outcome studies in fetal disease. We are all proud of his accomplishments and thrilled to have him join the Fetal Center team as faculty.

- Dr. Ramesh Papanna, MD, MPH
Psychosocial Stress (Poverty/Discrimination/More) & Cognitive Processing

Stress (to survive) leads to realignment of workspaces that limits cognitive processing

What might happen if an “under-resourced” and/or minority patient makes it to your office and then goes home?

Which ball(s) are your under-resourced and disproportionately minority patients likely to drop
- Rent, food, electricity, new tire, childcare, elder care or
- lifestyle recommendations, f/u visit, meds?
What might happen if a colleague has the usual work/life stress & the additive stress of work/life discrimination/isolation/navigation?

- Reduced spiritual connectedness
- Impaired interpersonal relationships
- Inability to remember
- Inability to implement
- Self-segregation, Avoiding other groups
- Fear, anxiety apprehension

Which ball(s) are your colleagues likely to drop if your institution is not a safe space?
The Way Forward: Society

• Don’t be afraid of bias
  • Everyone can work to minimize bias

• Don’t be afraid of the name Structural Racism. No one on this zoom owned an enslaved Black person or created structural racism
  • Structural racism - mutually reinforcing systems of housing, education, employment, earnings/benefits, credit, media, health care, criminal justice, etc.

• However, everyone can either:
  1. Support structural racism (actively or by doing nothing)
  2. Help to dismantle structural racism to move toward a more just and equitable nation.

Photo from UCLA Health Care Workers rally for Black Lives Matter – June 2020
For Countering Bias & Racism

• Overcoming Unconscious or Implicit Bias
  • Recognize it could be you
  • Focus on treating patients/peers/staff as individuals and not as a category.
  • Practice Empathy, Caring, Respect

• Unraveling the Institutionalization of Racism
  • Revise health system policies
  • Recognize your role as a community resource and/or leader for health – Help change laws/policies that promote inequity and adverse social determinants of health

• Remember: passivity - choosing to perpetuate structural racism

Adapted from Masters C, et al. Addressing Biases in Patient Care with The 5Rs of Cultural Humility, a Clinician Coaching Tool. JGIM 2019;34(4):627-630
Capers Q. How Clinicians and Educators Can Mitigate Implicit Bias in Patient Care and Candidate Selection in Medical Education. ATS Scholar. 2020;1(3):211-7
Caring for Marginalized Patients

What many Patients have

• Discriminated Group
• Limited Income
• Under and Un-Insured
• Low Educational Attainment
• Limited Access to Care
• Impaired Cognitive Processing
• Adverse biologic profile
• Multimorbidity

What many Patients need

• High Quality Care
• Treated with Respect
• Our Empathy
• Our Compassion
• Our Support
• To be given Hope
• Judgement
• Ire
• Lecture

Tell your patients and colleagues that you treat them like family
And then do it!
The Way Forward: Providence Leadership

• Use your platform to highlight the importance to address EDI issues

• Examine how racism/sexism/LGBTQ+ bias can influence hiring criteria/retention and how that may affect your group.

• Review policies to ensure BIPOC, Women, LGTBQ+, disabled and others are not disadvantaged.
  • Make sure you are being inclusive and equity-minded in your communications to your group.

• Adapt processes to measure the impact of EDI behaviors that are often not explicitly valued but critical to organizational success
1. Adding **new actions**, improving existing actions or **stopping ineffective actions**;
2. Increasing the quality and coverage of data available to **monitor progress** towards commitments made and actions taken;
3. Improving reports to better inform reviews of progress; **improving review processes**;
4. Ensuring that the results have meaningful consequences for action (e.g. bonuses, 5-year reviews).
   - This forces leaders to be accountable - not only to ensure commitments are met but to actually understand the issues.
The truth is that there is nothing noble in being superior to somebody else. The only real nobility is in being superior to your former self.

- Whitney Young, Jr.
### The Way Forward: Individual Level

#### Operationalizing implicit bias reduction

- Common identity formation
- Perspective taking
- Consider the opposite
- Counterstereotypical exemplars

#### The 5Rs of Cultural Humility

- Reflection
- Regard
- Respect
- Resiliency
- Relevance

Consider a “bias check” as part of rounds or usual check list

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Capers Q. How Clinicians and Educators Can Mitigate Implicit Bias in Patient Care and Candidate Selection in Medical Education. *ATS Scholar*. 2020;1(3):211-7
The 5Rs of Cultural Humility

**Reflection**

**Aim:** Approach every encounter with humility and understanding that there is always something to learn from everyone.

**Ask:** What did I learn from each person in that encounter?

**Regard**

**Aim:** Hold every person in highest regard, be aware of, and strive to not allow unconscious biases to interfere in any interactions.

**Ask:** Did unconscious biases drive this interaction?

**Respect**

**Aim:** Treat every person with the utmost respect and strive to preserve dignity at all times.

**Ask:** Did I treat everyone involved in that encounter respectfully?

**Resiliency**

**Aim:** Embody the practice of cultural humility to enhance personal resiliency and global compassion.

**Ask:** How was my personal resiliency affected by this interaction?

**Relevance**

**Aim:** Expect cultural humility to be relevant and apply this practice to every encounter.

**Ask:** How was cultural humility relevant in this encounter?