

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

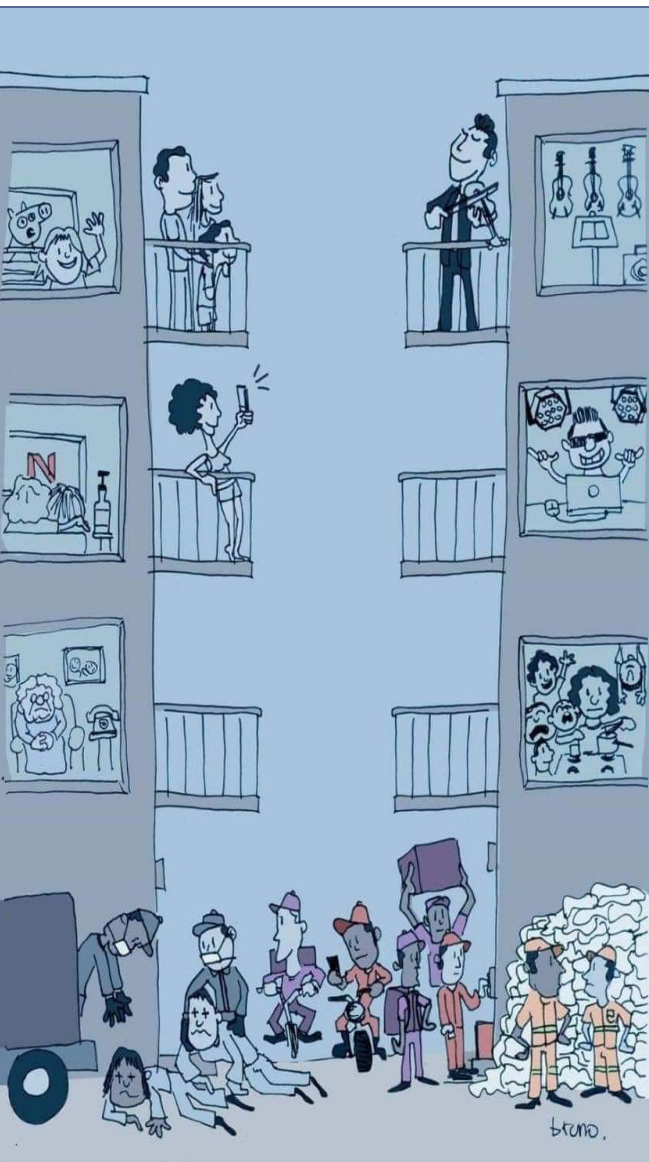


“Every system is perfectly designed to achieve the results it gets.” - Don Berwick





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.

CORONAVIRUS

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 | @dylanScott | dylan.scott@vox.com | Apr 17, 2020, 4:10pm EDT

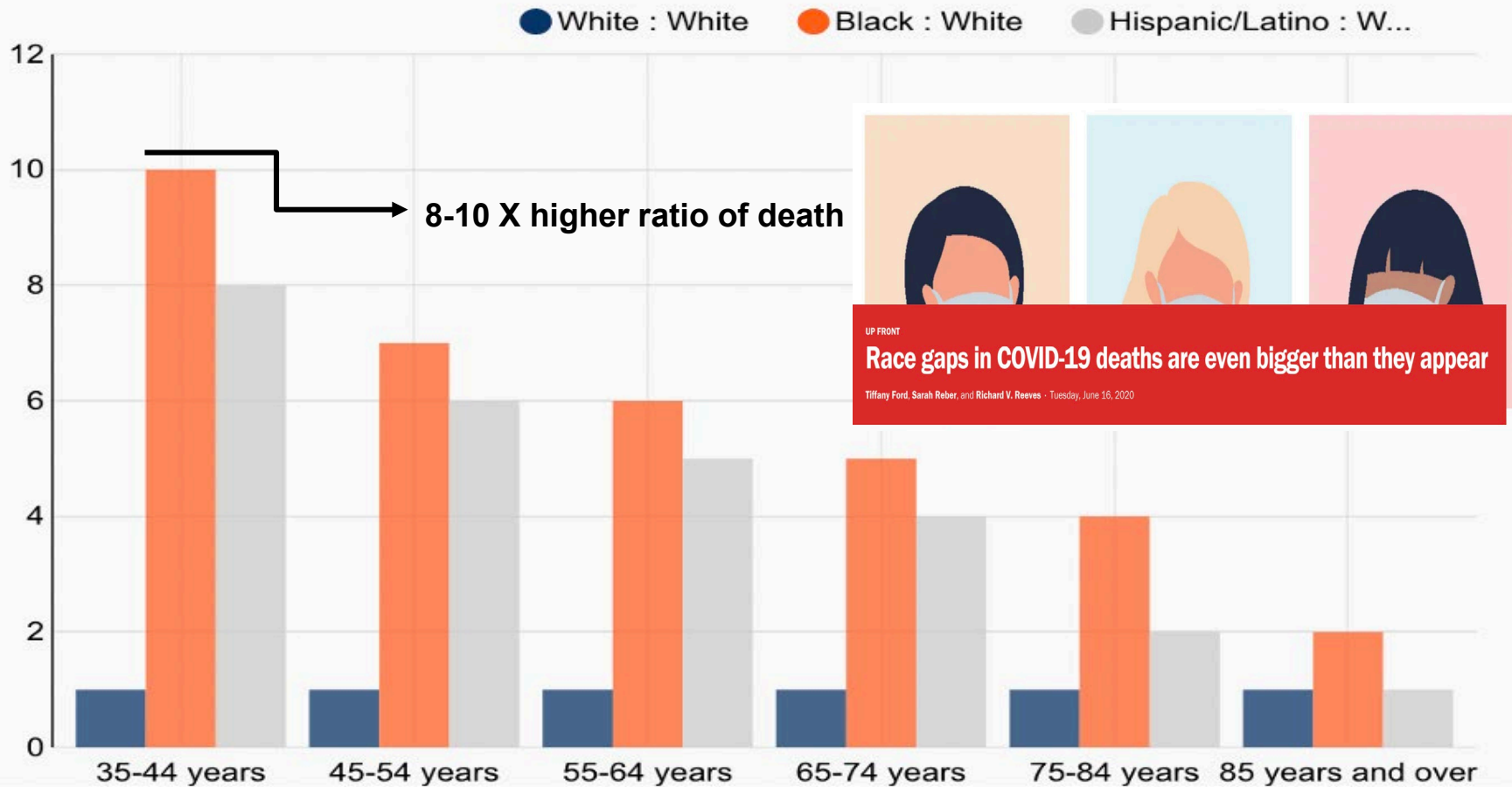


David Geffen
School of Medicine

Race Gaps in Covid-19 Deaths

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

Ratio of death rates



The Makings of a Disparity

Structural Racism*

(e.g. residential segregation, underfunded school systems, poverty, chronic discrimination)

Increase
Risk of
Exposure

Service Jobs

Poor housing
conditions

Public
Transportation

High Chronic
Disease
Burden

DM/CKD

HTN/CVD

Asthma/COPD

Lack of
Access to
Quality Care

Early testing
shortage

Poor
preventative
care

Low quality
hospitals



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”.





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

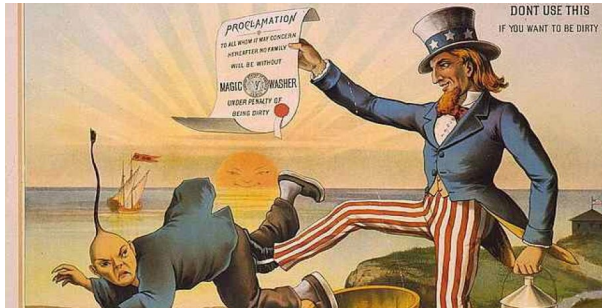


The Making of Race

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.



