



Brigham and Women's Hospital

Founding Member, Mass General Brigham

Emerging Topics for the Boards: Bringing Health Equity into Clinical Practice

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• Research focus: Health Equity

Disclosures

- No Disclosures



Today's Presentation

- *Review frameworks for incorporating health equity into clinical practice*
 - **Definitions:** structural racism, disparities, inequities, critical race theory
 - **Topics:**
 - Race as a social construct, not an accurate shorthand for biology or ancestry
 - Identifying and redressing structural racism within health systems



Take Home Points

- Addressing health equity requires attention to structural, institutional, and social determinants of health and healthcare delivery and access
- Effective clinical care requires community and stakeholder engagement to address these determinants
- Strategies exist to meaningfully address structural racism in clinical settings



Definitions

- **Structural racism**
- **Disparities**
- **Inequities**
- **Critical race theory**



Question 1: Which of the following is an example of structural racism?

- a) A Black patient is asked different social history questions than a White patient by the same physician
- b) A White pediatric patient prefers playing with a White doll over a Black doll
- c) Black Americans are disproportionately imprisoned in the US with longer average sentences
- d) A Latinx physician has disproportionately more Latinx patients than his colleagues
- e) None of the above



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Question 1: Which of the following is an example of structural racism?

- a) A Black patient is asked different social history questions than a White patient by the same physician **interpersonal racism**
- b) A White pediatric patient prefers playing with a White doll over a Black doll **internalized racism**
- c) **Black Americans disproportionately imprisoned in the US with longer average sentences** **structural racism**
- d) A Latinx physician has disproportionately more Latinx patients than his colleagues **patient preference/concordance**
- e) None of the above



Structural Racism

A system of structuring opportunity and assigning value based on the social interpretation of how one looks that:

- Unfairly disadvantages some individuals and communities
- Unfairly advantages other individuals and communities
- Saps the strength of the whole society through the waste of human resources

Jones CP. Levels of Racism: A Theoretic Framework and a Gardener's Tale. American Journal of Public Health. 2000; 90(8): 1212-1215.



Structural Racism

- Structural racism is “the totality of ways in which societies foster [racial] discrimination, via mutually reinforcing [inequitable] systems...(e.g. in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc.) that in turn reinforce discriminatory beliefs, values, and distribution of resources.”

