Examples of Systemic Racism in Healthcare. Round Table.
(Systemic Bias & Systemic Racism in Healthcare 3/4)

For the third installment of our mini-series exploring systemic bias and racism in healthcare, our panel of experts discuss various examples which illustrate how systemic racism is embedded in systems of healthcare and social determinants of health. These include measurements such as eGFR, BMI, and metabolic panels, scoring for post-operative risk; lack of diversity in dermatology textbooks; and how subjective information that is potentially deleterious to patients may be captured in EMR systems such as EPIC.

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Full Transcript:

Christin: You are listening to the Health Disparities podcast, which is a program of Movement Is Life. Welcome to the third installment of our miniseries, "*Exploring Systemic Bias and Racism in Healthcare*." I'm Christin Zollicoffer**,** she/her pronouns, and I serve as Chief Belonging and Equity Officer with Lifespan Health System. It is an academic medical center with Brown University Warren Albert Medical School. I'm also a member of the Movement Is Life Steering Group, and that was previously closely involved with our Operation Change program in Chicago. In our last episode, we explored definitions of systemic and structural racism, what they are, how they differ, and their consequences in healthcare. In this episode, we will have a roundtable discussion to continue that exploration by discussing some very real and well-documented examples in healthcare. By way of recap, systemic racism can be described as perpetuated discrimination within a system that was and is structured around racist rules, laws, principles, policies and practices. So, statutes and regulations enforcing slavery and resulting caste structure are systemically racist. And the policy of redlining is one example of perpetuated discrimination. So, when we think about structural racism, it is less immediately obvious because it is where cultural values in a society are so

ingrained in daily life that they are seen as the way things are and have become normalized. They've become normalized practices that are perpetuated from generation to generation. In fact, the income differential enforced originally by slavery is still seen as quote/unquote the way things are. And lower income communities may be criticized for being lower income communities, which in turn continues and promotes disinvestment. These distinctions help us to differentiate the more explicit examples of systemic bias that can be identified clearly because of written laws and policies as compared to structural racism, which is more implicit in that it has become normalized and embedded in culture. So today we will come to a number of examples during this discussion. Among others, we'll be talking about the role of race in health disparities impacted by things such as eGFR, AI being artificial intelligence, oximetry, bundled payments, and BMI or Body Mass Index. Joining me to help unravel the systemic and structural aspects of these and other examples, I'm delighted to introduce two physicians, one working in primary care, one an orthopedic surgeon, both making health equity central to their practices. So, talking to us today from Cleveland, Ohio is Dr. Carla Harwell, who is a nationally recognized leader in healthcare disparities, education and medical issues affecting minorities. She's a Medical Director at University Hospitals, Otis Moss, Jr. Health Center and Associate Professor of Medicine at Case Western Reserve School of Medicine, Division of Internal Medicine. She's also Vice Chair for the Board of Directors at Movement Is Life. Welcome Dr. Harwell.

Dr. Harwell: Thank you. And it's great to be with you and I'm looking forward to bringing to the surface issues around systemic racism today.

Christin: And Dr. Daniel Wiznia is Assistant Professor of Orthopedics and Rehabilitation at the Yale University School of Medicine. He is co-director of Yale's master's program in personalized medicine and applied engineering, and he has developed research programs in total joint replacement, musculoskeletal healthcare disparities and injury prevention. And he is also part of the movement, his life steering group. Welcome Dr. Wiznia.

Dr. Wiznia: Thank you so much for having me speak today, and it's really important to share research on this topic that we've been working on at Yale in health disparities in orthopedic care.

Christin: Excellent. So, we're just going to go ahead and dive in and our first example is the use of eGFR and decision making with kidney disease. Dr. Harwell, tell us a little bit more about instances of how eGFR measurements have negatively impacted your patients and how you would see the use of eGFR as being systemically racist.