Race Vs. Racism

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

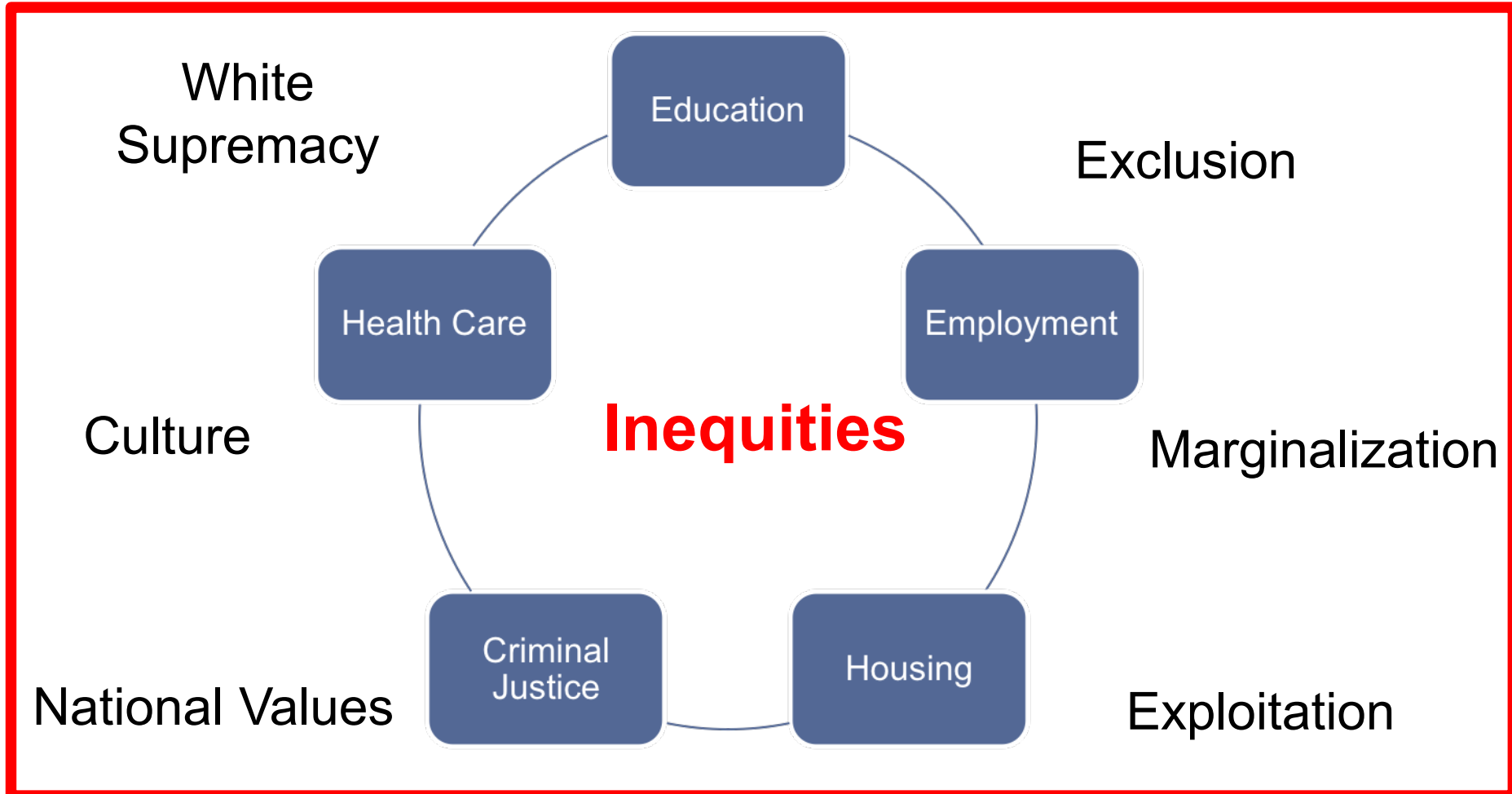
Criminal
Justice

Housing



Structural Racism

The System which perpetuates Racial Inequities

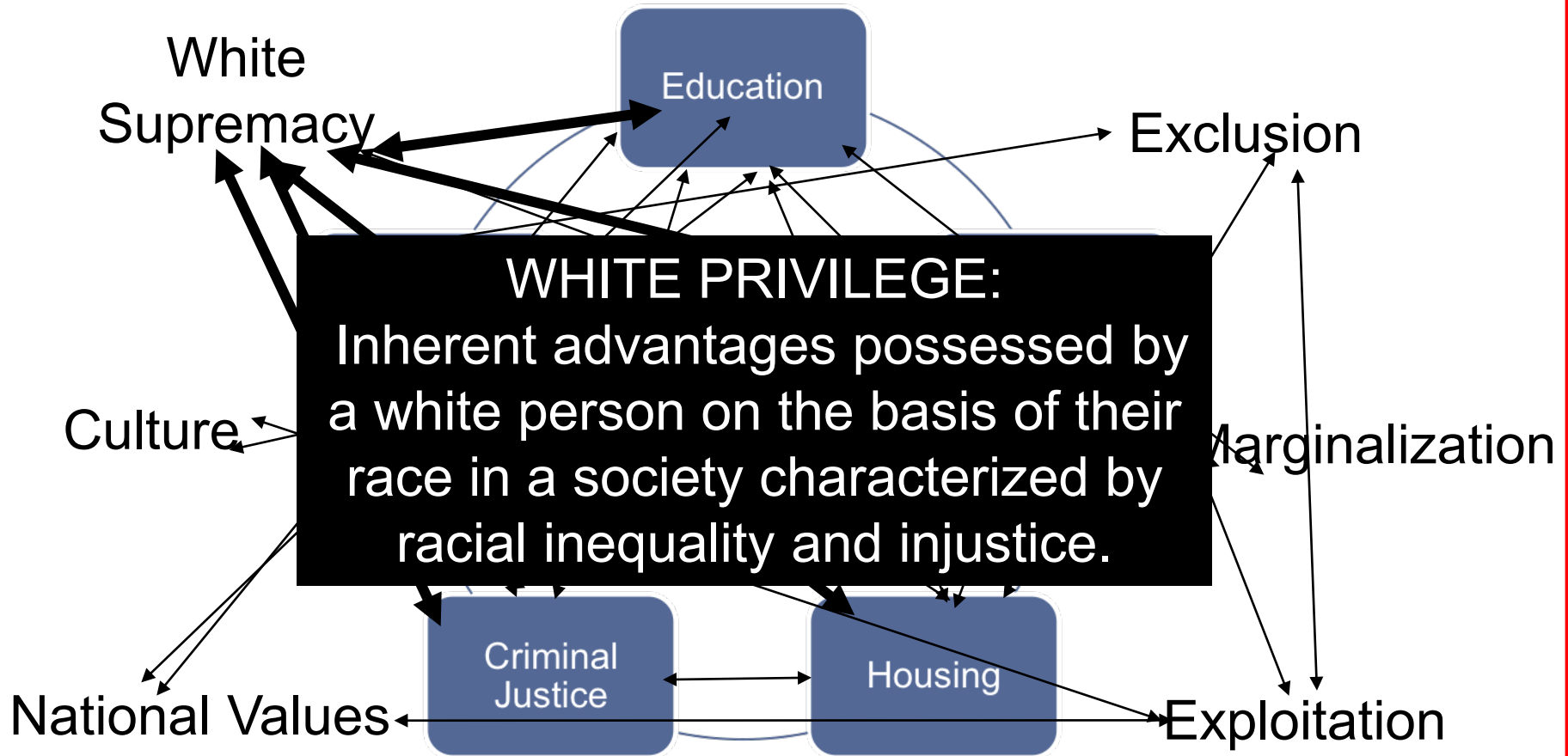


It's as ubiquitous as the air we breathe, for those allowed to breathe.



Structural Racism

The System which perpetuates Racial Inequities



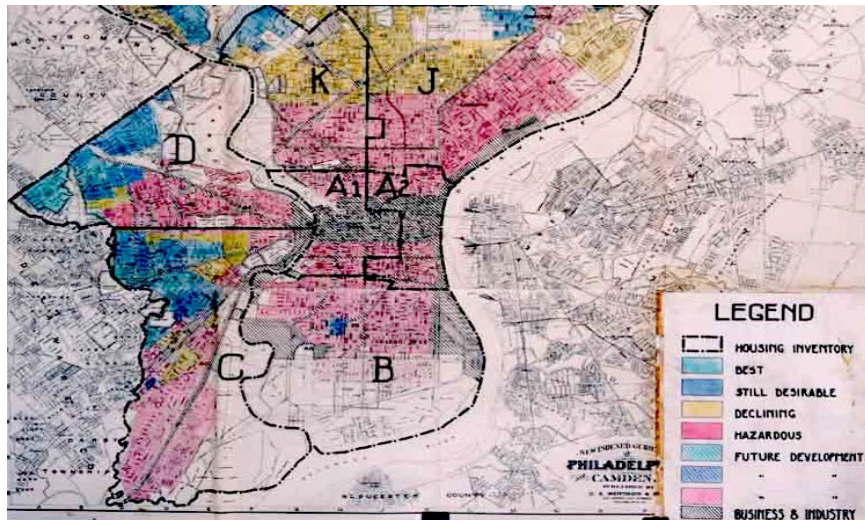
It's as ubiquitous as the air we breathe, for those allowed to breathe.



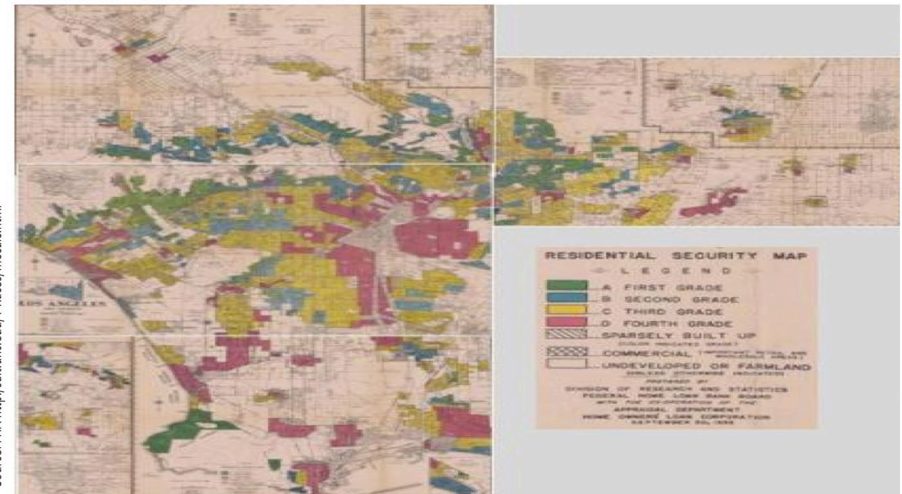
Structural Racism- Redlining

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



Redlining in Los Angeles



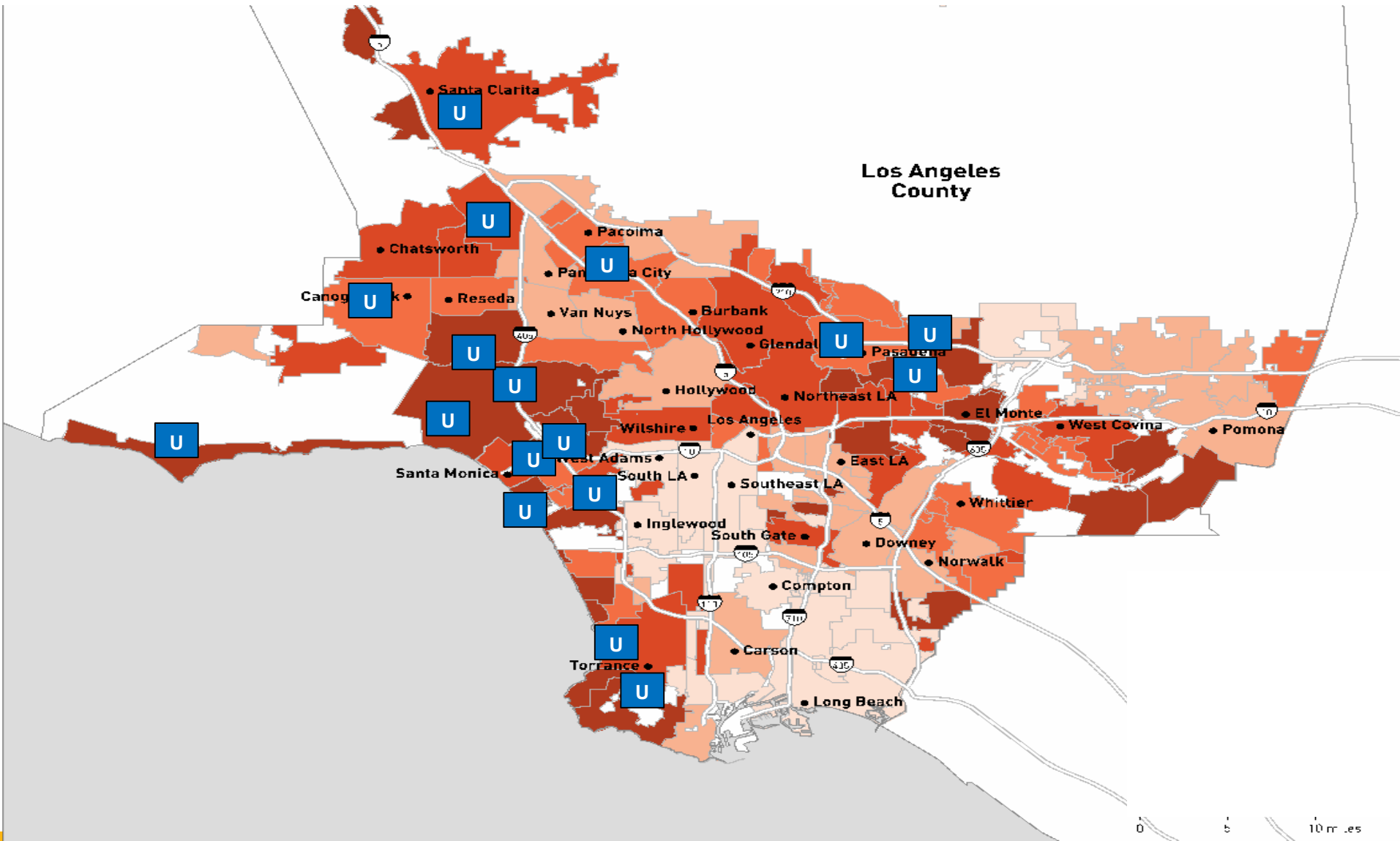
Source: FHA <http://salt.unc.edu/races/mosaic.html>

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.”