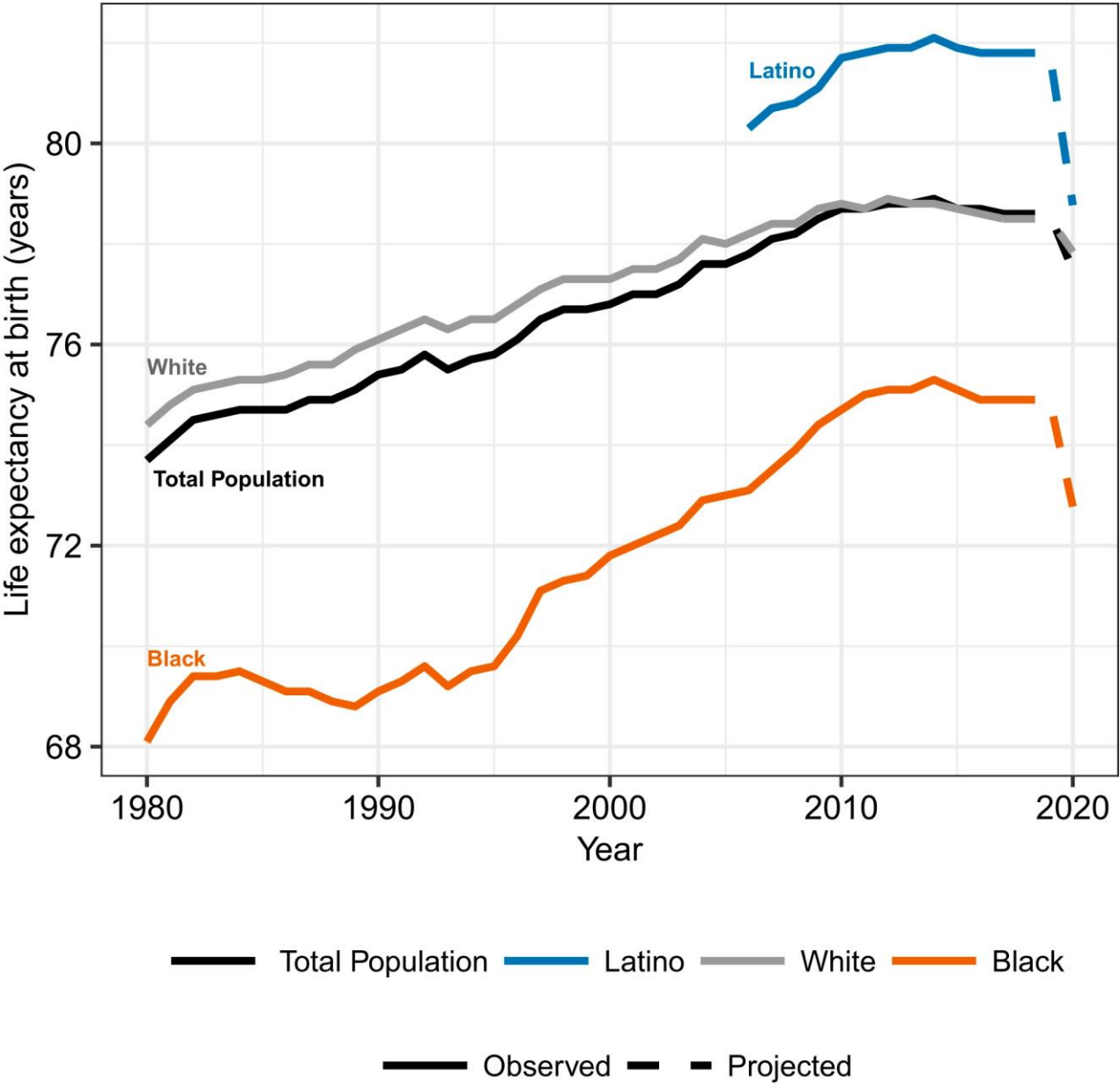
Bailey ZD, Krieger N, Agénor M, *et al.* Structural racism and health inequities in the USA: evidence and interventions. *Lancet*. 2017;**389**:1453–63. doi:10.1016/S0140-6736(17)30569-X