Dr. Harwell: Thanks Kristen. So eGFR, which stands for estimated glomerular filtration rate, tells us how well the kidneys are working and is used to estimate kidney function and thus chronic kidney disease. We now have incorporated race into multiple clinical equations that unfortunately places African Americans in danger. By adjusting for race and using these equations, the eGFR is actually increased in these individuals. This makes it appear that black's kidney function is actually better than it might really be. See, it was assumed that blacks have a higher average muscle mass, which the thought is that this could be genetically based, which by the way has actually never been proven by any reputable research. So, taking this into account makes a lab test called the creatinine actually appear higher in blacks. So, healthcare providers can get comfortable with this because it looks like the creatinine is actually okay. And so now these healthcare providers can now be failing to diagnose early stages of chronic kidney disease in blacks. This causes a delay in secondary prevention. So, we know that diabetes and hypertension are leading contributors to chronic kidney disease in blacks, and we need to be controlling for these factors earlier so that chronic kidney disease doesn't progress in these individuals. But when you have these lab tests that now have factored race into the equation, you're getting these overestimates of renal functions in black individuals. And this can have some very dire consequences and contribute to some of the systemically racist things that we see going on when it comes to things like blacks getting delayed access to specialist care or even kidney transplants or even getting put on the list because if blacks aren't reaching that magic number, that magic creatinine number, that magic eGFR number, then they're not being referred to kidney specialists at the same rate as Caucasian counterparts. And I see the impact of this in my patients when personally I see their GFR and their creatine numbers. Should I be referring my patients sooner than I am? A lot of medicines that are metabolized through the kidney. So, if you have a black patient and it looks like their eGFR or their creatinine is quote/unquote okay, when really it may be being projected higher than it really is, healthcare providers might continue blacks on medicines that can be what we call nephrotoxic or not good for the kidney at certain levels. So, actually multiple institutions now have now eliminated the use of race in renal function estimation. Specialty societies have also moved towards the elimination of race in these equations.

Christin: Thank you, Dr. Harwell. Dr. Wiznia, do you want to add your thoughts?

Dr. Wiznia: That was so nicely said Dr. Harwell. One other thing I'd like to add is the estimated glomerular filtration rate, it's baked into a very common test that we all get from our doctors, the metabolic panel, and it's one of the 10 lab values and this is a very common test that's done all the time and there's no explanation of how that value is calculated. So, when a medical practitioner is reviewing that, they don't understand how it's calculated and how race is an element within that calculation. The formula is actually wrong. So, it's found its way throughout the

entire practice of medicine in the us and so it's a very, very commonly used value that is misdirecting healthcare practitioners in many different ways.

Christin: Well, Dr. Wiznia, you made a good comment. You said it's found its way, and so when you say found its way for many generations, it really does speak to the baking of racism and systemic racism going back generations, even centuries, right, for when medicine was defined and then values were established and just those values were taken at face value and incorporated into other medical calculations. So, thank you for that. Okay, so our next example is something that Dr. Wiznia you've researched. Can you tell us a little bit more about scoring for postoperative risk using race as one of the criteria and why this is potentially contributing to health disparities? And Dr. Harwell we will ask for your thoughts afterwards.

Dr. Wiznia: So, surgery is a really big undergoing for patients and there's always risks with surgery. With surgery you can have a medical complication like a heart attack, a stroke, or an infection. So, before we do surgery, it's very important to understand the risks for each individual patient and get that patient as healthy as possible before the surgery. If I can identify what medical issues you have before surgery that I can modify and improve, I can make you a healthier candidate and I can lower your risk of a complication so that you have a successful surgical outcome. In order to evaluate those risks, doctors across the country, researchers have been developing risk scoring systems. These systems calculate based on a patient's comorbidities and other factors, elements of the patient's risk, and patients are given a score and that score then influences the hospital and the surgeon whether to proceed with surgery. In principle, this all sounds really good. We're going to make patients healthier, we're going to operate on patients who are safe for surgery. But in practice, if the risk scoring system utilizes variables that have inherent race components that don't take in the weights of social determinants of health and instead bake in race components, you can actually negatively impact patients and prevent them from getting surgery even though they may actually be very safe candidates. So, as an example, in the Journal of the American Medical Association, there was a study that looked at risk of patients for total hip replacement. So, total hip replacement can be a surgery that carries risk if you were to get an infection or a blood clot. And the best way to ensure that patients have a successful hip replacement is to make sure that they're healthy. In this article, they created a risk score, and they identified a lot of medical comorbidities, liver disease, heart disease, diabetes, obesity. Those are medical comorbidities that can be influenced and improved and modified. And a preoperative optimization program, a group of nurses can help a patient get healthier and improve those factors. But then they also included in the risk score, African American, and if you were African American, you automatically were docked an additional three points on your score. Their argument is that they found that African American patients had