Structural Racism in Action- Health Care



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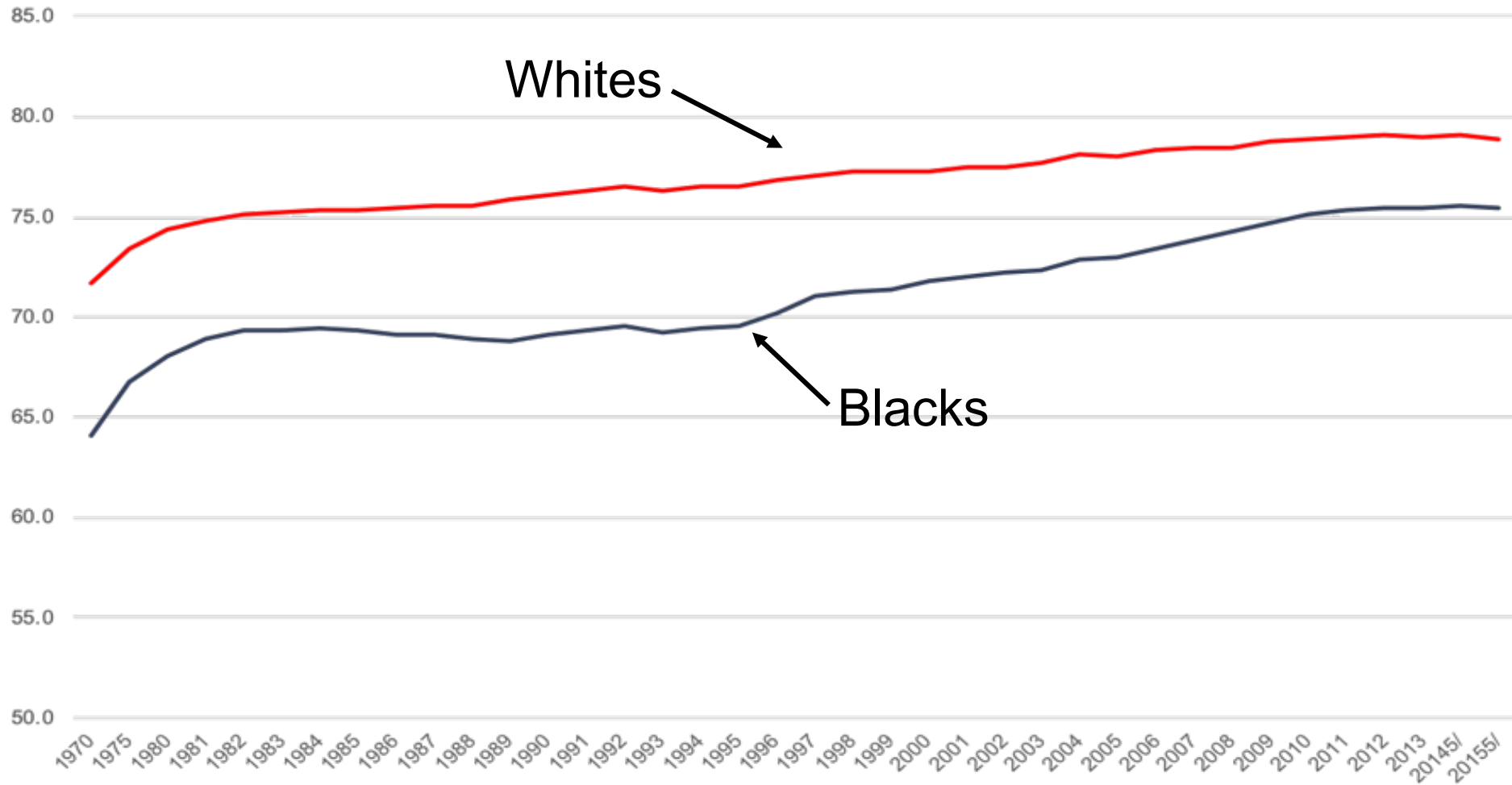
The Biology of Racism



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



US Black vs White Life Expectancy: 1970 - 2015



Biological “Weathering”

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”

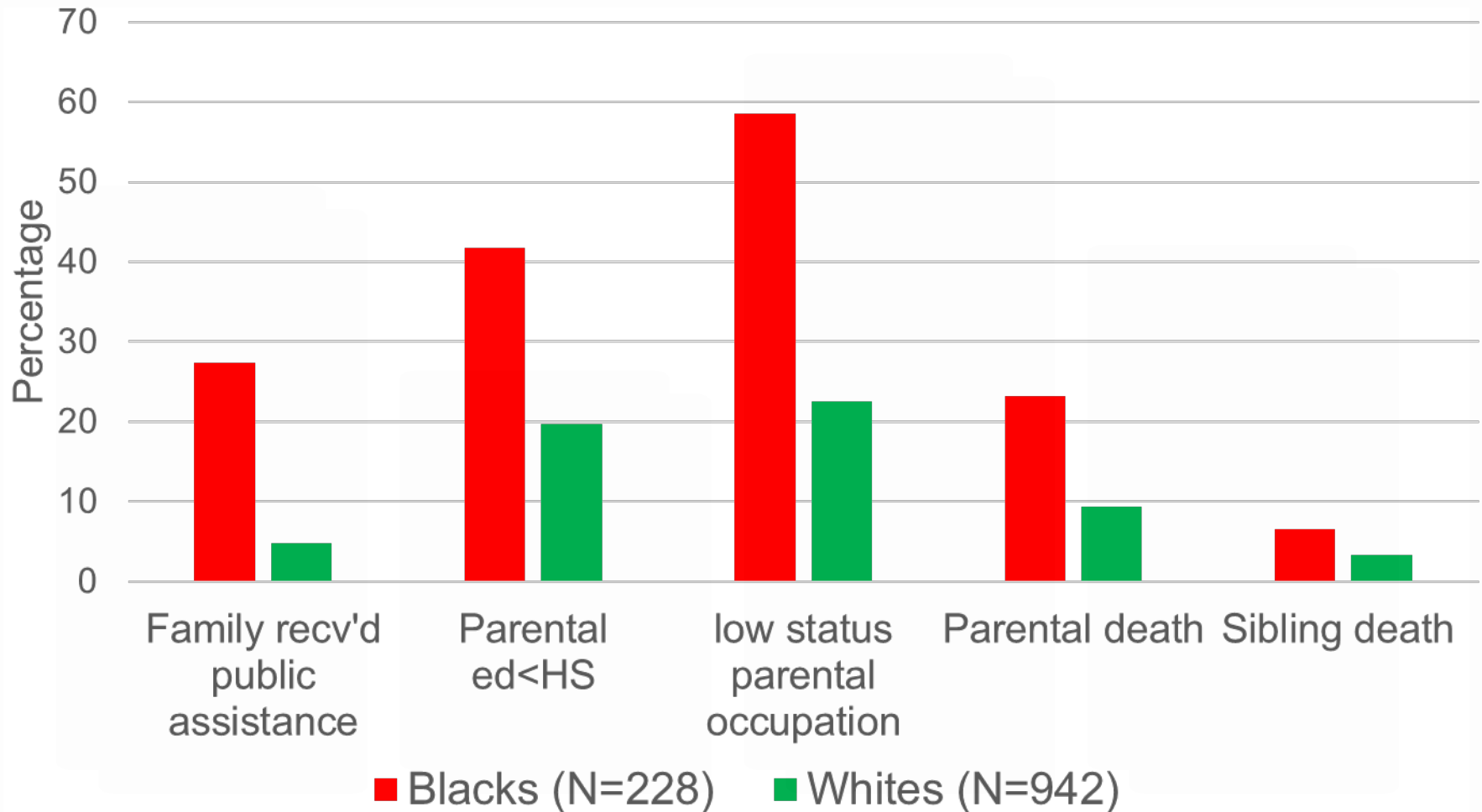
Arline Geronimus



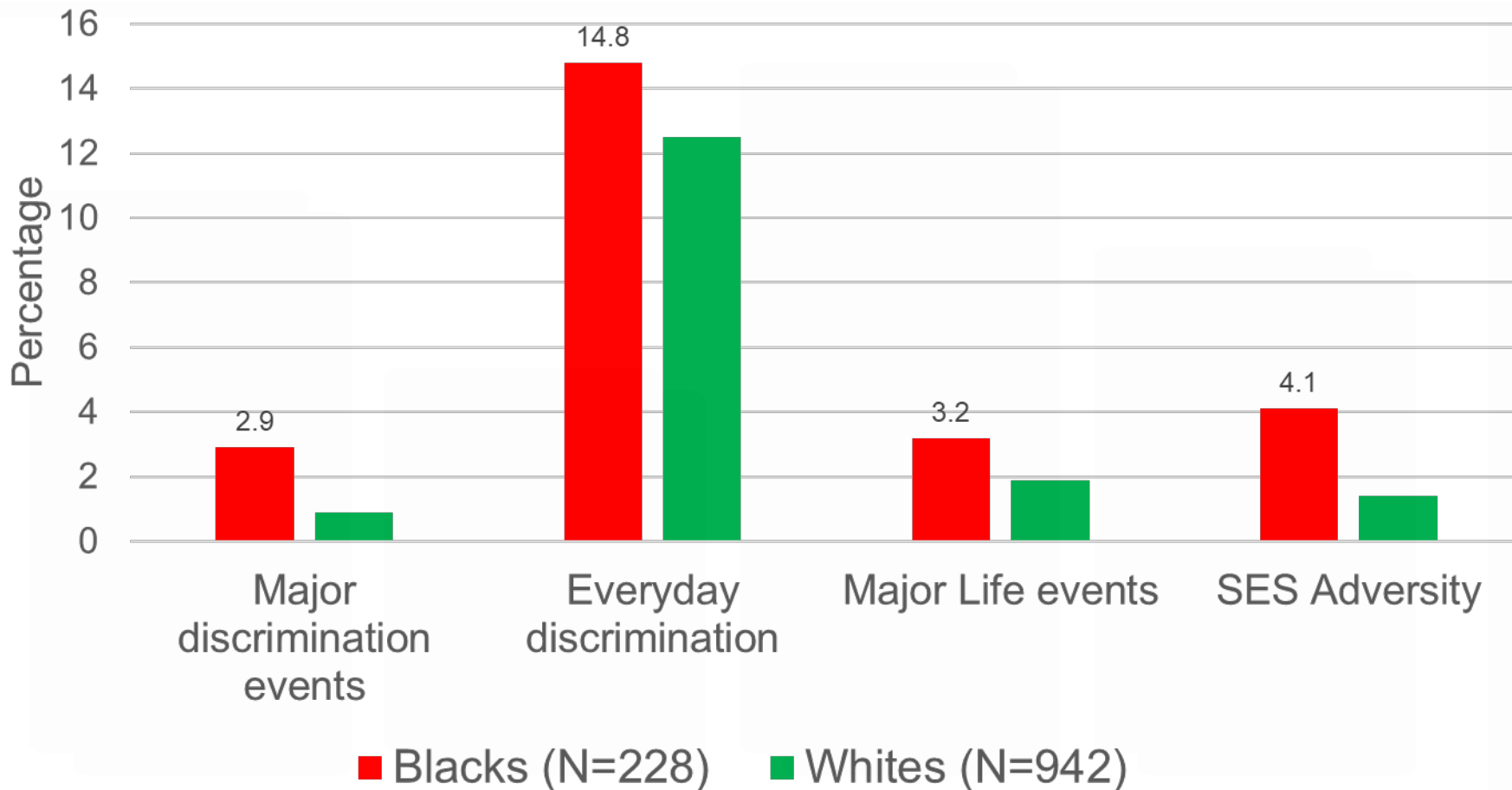
The Aging of the President



Black vs White Differences in Childhood Adversity



Black vs White Differences in Adult Adversity



Differential Weathering in the MIDUS Cohort

(ages 35-85)

	Blacks (n=228; avg age=53)	Whites (n=942; avg age=58)	Race Difference
Fasting glucose (mg/dL)	111.1 ± 42.3	99.9 ± 23.4	<.001
HOMA-IR	1.5 ± 0.64	1.3 ± 0.55	<.001
CRP (ug/dL)	1.34 ± 0.80	1.0 ± 0.68	<.001
Il-6 (pg/mL)	1.5 ± 0.54	1.2 ± 0.51	<.001
E-selectin (ng/mL)	52.1 ± 28.9	41.3 ± 20.6	<.001
Waist	101.4 ± 18.1	96.5 ± 15.7	<.001
BMI	32.8 ± 8.6	29.0 ± 5.9	<.001





Allostatic Load

What is Allostatic Load and how it is important to Structural Racism?