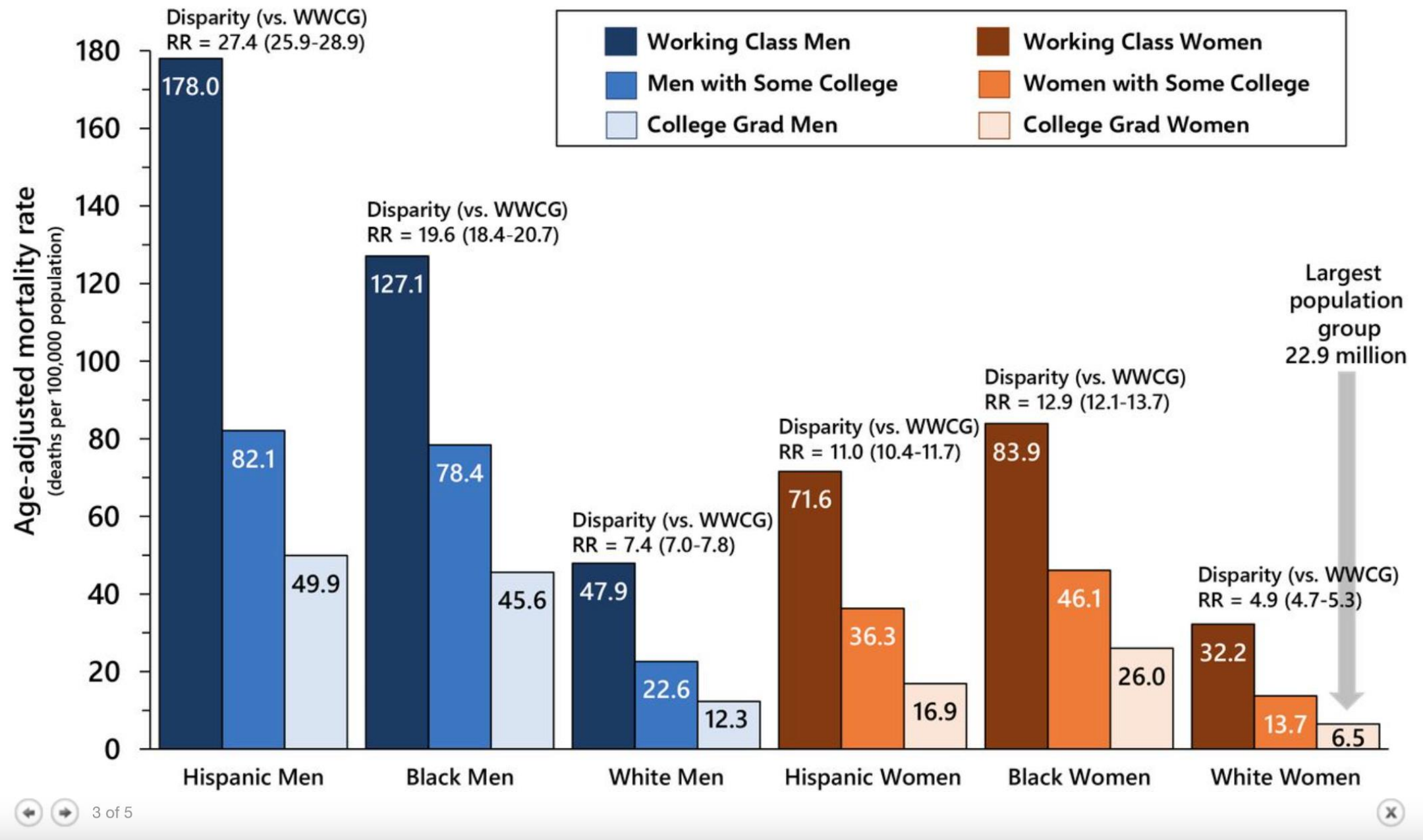


Reductions in 2020 US life expectancy due to COVID-19 and the disproportionate impact on the Black and Latino populations

Theresa Andrasfay  and Noreen Goldman  [Authors Info & Affiliations](#)

January 14, 2021 | 118 (5) e2014746118 | <https://doi.org/10.1073/pnas.2014746118>

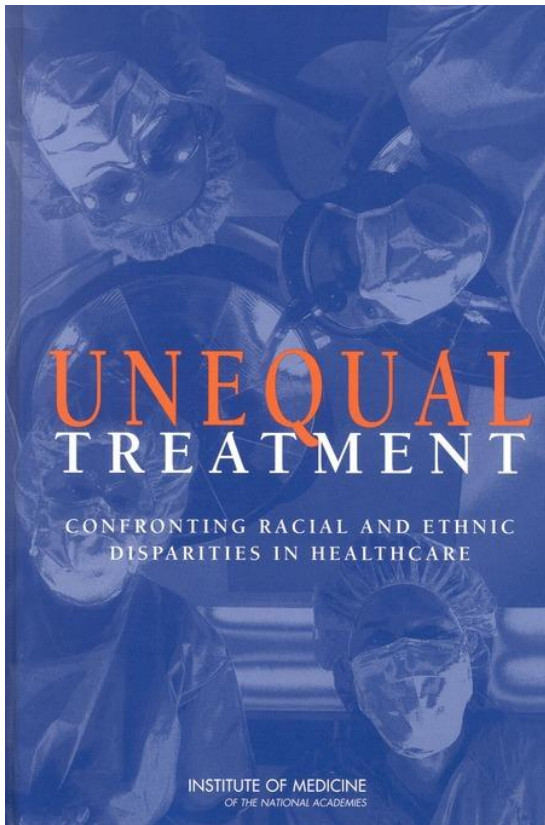




Parthak et al. Social Class, Race/Ethnicity, and COVID-19 Mortality Among Working Age Adults in the United States, pre-print: <https://www.medrxiv.org/content/10.1101/2021.11.23.21266759v1.full>

Institutional Racism

Are we improving?



New York Times Opinion, March 2002:

“...a disturbing new study by the Institute of Medicine has concluded that even when members of minority groups have the same incomes, insurance coverage and medical conditions as whites, they receive notably poorer care. Biases, prejudices and negative racial stereotypes, the panel concludes, may be misleading doctors and other health professionals.”

Source: New York Times

<https://www.nytimes.com/2002/03/22/opinion/subtle-racism-in-medicine.html>



Institutional Racism

STAT+

SPECIAL REPORT

20 years ago, a landmark report spotlighted systemic racism in medicine. Why has so little changed?