more complications than white patients, but this doesn't take into account the fact that from a genetic level, African American patients are not riskier surgical candidates. There's absolutely nothing about a Caucasian patient versus an African American patient that would indicate that an African American patient has got to do worse for hip replacement. What these researchers did not take into account were the social determinants of health that were impacting African Americans that were causing them to be a higher risk for surgery, but it wasn't inherent to their race or their genetics that they were higher risk candidates. This same team then went on to publish a second study and another prestigious journal, the Journal of Bone and Joint Surgery, and in this journal, they looked at total knee replacement patients. They also included race, African American, and then they also singled out patients with Medicaid. And they said that patients with Medicaid insurance were at a higher risk for a complication. Now, there's nothing different between a patient who has Medicaid and a patient who has a private insurance like Aetna or Blue Cross. They're just two individuals. They're two humans. They just happen to have different insurance. What this risk score did not take into consideration is well, maybe the patient with Medicaid has other social determinants of health that make them a riskier candidate for surgery and those can be addressed usually. So fortunately, in this circumstance, both of these risk scores did not make their way into the health systems to be incorporated and used to evaluate patients prior to surgery. But these two published papers and highly respected journals could definitely have a negative impact if data including race or insurance status is being included in the decision whether a patient can have surgery.

Christin: That that was well explained. I appreciate the thoughtfulness and the detail. Dr. Harwell, do you have anything you'd like to add?

Dr. Harwell: I think Dan did a great job describing that blacks have so many of the comorbid conditions that are taken into account on that scale and the social determinants of health that Dan mentioned that are not taken into account that it's almost for sure going to kick blacks out of being that quote/unquote ideal patient for surgery. So as Dan said so eloquently, these are things that again contribute to the continued impact that race has on these factors.

Dr. Wiznia: So, what they would do is they would assign points for each element in this risk score. So, for the total knee risk score, if you were an African American, you automatically received seven points. If you had Medicaid, you automatically received nine points. The recommendation was if you had 15 points, you were not a surgical canon. Now what is an African American patient on Medicaid going to do about that? There's nothing modifiable that they can do and neither of those components have any influence on their risk for surgery.

Christin: Well, you can read a lot into that. Sounds like ultimately the system is looking to weed out the poor and blacks. And those risk factors, those operative risk factors, we have to tell it to you straight. Next one, we'll talk about BMI. BMI is also very important in operative decisions. Dr. Harwell, can you start us off by giving us an overview of what BMI plays in decision making and how disproportionately it impacts minoritized populations and structural reasons why BMI has an inequitable impact?

Dr. Harwell: So, BMI, which stands for body mass index is a measure of body fat based on height and weight that applies to adult men and women. Now, people of African descent have been shown to have lower body fat percentage and higher muscle masses than whites at the same BMI. So, what this means is that at that same BMI blacks may actually be at a lower risk of obesity related diseases like we just discussed with postoperative risk scoring. Blacks will likely get a point for being obese while a Caucasian counterpart doesn't based on BMI with all things equal, and this has a tremendous impact in many arenas where one's weight is taken into account. Just the social and emotional effects of obesity including discrimination, lower wages, lower quality of life, and a likely susceptibility to depression. These are all real. These are all, we always think about BMI just in terms of risk for certain diseases and our risk factors for surgery, these sort of health issues. But again, fat shaming is real. There's discrimination out there for people that are overweight/obese. We have to look at really what the impact that BMI is playing in all facets of a person's life, not just even from a health standpoint. And actually, the American Medical Association under a newly adopted policy recognizes issues with using BMI as a measurement. And this is due to again, the historical harm and its use of racist exclusion, and because BMI is based primarily on data collected from previous generations of non-Hispanic white populations, then this just has a tremendous effect on all aspects of black person's life when they're being held to this BMI that we're not sure that this equation is even accurate for people of color.