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 ones 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 (>80mmHG)
 - BMI (>30.9)
 - Glycated hemoglobin (HgA1c > 5.4%)
 - Albumin (<4.2g/dL) *
 - Creatinine clearance (<66 mg/dL)*
- Triglycerides (>168 mg/dL)
 - C-Reactive Protein (>0.41mg.dL)
 - Total Cholesterol (>225mg/dL)



Early Age Differences and Allosteric Load

a

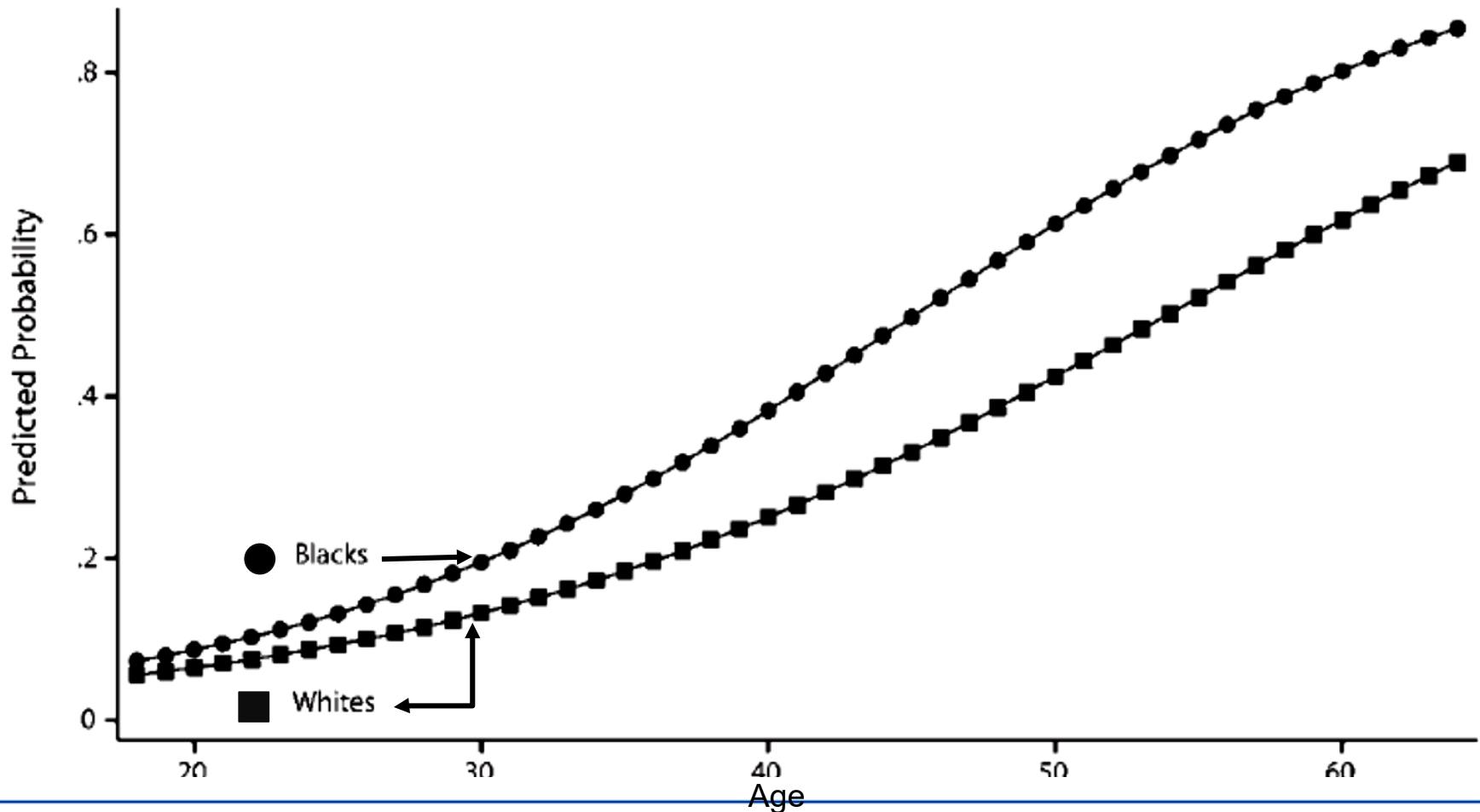


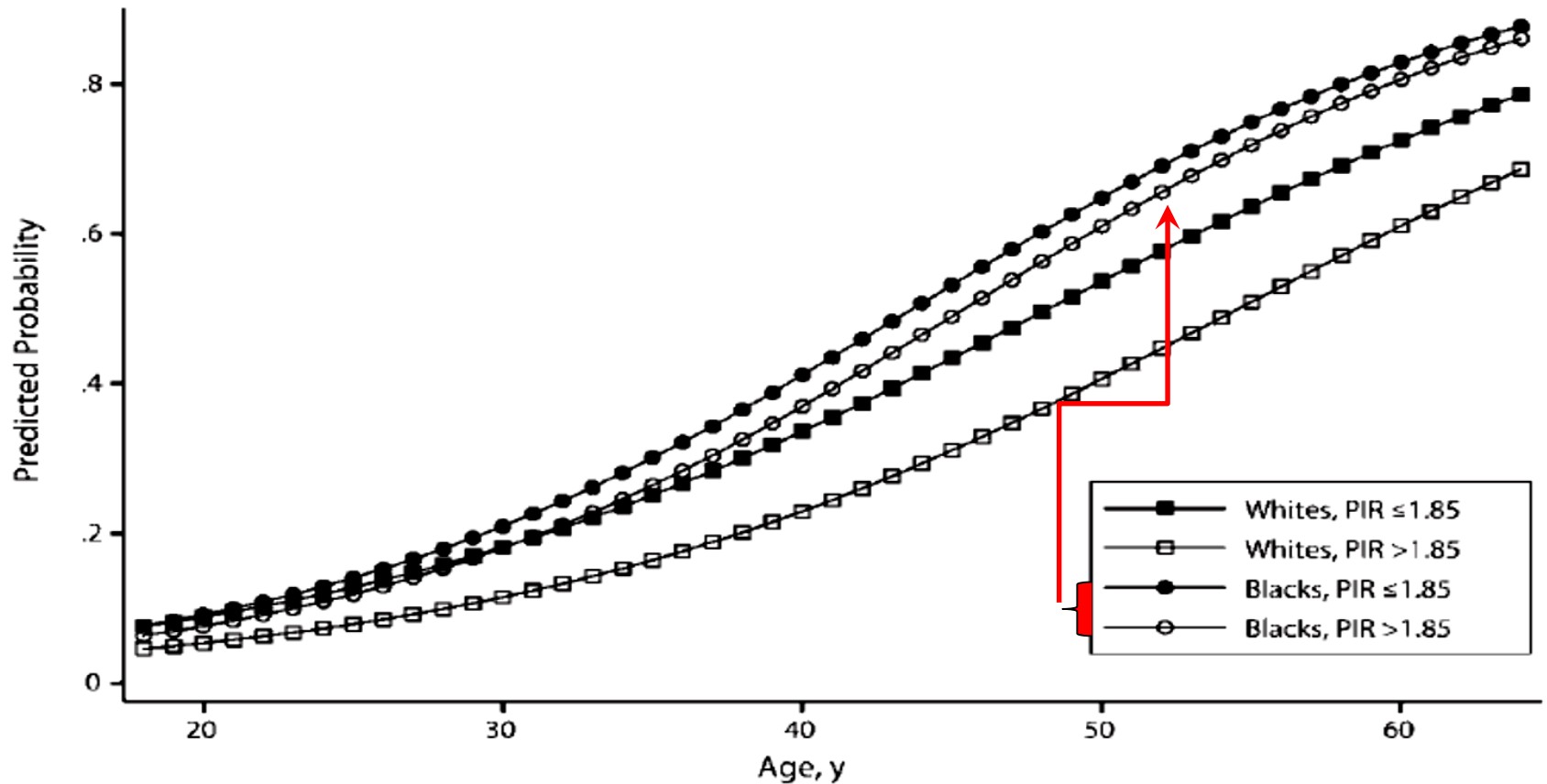
FIGURE 1—Probability of having an allosteric load of 4 or higher, as predicted by race (a)



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Geronimus AT, et al. "Weathering" and age patterns of allosteric load scores among blacks and whites in the United States. *Am J Public Health*. 2006;96(5):826-833. doi:10.2105/AJPH.2004.060749

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).





Perceived Discrimination & Blood Pressure: Chicago Health & Aging Study

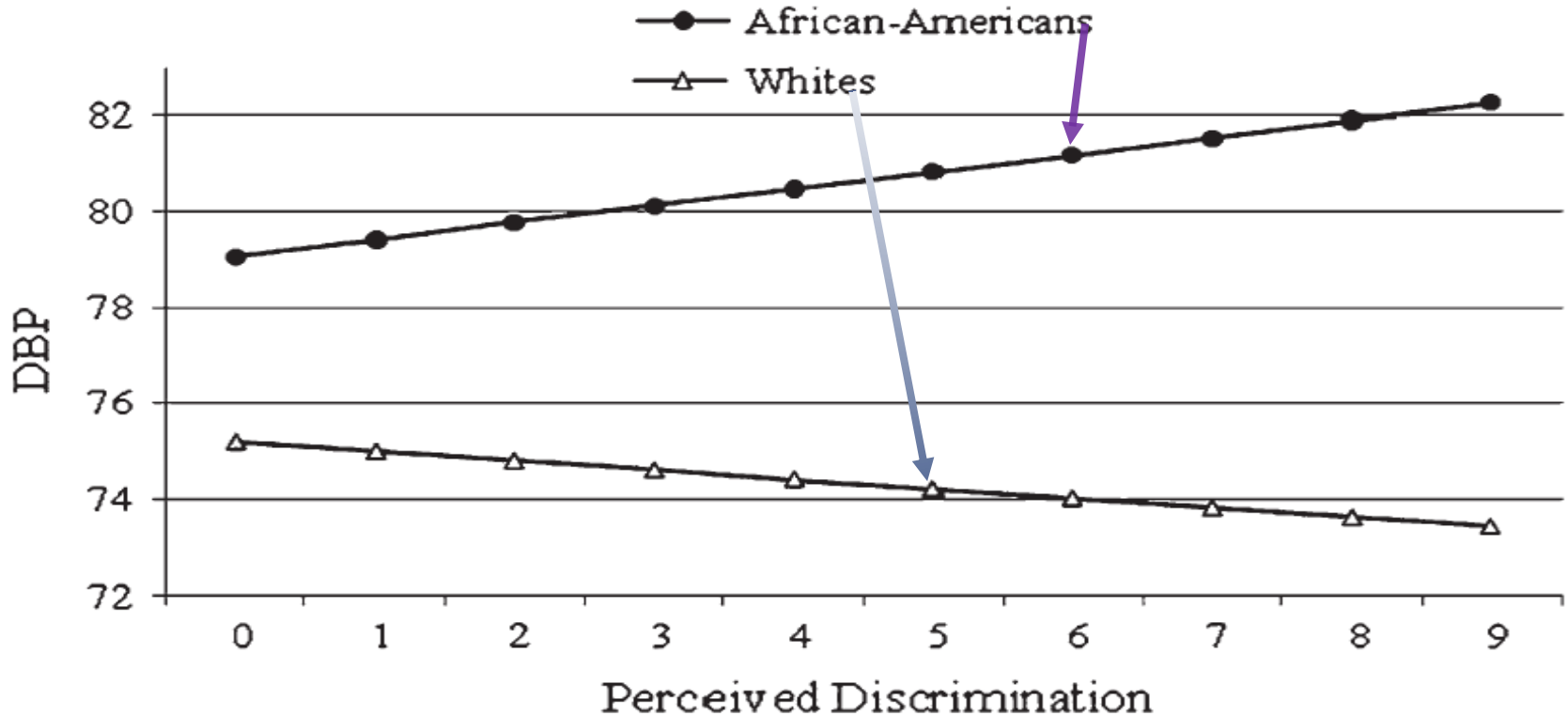


Figure 3. Predicted diastolic blood pressure (DBP) by PERCEIVED DISCRIMINATION scores in older African Americans and whites.