By Usha Lee McFarling  Feb. 23, 2022

<https://www.statnews.com/2022/02/23/landmark-report-systemic-racism-medicine-so-little-has-changed/>



Question 2: Which of the following is a health disparity but not a racial health inequity?

- a) Black Americans have higher COVID-19 mortality rates than White Americans
- b) White Americans are more likely to have employer-based health insurance than Black or Latinx Americans
- c) Black patients are less likely to have their pain adequately treated than White patients
- d) American Indians have higher rates of vaccination against COVID-19 than White Americans
- e) All of the above are both disparities and inequities



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Question 2: Which of the following is a health disparity but not a racial health inequity?

- a) Black Americans have higher COVID-19 mortality rates than White Americans **unfair, unjust, and avoidable**
- b) White Americans are more likely to have employer-based health insurance than Black or Latinx Americans **unfair, unjust, and avoidable**
- c) Black patients are less likely to have their pain adequately treated than White patients **unfair, unjust, and avoidable**
- d) **American Indians have higher rates of vaccination against COVID-19 than White Americans** **difference not due to historical injustice and/or structural racism**
-  e) All of the above are both disparities and inequities

Definitions

Health Disparities

- The differences between the health of one population and another in measures of who gets diseases, who has a disease, who died from disease, and other adverse health conditions that exist among specific population groups in the US.

Health Inequities

- The differences in health status or in the distribution of health determinants between different population groups, and ***these differences are systematic, avoidable, unfair and unjust, and are rooted in racial, social and economic injustice***, and are attributable to social, economic, and environmental conditions in which people live, work and play.



What can we do to address health inequities?

Traditional Approaches:

- Use population health data to identify differences and clinical needs
- Standardize care to minimize uncertainty
- Expand diversity of the care team to check bias and discrimination
- Incentivize change through payment models



Ideas and Opinions | October 2021

Disparate Impact: How Colorblind Policies Exacerbate Black–White Health Inequities

Scott W. Delaney, ScD, JD, MPH , Utibe R. Essien, MD, MPH , and Amol Navathe, MD, PhD 

[Author, Article, and Disclosure Information](#)

The fallacy of race-blind or “equal opportunity” approaches is that they fail to account for historical and structural racism and thus can often exacerbate existing inequities by benefitting primarily those who have accrued advantages from centuries of policies and practices benefitting whites

<https://pubmed.ncbi.nlm.nih.gov/34516269/>



A race-conscious and reparative approach: Healing ARC

Goals:

- Institutional accountability
- Broad education on racism and its clinical manifestations
- Redress for patients
- Input from impacted communities
- Reparative and restorative justice



Heart Failure Care at the BWH

- Patients admitted to the Shapiro Cardiovascular Center receive:
 - Specialty-trained nursing, pharmacy and discharge planning
 - Single, larger and nicer rooms
- Previous research indicates better outcomes for heart failure (HF) patients admitted to Cardiology vs GMS
- Shapiro cardiology remains a limited resource: ~2/3 CHF patients admitted here