Christin: You talked about so many points there, right? And when you're looking at the impact now, it doesn't explain how redlining impacts us. If you talked about this in previous segments, redlining allowed for communities to have lower investment. So, the only restaurants that could afford to come into those places that had high preservatives, which are fast foods. So then if you have communities that have disinvestment and then you penalize them for a higher BMI, but they've, because they've been eating fast food and they've learned fast food for generations, who's accountable and who's talking about and connecting all the dots?

Dr. Harwell: All the dots, right. It's like BMI has become that scarlet red letter on your forehead. But there's many reasons why blacks have these higher BMIs, including the equation itself that doesn't seem to be equitable.

Christin: The equation itself and it is baked into decades and generations and centuries, once again. This is why we say this is systemic and structural because it is baked in at a very, very deep level. Dr. Wiznia, did you want to contribute?

Dr. Wiznia: I think you both gave a great explanation for how BMI affects different populations disproportionately. As an orthopedic surgeon, we spend a lot of time considering BMI when we're thinking about whether a patient's safe as a surgical candidate. And what we have found when we've done large studies looking at over 50,000 patients or so, is that African American patients have a higher BMI than Caucasian patients or Hispanic patients. Because they have a higher BMI, many of them are refused surgery and that is a systemic issue because these are patients for the most part who have higher incidences of arthritis and there's a higher prevalence of arthritis in that population. So, the motivation should be to try to get these patients to surgery to treat them. But the BMI, which impacts the African American population more than other populations actually is preventing a lot of the patients to get surgery.

Christin: No, you're right. And you speak of those comorbid conditions like stroke and hypertension, and once again, you go back to the food, is it chicken or the egg, right? Which one comes first? Is it the food that historically is fed that is high sodium or is it the egg in this respect being denied for surgical procedures because you have those comorbid conditions? At some point, who interrupts? Who interrupts? Who's responsible for interrupting the systemic racism built into medicine? Okay, we're going to go ahead and shift to bundle payments. Dr. Wiznia, when we think about value-based payment models that have been shown to widen disparities because they reduce the willingness to treat complex patients. You just mentioned that and declining black and folks who are on Medicare or Medicaid thereby negatively impacting minority patients disproportionately, it's a process that's called cherry picking and lemon dropping. Who are the cherries? Who are the lemons? Why is this process part of systemic racism in healthcare?

Dr. Wiznia: The concept of bundled payments was put together and launched nationally by Medicare. The goal was to try to save money on joint replacement. When Medicare examined how much a patient's joint replacement was costing, they came up with an average value. Let's just make it easy, $50,000 that included fees to the hospital fees to the surgeon, to the rehab facility, to the physical therapist, all of the medication the patient needed after surgery, and there's a lot of services involved as you can tell. The goal was to give a medical system a specific amount of money and only that amount of money for each patient then say you only, instead of the $50,000 that it's costing, we're only going to give you 30K. And if you spend less than 30K, you get to keep the savings. If you spend more, then you're going to lose money. And this was a way to try to incentivize the health system to cut down on extraneous costs, become more efficient, drive

efficiencies by improving how these systems cared for the patients. Unfortunately, by creating a fixed reimbursement value and not making adjustments for a patient's risk factors or comorbidities, the health systems were incentivized to only operate on the healthiest patients. If the health system is only going to get paid, let's say $30,000 to treat a patient, why would they want to operate on a patient that's sicker who might have a complication, might have to get readmitted, might require a longer hospital stay, might end up being in a nursing home for a longer period of time. All of those comorbidities place the hospital at risk that the patient is going to cost more than they're getting reimbursed for the entire care of that patient. While if you focus on just the healthiest patients, the risk to the hospital is a lot less. When you do this where you have a fixed payment that does not adjust for patients who are sicker or more complicated, it really drives incentives of the hospital to only operate on the healthiest and that disproportionately affects minority patients who we know have more comorbidities. So bundled payments can very negatively impact access to care for patients in underserved communities who have more comorbidities. This is called cherry picking. So, the hospitals are cherry picking the healthiest patients and they're lemon dropping the sicker patients. Over time, as surgeons and medical teams who treat patients in these underserved communities complained, Medicare denied that there was any influence in terms of affecting patients from minority backgrounds. But as the data started to come in over time, the data strongly demonstrated actually that sicker patients, patients from these underserved backgrounds such as African American patients, were not receiving the surgery and were having a far harder time getting surgery. So bundled payments, the way it was executed by Medicare was improperly done and it really negatively impacted patients for many years.