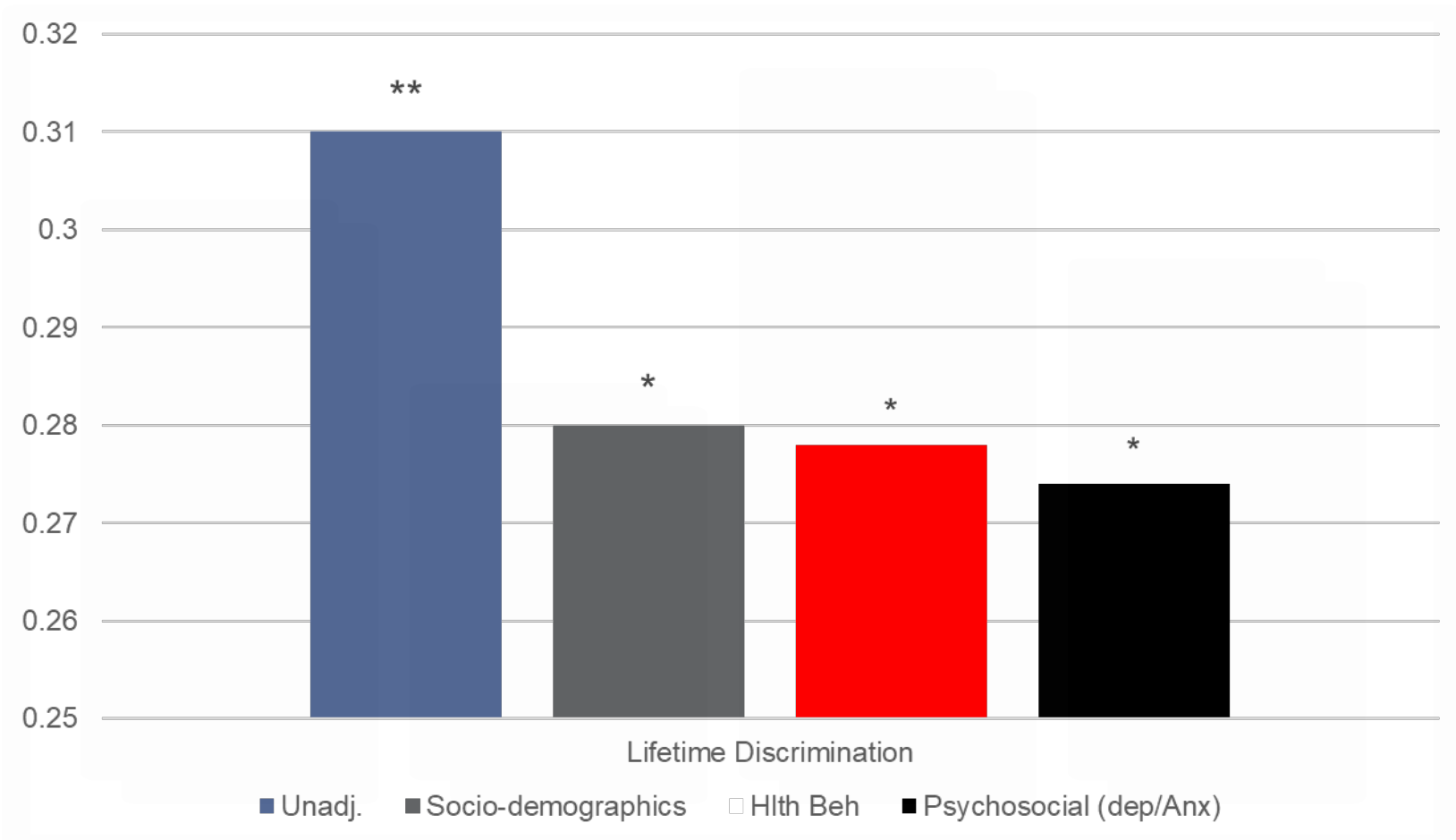
Differential Weathering in the MIDUS Cohort

(ages 35-85)

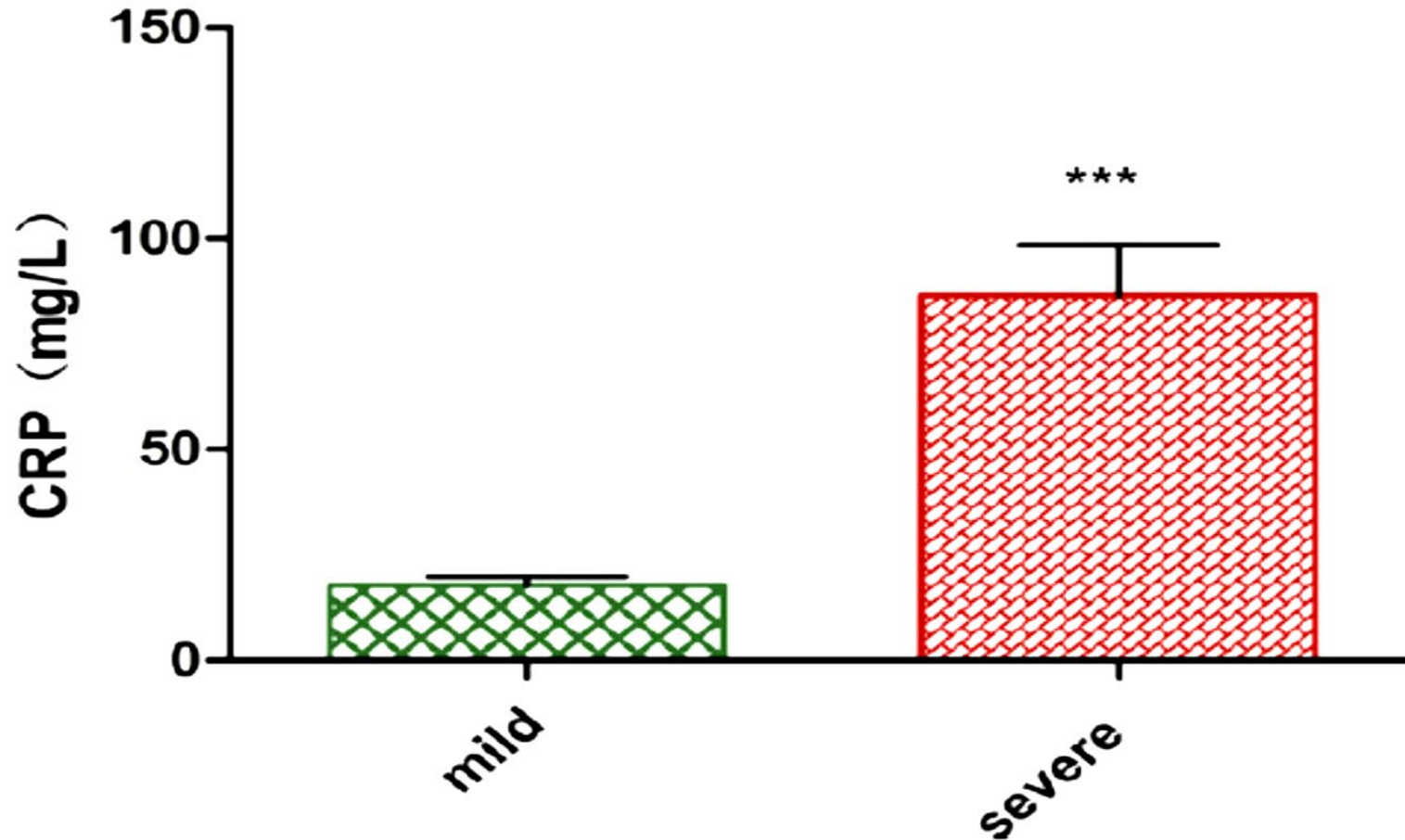
	Blacks (n=228; avg age=53)	Whites (n=942; avg age=58)	Race Difference
Fasting insulin (uIU/mL)	16.5 ± 15.4	12.7 ± 12.2	<.001
Fasting glucose (mg/dL)	111.1 ± 42.3	99.9 ± 23.4	<.001
HOMA-IR	1.5 ± 0.64	1.3 ± 0.55	<.001
CRP (ug/dL)	1.34 ± 0.80	1.0 ± 0.68	<.001
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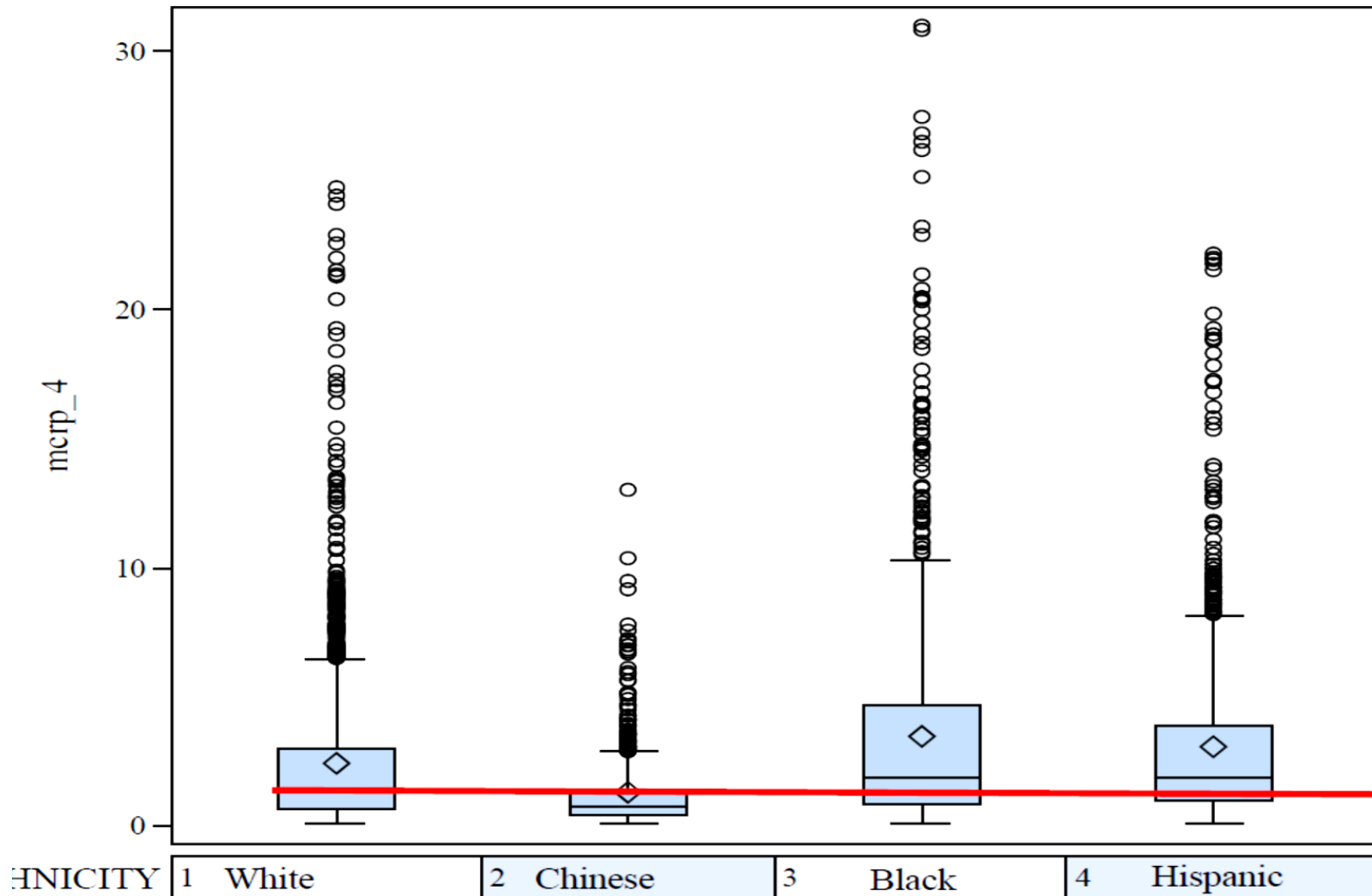
Lifetime Discrimination & Inflammation Burden*in Adults: Mid-Life in the US (MIDUS)