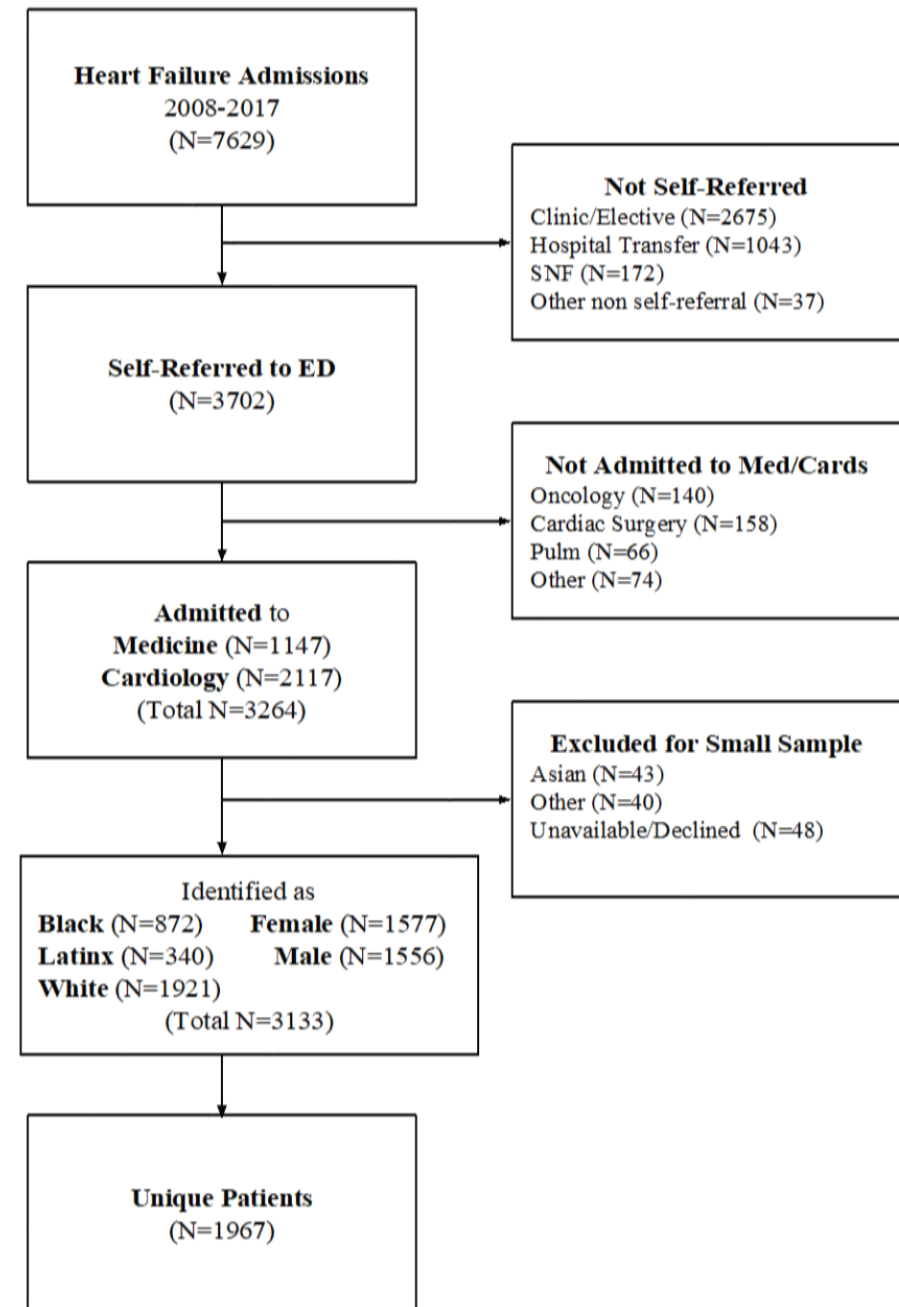
ORIGINAL ARTICLE

Identification of Racial Inequities in Access to Specialized Inpatient Heart Failure Care at an Academic Medical Center

- Guided by Public Health Critical Race Praxis
- Considered race to be a social construct
- Hypothesized that differences in HF outcomes were due to structural drivers rather than biological causes.

Study:

- All admissions, 2008-2017, with principal diagnosis of HF
- Only patients self-referred to ED and admitted to Medicine (GMS) or Cardiology
- Primary outcome: admission to Cardiology



Question 3: Which of the following is false regarding critical race theory?

- a) Critical race theory was developed by scholars to explore why racism and its outcomes persisted despite the achievement of full civil and political equality for Black Americans in the 1960s
- b) Critical race theory is currently taught in some public and private high schools
- c) A key tenet is that race is socially rather than biologically constructed
- d) Critical race theory has been applied to public health and clinical research through the Public Health Critical Race Praxis
- e) All of the above are true



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Critical Race Theory

Some Key Tenets:

- Racism is embedded in society – it is ordinary
- Race is socially constructed
- Differential racialization
- Intersectionality
- Unique voice of color
- Interest convergence
- Racism serves the material and psychic interests of the dominant group
- Race-consciousness



What does ‘socially constructed’ mean?

Races can be understood as a “traces of history,” since racialization acts to reflect, justify, and reproduce—into the present—the unequal relationships engendered by specific historical agendas of colonization and domination.

E.g. racism may be redundant since *race is already an ‘ism’*



Definitions

Race

- A historically contingent, socially constructed means of hierarchically grouping people, linking physical characteristics to cognitive, moral, or cultural ones. Modern racial groups lack a genetic or biologic basis and were generated from specific forms of European colonialism. Race and racial groups change over time.