Christin: Dr. Harwell?

Dr. Harwell: Well, this is my world because that's the patient population that I see. They're the ones that's being dropped, they're the lemons. And again, I think it's because of a lot of the things that Dan mentioned and that we have talked about already in terms of blacks and people of color who have these comorbidities that puts them at increased risk for not so good outcomes. Who wants to take care of that patient population? Who wants to get paid for taking care of that patient population? When you can have caps on how much money you're going to get, if you're only going to get X amount of dollars to do an orthopedic surgery procedure, you don't want to have that patient that has these comorbidities that's carrying that high BMI that designates them as obese or even morbidly obese and all the comorbid conditions that go into worse post-op outcomes. And so, it's really sad because it is a lot of individuals out there that's being looked over that's being lemon dropped because of that. And again, this whole discussion here, we're talking about systemic racism. I think this is the example at its, I don't want to say at its best, but at its worst when you have the cherry picking and

lemon dropping that goes on with what patients even want to be seen by providers.

Christin: There's so much that we could talk about just in that response from both of you, but certainly want to make sure we move on. You've brought this up a little bit of times, a few times so far today. So, I wanted to just pull this forward. So minoritized patients are known to present later and they're diagnosed later than other patients. There was a study at University of Pennsylvania that found that even after diagnosis, African American women waited nearly two years longer than white women to receive treatment. Dr. Harwell, you want to start us off by talking about why this is a form of systemic racism and how it impacts health outcomes?

Dr. Harwell: Well, Christin, I think the elephant in the room here is the question why. The real issue here is why, and I think potential barriers can be occurring really at three different levels. You have the patient level, you have the provider level, and you have the system level. And barriers at the patient level can be related to many patient characteristics such as health beliefs and attitudes, perceived illness and personal health practices. We've talked about some of these social determinants of health that come into play. And so, a lot of things can be going on at just obviously the patient level. And then, there can be barriers at the provider level. And now we're looking into some of the provider characteristics such as their skills and their attitudes. We know about unconscious bias that some providers have that can be perceived by women, these African American women and African Americans in general, that question whether this provider really have their best interests in mind. And then this can escalate all the way up to barriers at the system level and system level characteristics, just the organization of the healthcare system itself. How easy is it to maneuver through the system? I have to go from pre-admission testing. They tell me I need a ride there, I need a ride back. They're not going to do my surgery if they don't see somebody sitting there that's going to bring me, that's going to take me home. So, you look at patient level, provider level, system level, all these different barriers that come into play. And I think a lot of times people don't take into account that all of those things are going on. All of those things are running through people's minds and that you have to really look not just, oh, well, it is not as obvious as, wow, you've been given this diagnosis, you know, you need treatment, but yet you wait two years to get it. There’re so many different variables that come into play here. Like I said, a lot of them sometime we are our own worst enemy, but sometimes we are our own worst enemy from a patient standpoint because of things such as the social determinants of health that don't allow us to necessarily do things in a timely way. And so, I think in this case, we as healthcare providers, we as individuals, and we as hospital systems and healthcare systems need to broaden our range of how we look at why a person is delaying treatment and try to dig deep into that big question of why. And then make accommodations, do something about it,

make it easier. Is someone actively reaching out to say, hey, it's been a month, it's been two months, it's been six months. Are those things in place to sort of capture these individuals that get lost and delay this treatment? It's not just the patient, it's the patient, it's the provider, it's the system, I think that all play into that.

Christin: You're absolutely right. Absolutely right. Dr. Wiznia?