CRP on admission



CRP Distributions by Race/Ethnicity: MESA





Summary/Introduction

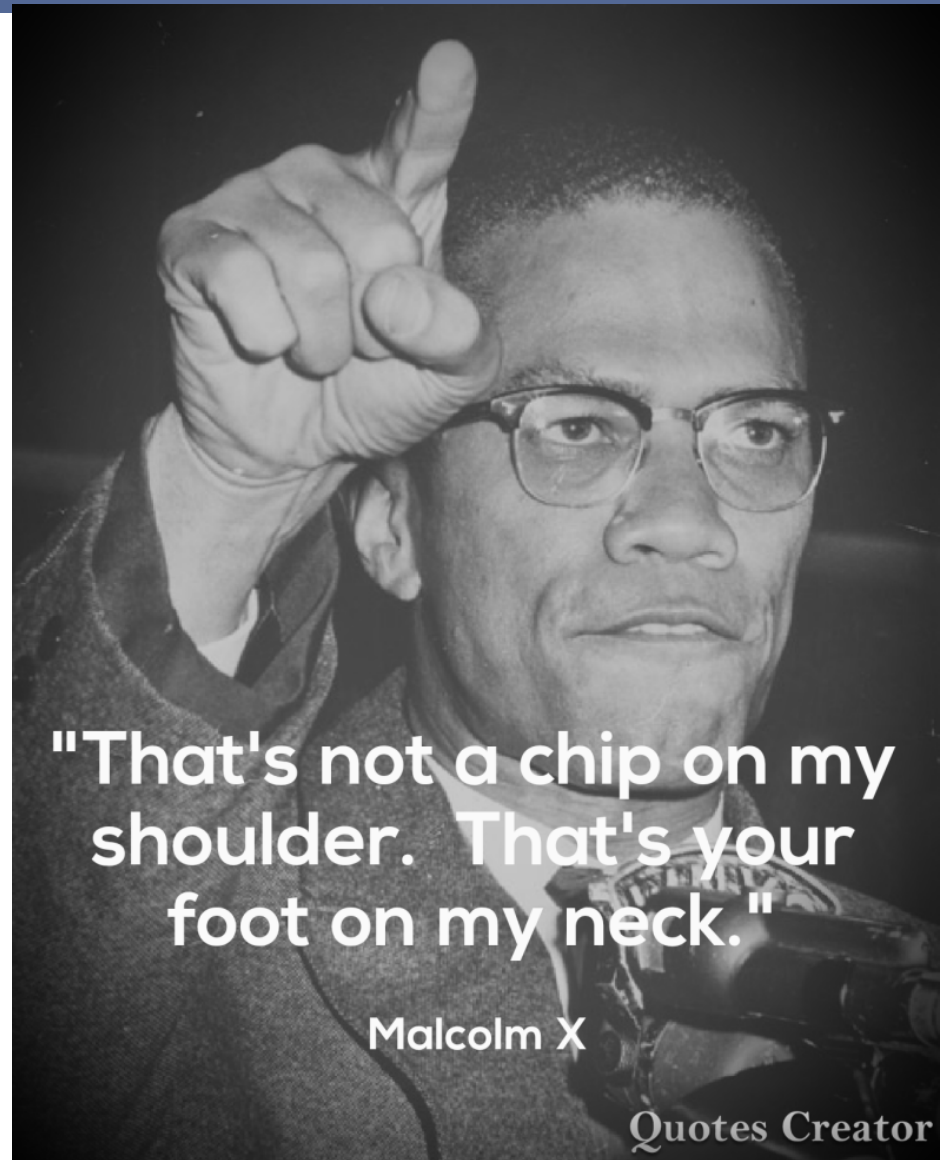
- Summary of health inequalities:
 - How long people live
 - How health differences during their life-times
 - Earlier deterioration in how body systems function
 - Earlier onset of chronic health problems – hypertension, diabetes
 - Worse outcomes from diseases – e.g. COVID-19
- How We Address Health 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.



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





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?

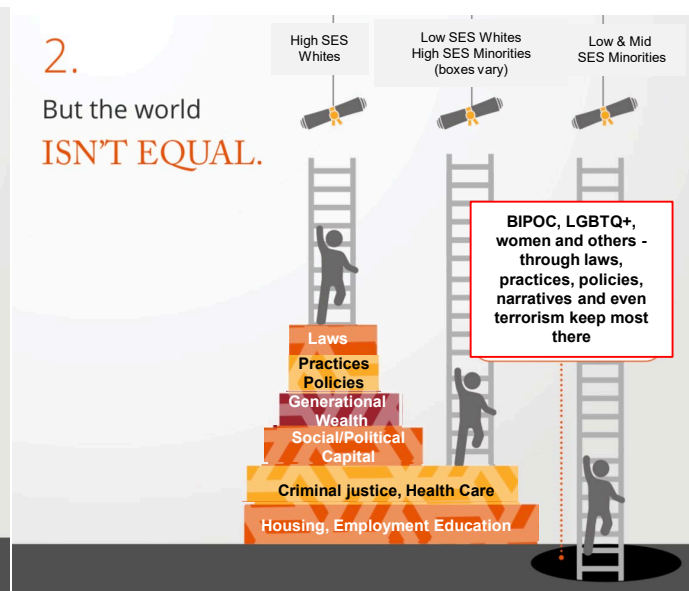
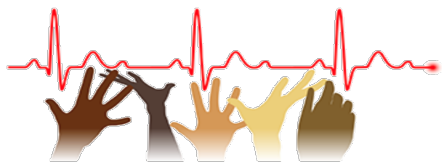




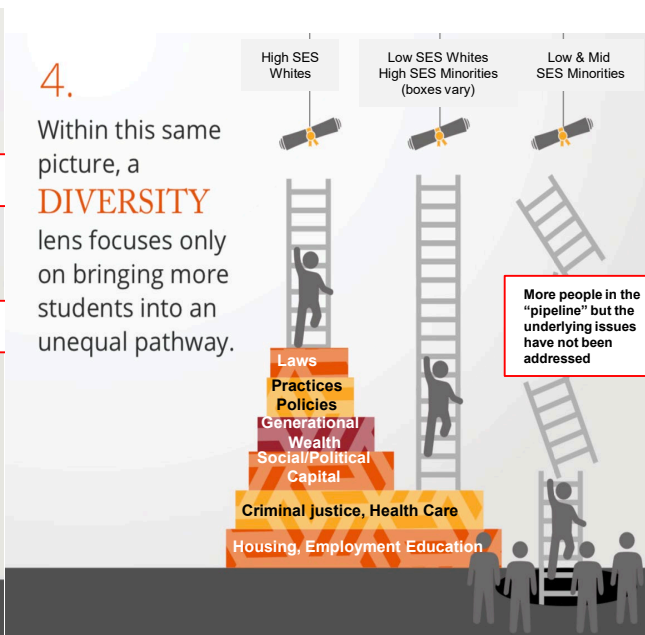
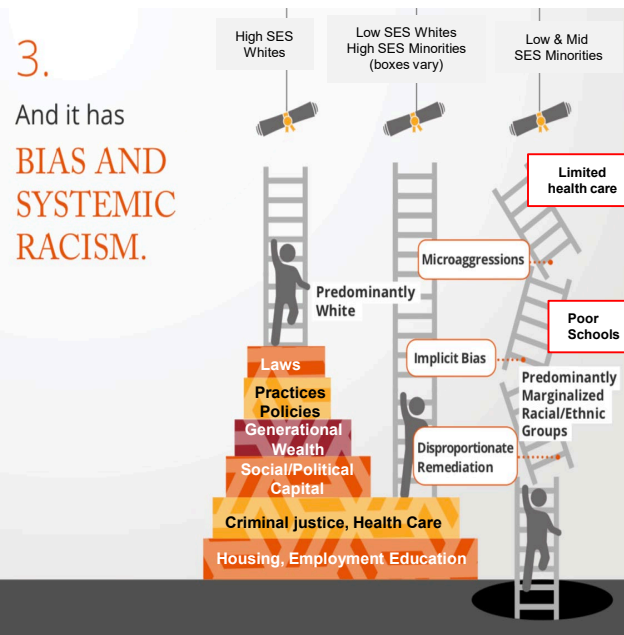
Time For A Cure



Equity vs. Equality



Adapted from the USC Center for Urban Education



Race, Racism, Bias & Health Institutions





The Pipeline/Affirmative Action Problem:

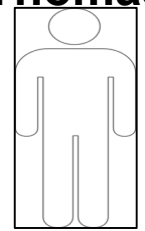
A legal memo was drafted by a White and Black 3rd year NYU law associates –went to 60 partners at 22 law firms who agreed to review