Wolfe P. *Traces of History: Elementary Structures of Race*. Verso. 2016.



Heart Failure: Study Outcomes

Raw data:

- 67% of White vs 53% of Black and Latinx patients admitted to Cardiology

Primary Outcome, multivariate analysis:

- Black and Latinx patients admitted to Cardiology less frequently than White peers

Secondary Outcomes, Cardiology admission associated with:

- Significantly decreased likelihood of hospital readmission (hazard ratio = 0.84, 95%CI 0.72-0.97)
- Increased outpatient Cardiology follow up (46% vs 25% for GMS)

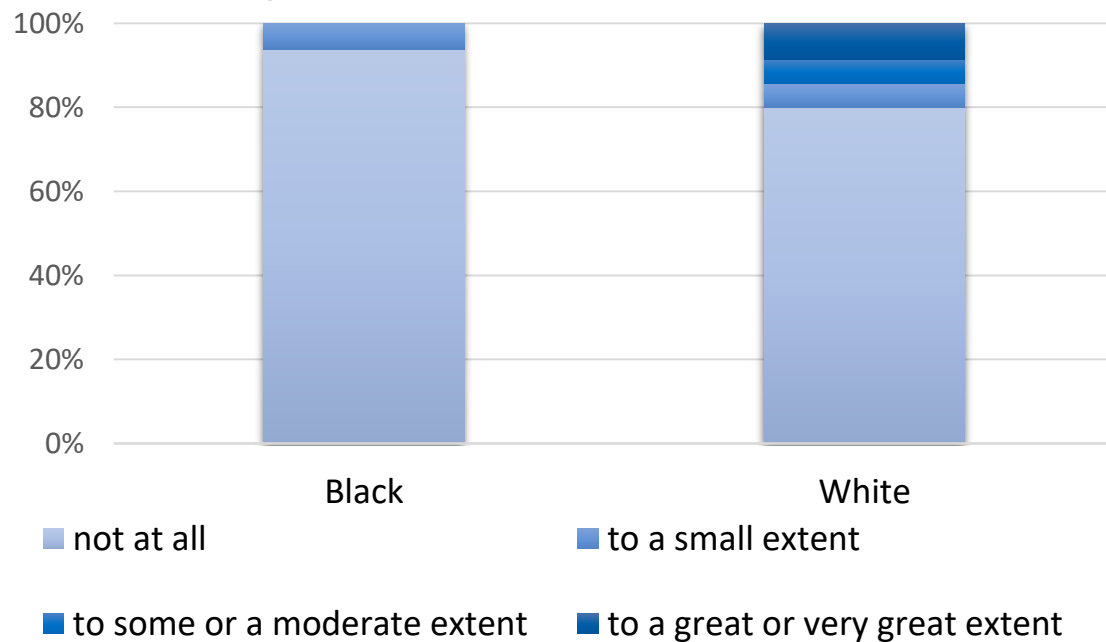


Characteristic	Multiply Imputed Analysis		
	Adjusted RR	95% CI	P Value
Race			
White	ref		
Black	0.91	0.84–0.98	0.015
Latinx	0.84	0.73–0.96	0.012