Dr. Wiznia: Yes, I really enjoyed what Dr. Harwell discussed about the challenges that we have in serving underserved communities. So, Dr. Harwell is in a practice where many of our patients are underinsured or have limited resources. I'm in a practice where a lot of my patients are also very challenged and there are so many elements that add up that make it very challenging for the patients to be able to get access to care. Access, one of the major barriers is insurance and having an insurance that is accepted. The majority of musculoskeletal clinics across the country do not accept Medicaid. So, if you do not have the right insurance, you're not going to be able to get care. And that is a major contributor to delays in care. Another example is the challenges that patients face just getting to the clinic. Do they have access to transportation? Can they afford the transportation? Do they have a phone that helps them communicate with that clinic so that they can set up an appointment? Are they able to take time off from work so that they can get to that clinic? And there's so many elements that make access challenging for patients. So, I think that those are major contributors to the delayed treatment, late diagnosis and is that patients have a lot of trouble accessing care.

Christin: Interestingly enough. We're going to take a quick pivot here and go on over to trial participation. We see that it's very, we saw the fact that pulse oximeters when they were tried on patients, they weren't tried in clinical trials, right? So, they didn't know of their efficacy and whether they worked or not. So, let's move on to trial participation and how important that is. Dr. Wiznia, I'm going to ask you to start us off on knowing that clinical trial participation, there's wide race and ethnicity disparities in clinical trials, and that's who gets to participate. How do you find out about them? This is often attributed to a lack of trust within communities, but it's also an equitable distribution of clinical research centers and sites far from minoritized communities, disinvested communities, that has also resulted in reduced clinical trial participation. And how does this fit into the patterns of systemic racism that we see and how is it? Is it by accident? Is it by design? Lots of questions for you.

Dr. Wiznia: So, there's a lot of elements that contribute to the design of a clinical trial, and you can imagine if you are a med device company or a pharmaceutical company that you want to design a trial that is simple and that has the best chance of showing efficacy and improvement. Part of that element is to limit patients who would be eligible to participate in the clinical trial, to just very simplified patient

profiles and not patients who are perhaps a little bit sicker or who have unusual medical issues that could potentially put the trial at risk. So, the design of the trial can inherently exclude patients who would benefit from the intervention, but the industry is concerned that the intervention on these higher risk patients or potentially patients that don't fit their strict guidelines, could show a less efficacious outcome. Moving forward, there has been a big emphasis to have more diversity in the clinical trials, and it's really important that a trial demonstrates that the intervention, the medication or the device really works on all patients or has been designed to be personalized, to work appropriately on all patients. And there's an effort now and more of a focus on this, but it's imperfect because there's great distrust in communities regarding clinical trials and that affects recruitment and there's also challenges in accessing the clinical trials.

Christin: Thank you so much, Dr. Wiznia. So, are there any other examples? I think it's interesting to see how these processes are being critiqued and the eGFR and BMI processes are now being revised. Do any other examples of structural racism in healthcare come to mind?

Dr. Harwell: I like to bring up a quick one. I like this one in dermatology. The dearth of images depicting lesions on dark skin and medical and dermatologic textbooks and the lack of representation of providers with darker skin in the specialty may result in some reduced clinician's ability to identify life-threatening dermatological presentations on people of color. And I have this wonderful book that I go to all the time, a dermatological book that I refer to all the time. I've had it I think since I was probably a resident. And there's very few depictions of people of color when they're showing pictures of these various conditions. And I was a resident a long time ago, so I recently bought a book maybe about a couple of years ago. And still there are very few depictions of colored skin illustrated as illustrative examples in this book. And sometimes it can be hard to see a skin infection on darker skin. We call that cellulitis or if they're having a severe drug reaction to a medication again on darker skin. And so, when I turned to that book to look for some help and look for some pictures, I hardly ever see any examples of people of color in these books. And who knows? I mean, obviously as a clinician, I have to still go through my own differential of what I think this could be, but I mean, boy, it would be helpful if I had something to reference to. And it amazed me because I still have that first book that I had, and it actually amazed me when I bought this, a newer book and still very few pictures are depicted.