- **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

Thomas Meyer



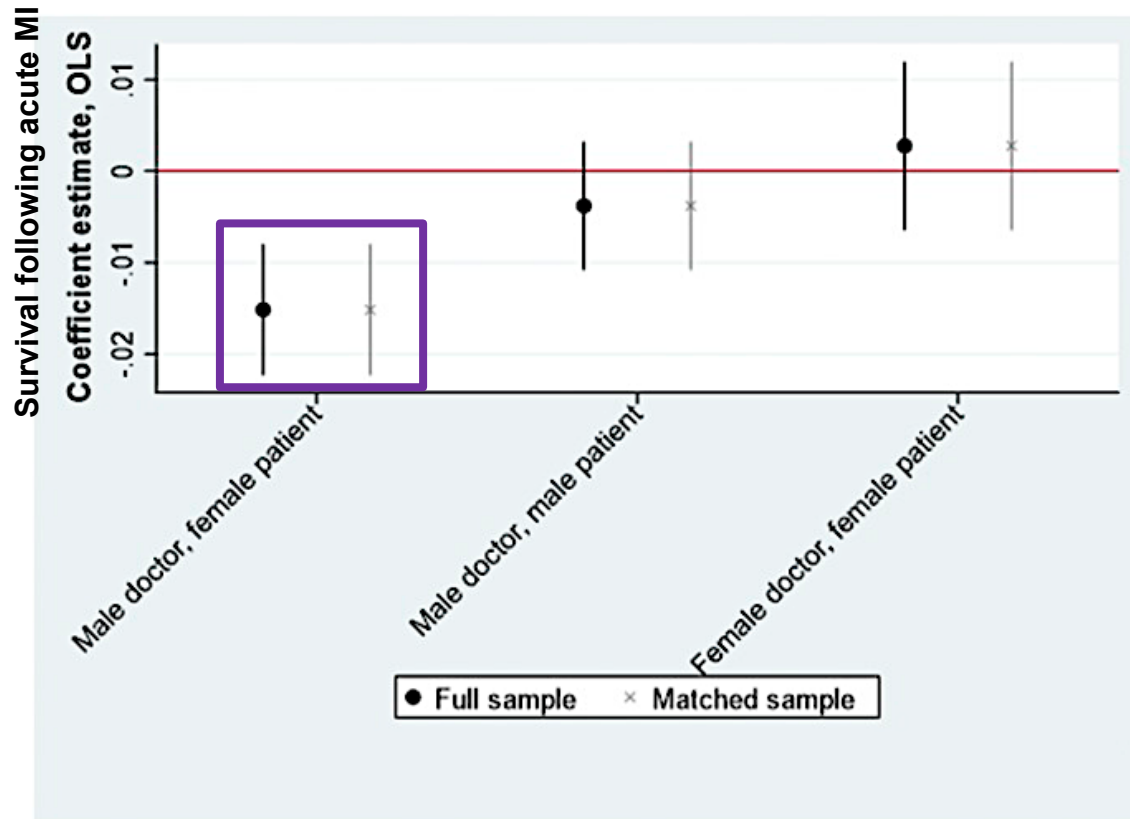
Memo 1 and 2 were identical with identical names

Thomas Meyer



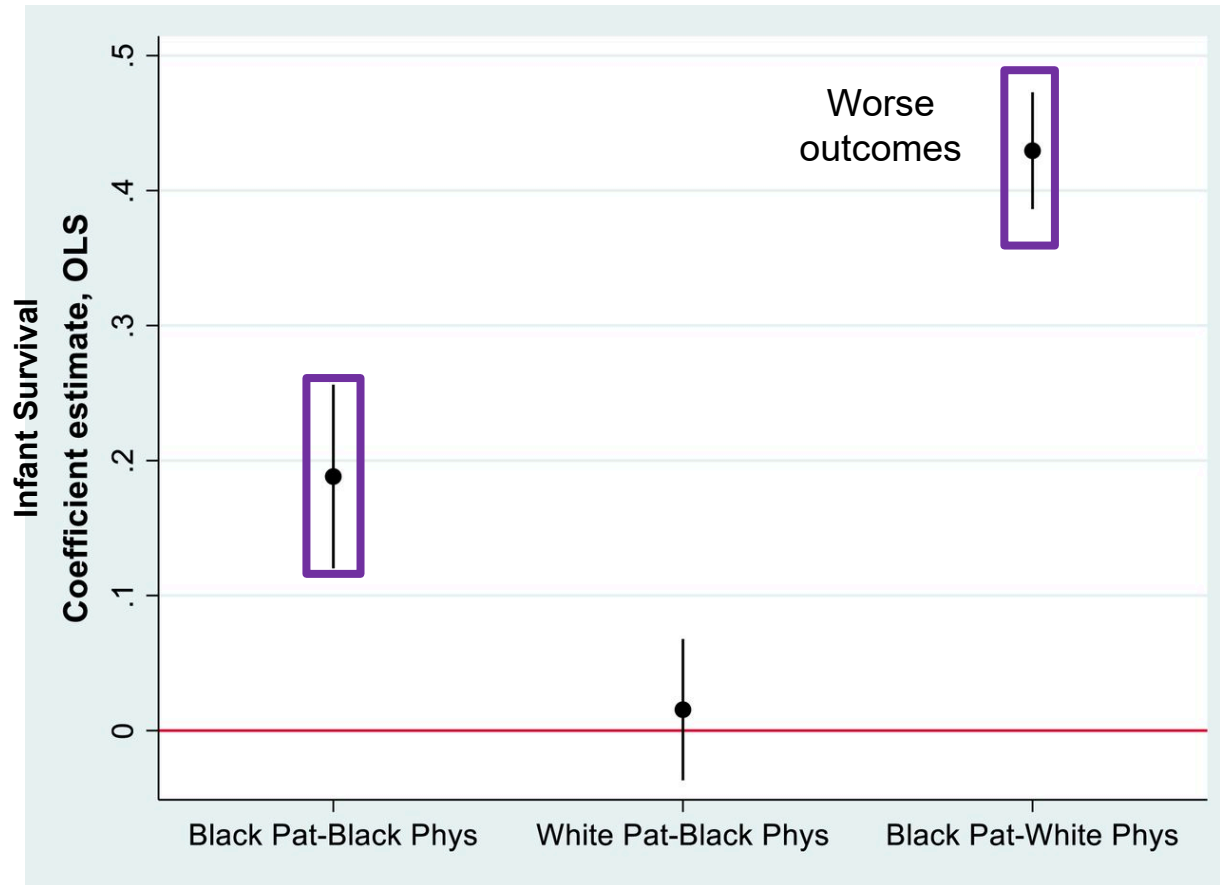
We can and do compromise quality for Bias every day

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

Effect of racial concordance on infant survival

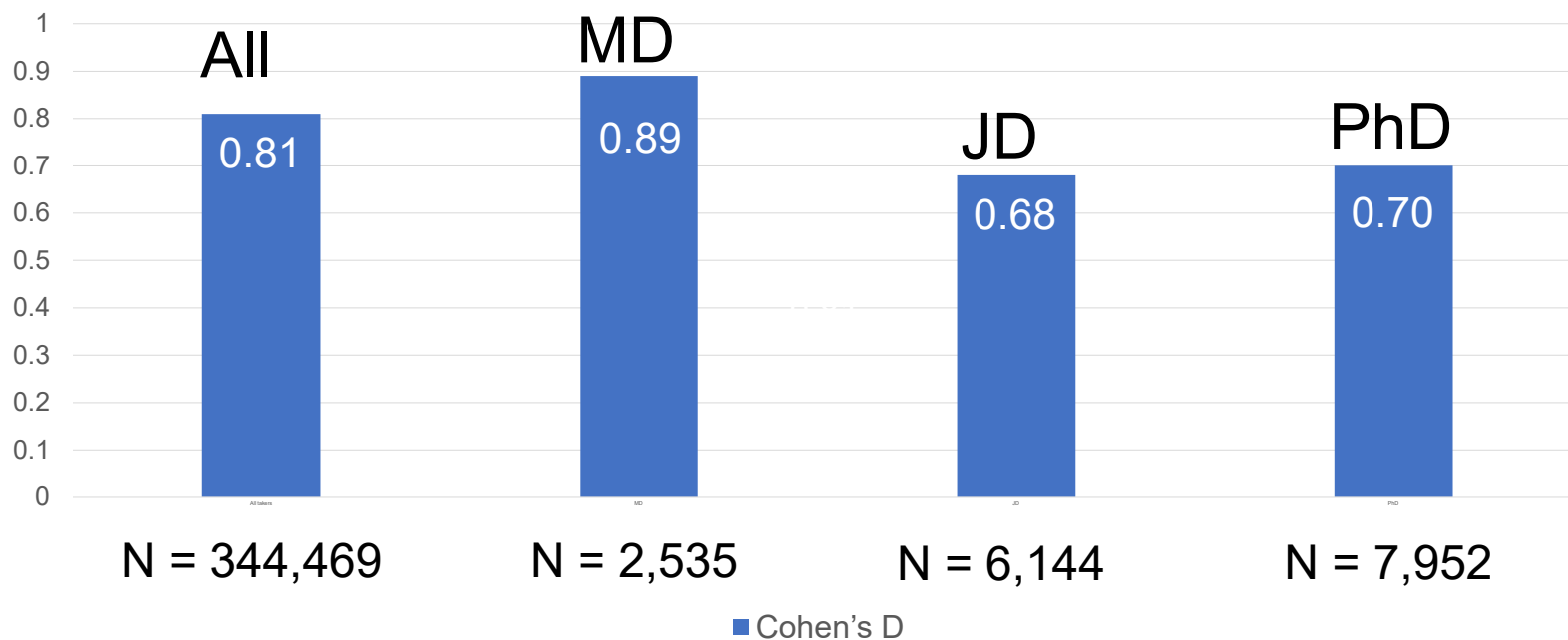


Estimates displayed in the absence of the physician fixed effect to allow comparison across physician race. Includes controls, hospital fixed effect, and time fixed effects. The 95% CI is displayed.

Ref - Patient White-Physician White



Race Implicit Association Test (IAT) Doctors, Researchers and Lawyers



D of 0.5 = medium effect
D of 0.8 = large effect

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/>)



David Geffen
School of Medicine

Sabin J, et al. Physicians' implicit and explicit attitudes about race by MD race, ethnicity, and gender. *J Health Care Poor Underserved*. 2009;20(3):896–913.



Fiona White, MD

*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

 **UTHealth** | **McGovern** #Classof2020
The University of Texas Health Science Center at Houston Medical School @UTHealthObGyn



Susan Nasab, MD

*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!*

- Adekorewale (Wale) Odulate-Williams, MD

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Chizaram Nwogwugwu, 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

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Ivana Simpson, 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** chief; 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

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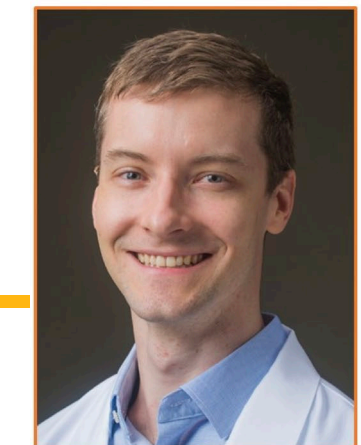


Clifton O. Brock, MD

*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 monozygotic 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

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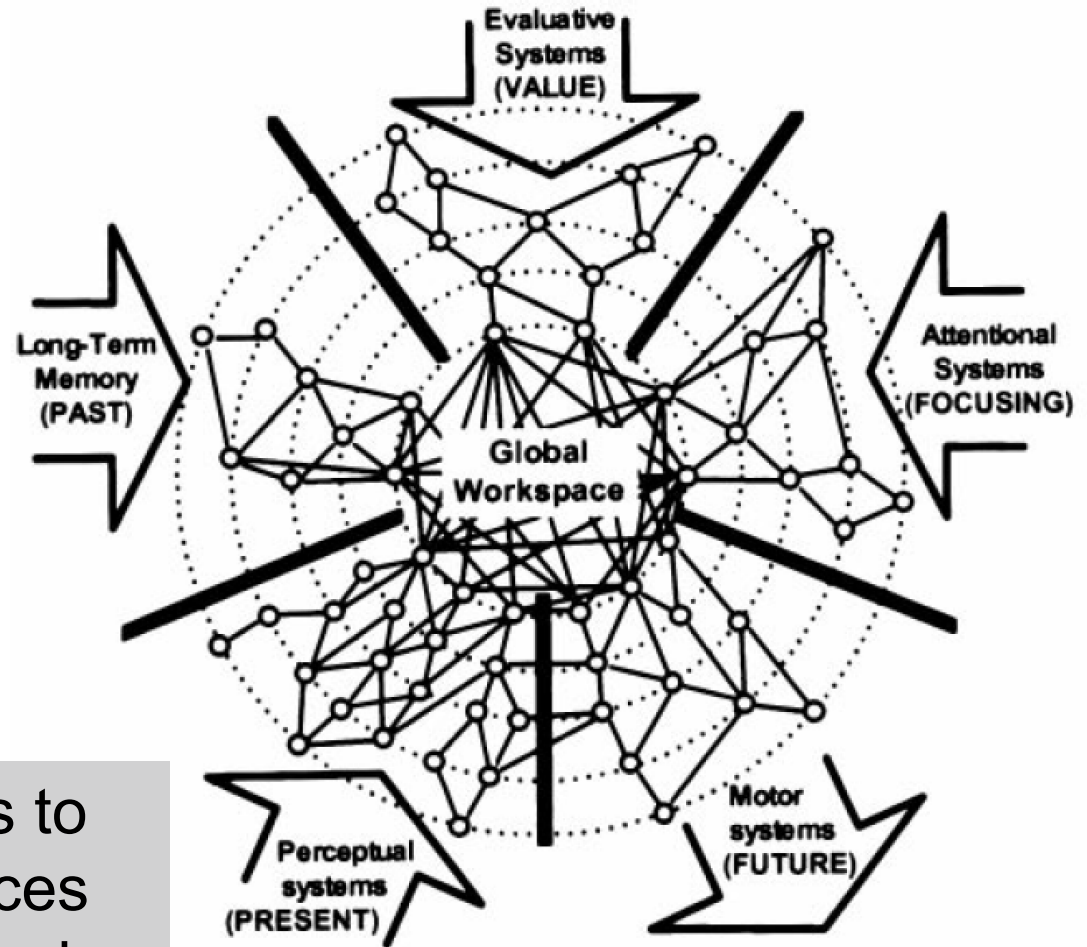
Eric Bergh, MD