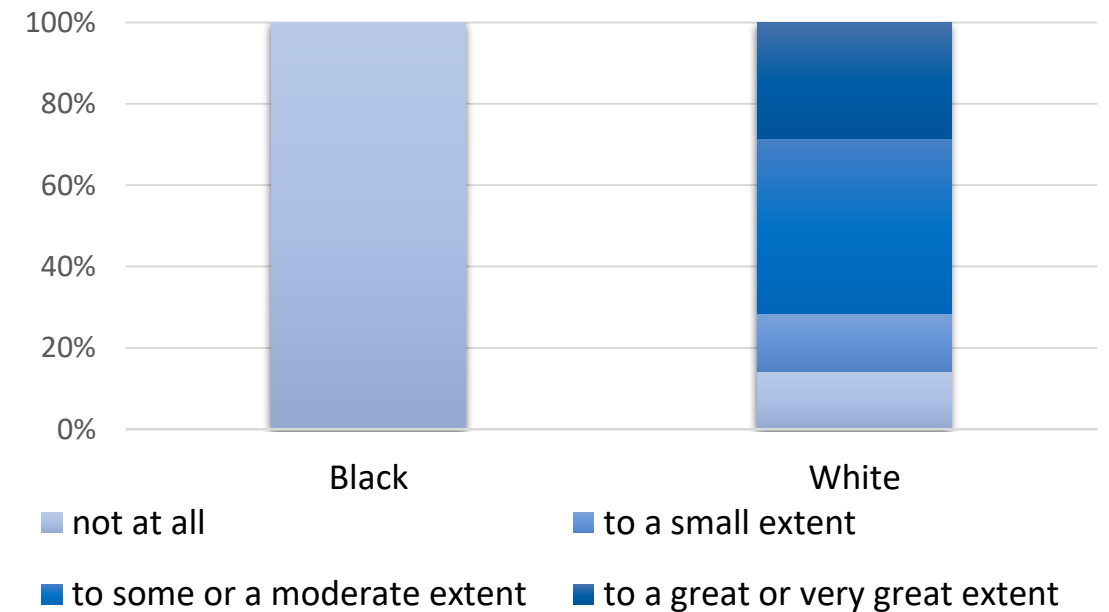
	Rate Ratio of Admission to Cardiology	95% CI	P Value
Black vs white	0.74	0.63–0.87	0.0001
Latinx vs white	0.75	0.60–0.95	0.014
Female vs male	0.86	0.77–0.96	0.0055

Heart Failure Admission Service Triage (H-FAST): *identified racialized differences in perceived patient self-advocacy, as a driver of admission inequities*

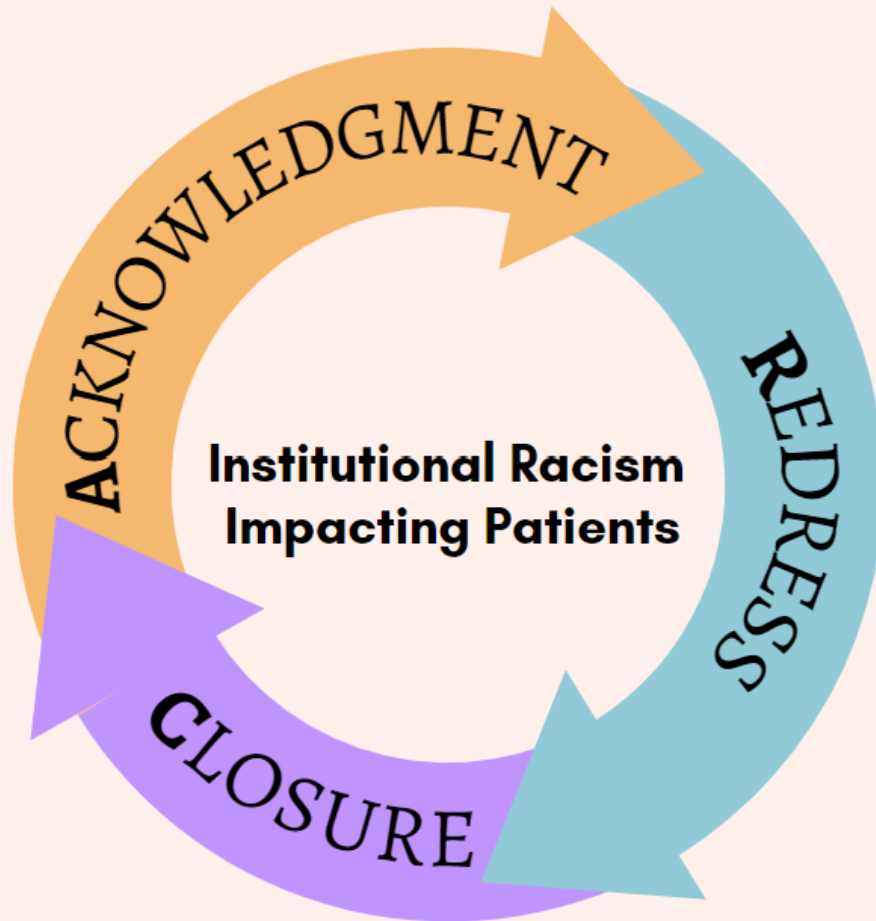
**Did the patient and/or their family indicate
a preference for admission location?**



**To what extent did this affect your decision
for location of admission?**



Healing ARC



A Reparative Approach



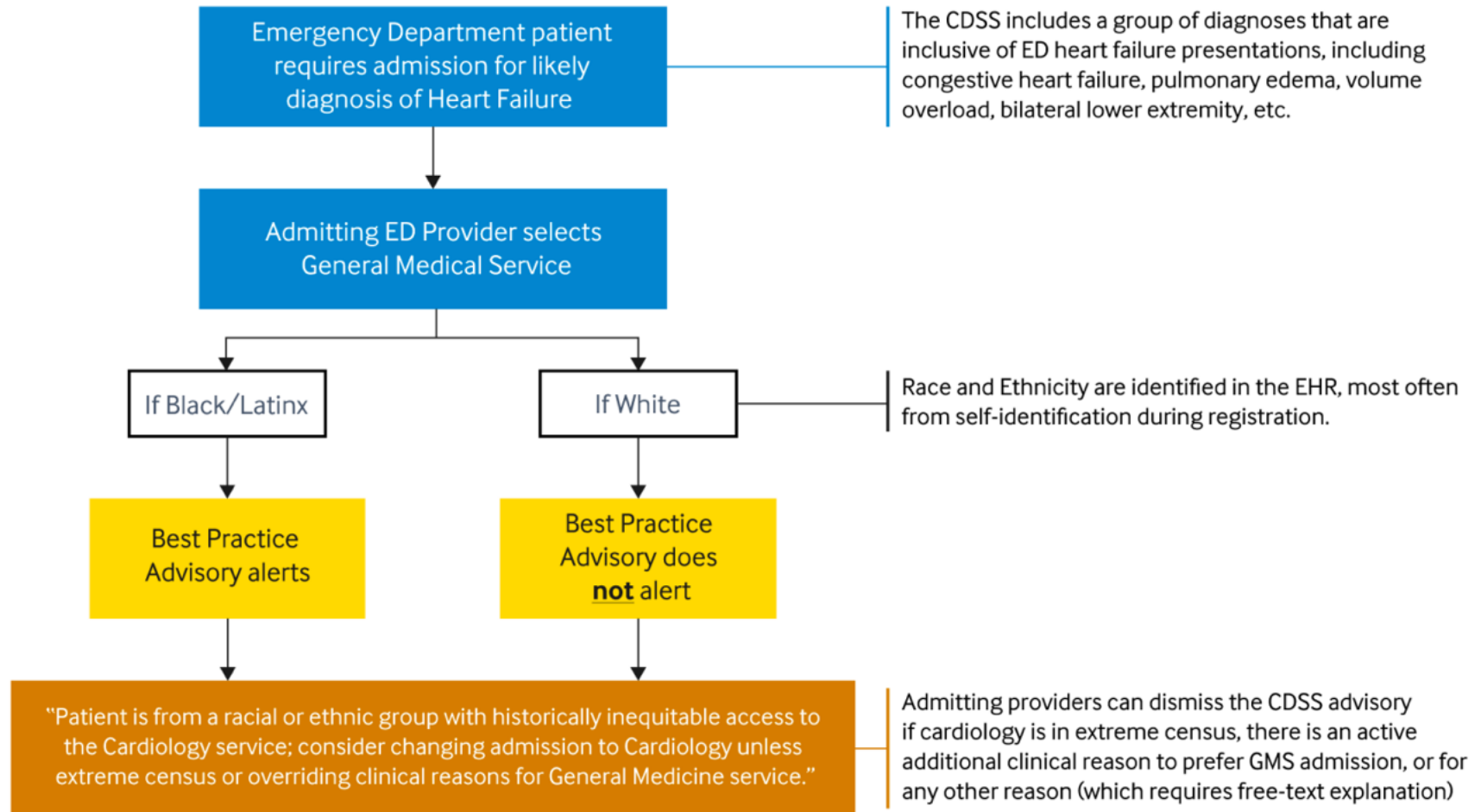
Wisdom Councils Guide Healing ARC Implementation for Institutional Accountability

This figure shows how the Wisdom Council facilitates the implementation of the Healing ARC model of addressing institutional racism.



Source: Content supplied by A. Kirsten Mullen, William A. Darity, and authors
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The Redress Component of Healing ARC:



Source: The authors

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

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