*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

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The University of Texas Health Science Center at Houston Medical School @UTHealthObGyn

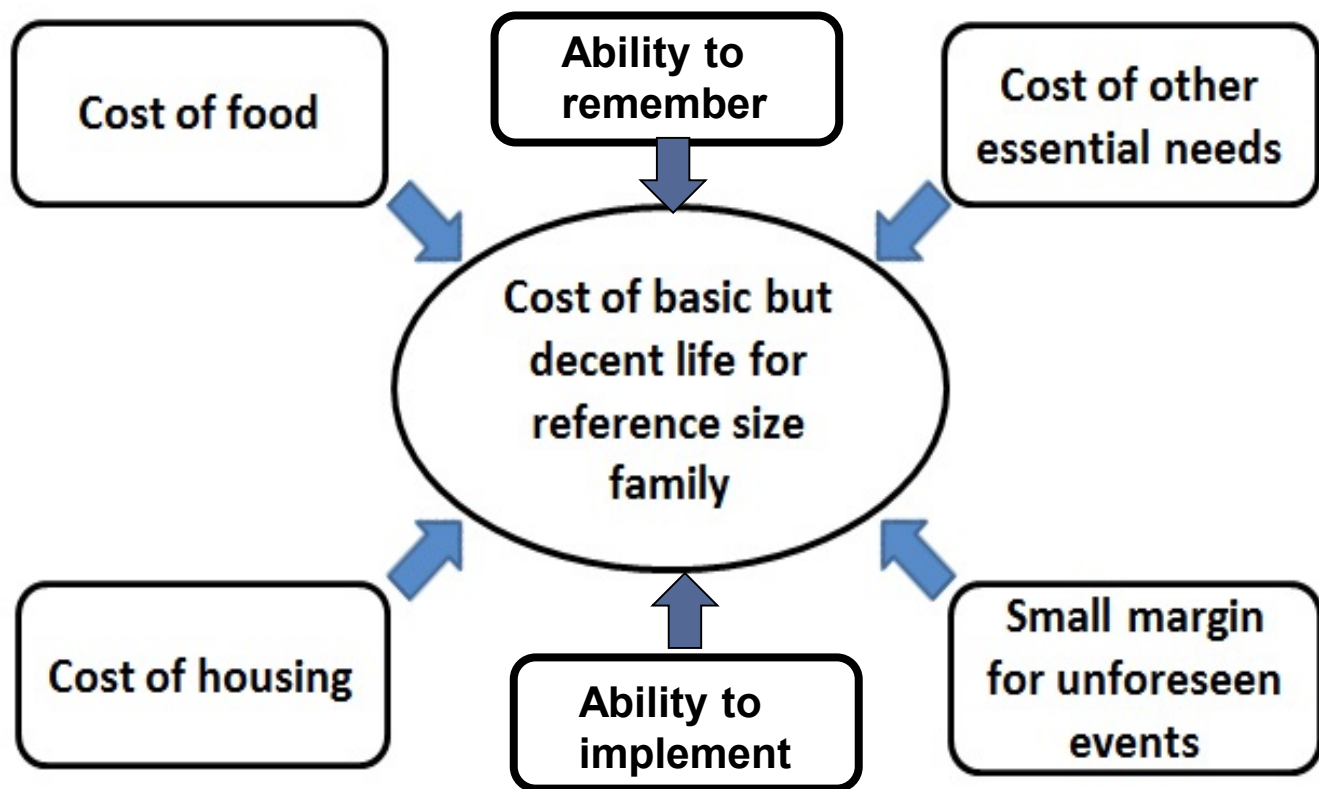
Psychosocial Stress (Poverty/Discrimination/More) & Cognitive Processing



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



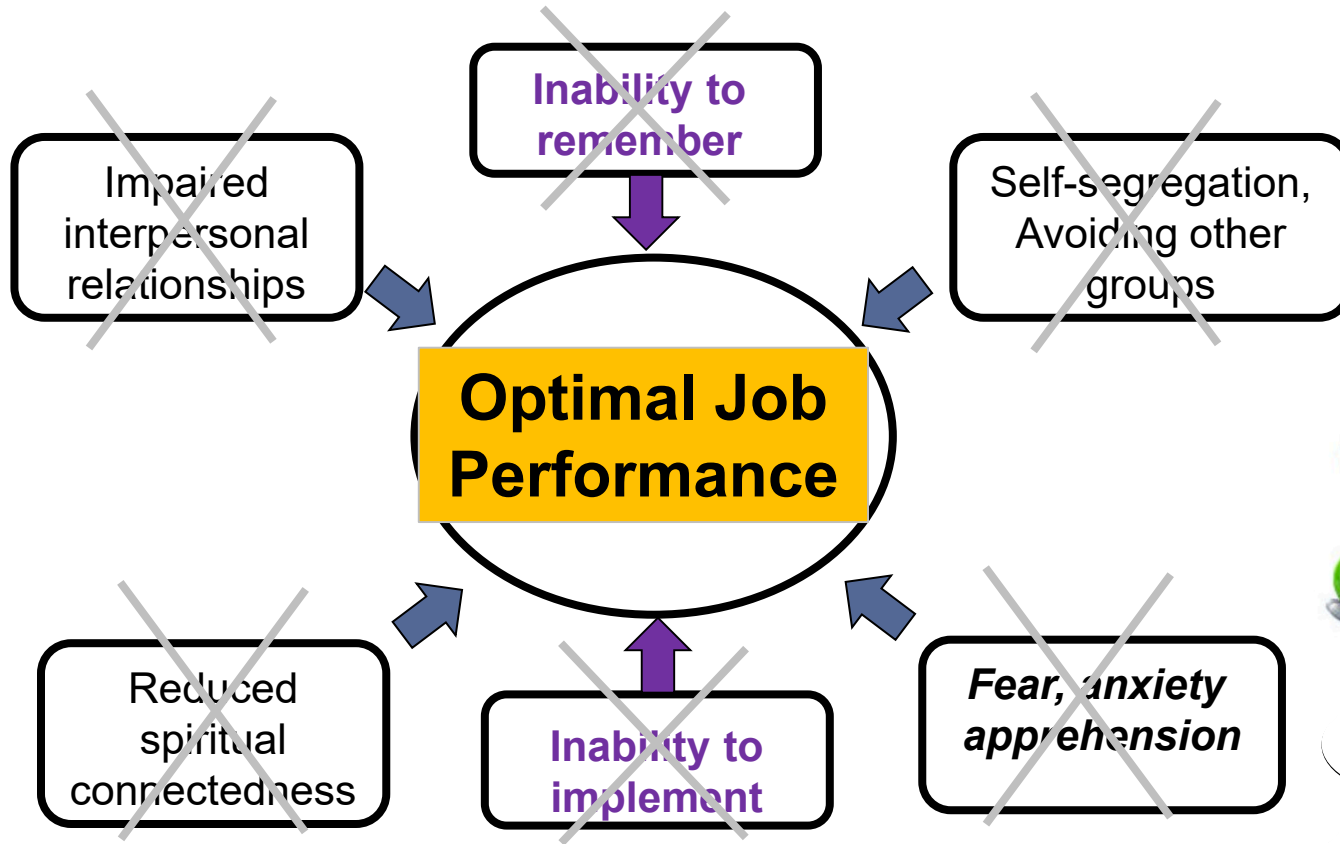
What might happen if an “under-resourced” and/or minority patient makes it to your office and then goes home?



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?



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.**



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

Empathy is

seeing with the eyes of another,
listening with the ears of another,
and feeling with the heart of another.



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!



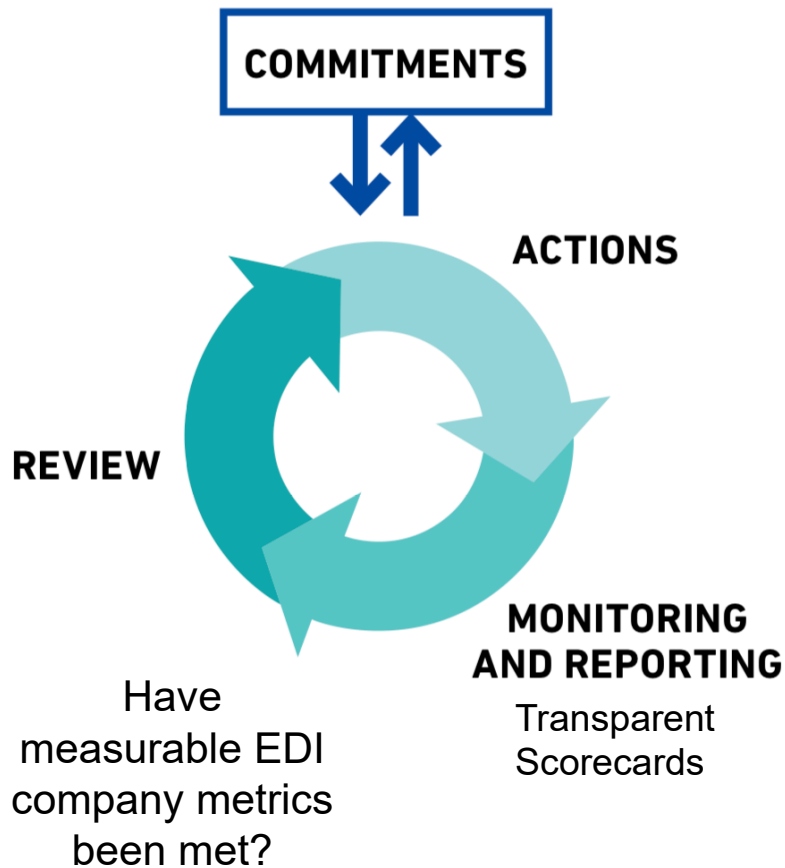


The Way Forward: Providence Leadership

- Use your platform to highlight the importance to address EDI issues
- Examine how racism/sexism/LGTBQ+ bias can influence hiring criteria/retention and how that may affect your group.
- Review policies to ensure BIPOC, Women, LGBTQ+, 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



Institutional Justice & Equity Accountability Framework



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





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?

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