Christin: This is in 2023 when we have a plethora of shades of skin to choose from and photos. Why is this the case? Dr. Wiznia?

Dr. Wiznia: One issue I want to highlight that's actually going to be impacting healthcare on a national level is a new requirement by Medicare to collect social determinants of health. So, in 2024, there's going to be a requirement that the health systems

collect social determinants of health on five factors. These include housing, safety at home, access to food, access to transportation. And from a high-level view, this sounds like a great idea. We're going to interview patients, identify where they're having issues, and then refer them to groups in the community to help them. So, you're having a transportation issue, well, we'll have a social worker help you so that we can arrange for a car to pick you up and bring you to the hospital. You're having an issue paying your utility bill or we're going to have a social worker help you with that. And the danger of this requirement is that institutions may not have the resources like a social worker to help the patient. So now what you're doing is you're identifying social determinants of health and perhaps saying, well, you have a housing issue until you get this housing issue, you are not eligible for surgery. So, until you can find a home and not live in a shelter, we're not going to be able to help you. And now what you've done is you've added another layer potentially of barriers to surgery. If the social determinants of health are collected properly with the right amount of assistance, social workers, community health workers, then it can actually really improve the community. But if it's not done properly, I fear it could actually end up impacting people.

Dr. Harwell: Significant impacts, right? Significant impacts over time. And that was one example looking at dermatology. But if we look at a common calculator use to predict the success of vaginal birth after cesarean, which is a VBAC session that's had a correction factor for both black and Hispanic or Latina races that decreased the success of VBAC for patients by 67% and 68% respectively lead for our black or African American populations and our Hispanic or Latina populations. This tool may easily bias providers and to disproportionately counseling these patients towards undergoing cesarean section.

Christin: Again, just yet another example, I mean there's so many, we could be here all day, all night, coming up with multiple examples of these things. And again, I think the take home message is awareness and that there needs to be a call for action. This has gone on for way too long and it's not getting any better. This systemic racism that's so abundant in so many areas in the healthcare profession.

Dr. Wiznia: And one thing I want to highlight is I don't think the vast majority of these were done with the understanding of the impact that they would have. I think most people were very, very well intentioned when they developed these tools and instruments to help patients. And I don't think they fully understood the power of some of these instruments to negatively impact patients and how to properly design a tool so it wouldn't have that impact. So, I just want to underscore that, that it's not as though evil people were developing these things. I think it was done with the best intentions, but there was some ignorance and lack of understanding that as is proliferated through the health system. So it's important

for us to make sure that every physician understands that these examples exist, and as researchers are developing new tools and instruments and as policy is being developed, that everyone is very careful how they move forward with these new elements that are being inserted into the health system to make sure that they're not going to have that impact.

Christin: Dan, you said that so well, and it is not ill-intentioned people who are doing this work. It does come at a cost when individual folks are making broad decisions. I'll give you an example. I sit on the Equitable Care Brain Trust. Epic is the health medical record that a lot of health systems use to capture patient content. And we were on this conversation, and this is two months ago, and we were talking about 2024 expectations coming up now to report on workplace violence and how they wanted to build that into the system of calculating and capturing workplace violence. So, you have folks who are sitting at an institution who is well intentioned, is to collect content on specific situations, and they have a situation in their mind that they're addressing. However, if you don't have the experience of being poor, a single parent in the community, how do you then think about the person who you're asking to come to the emergency room, have the same literacy rate that you have, talk to you in the same tone that they have, but they've had to take three buses to get here with a sick child and they're hungry, they're irritable, and you want them to talk to you in the same tone, volume and words that you as a credentialed clinician wants to be able to hear someone in. And so, then you want to capture them as violent, right, quote/unquote violent, but then you think about, okay, well have you been in that situation before? Have you had to take the bus a couple of times and be late to an appointment? You have to sit and wait and you're hungry and not to mention if there are language barriers. And then are you connecting even thinking about how that connects to social services? Does that connect to child services? We are going to wrap up and say thank you. We brought to the surface some great insights. In our next episode, we will discuss some of the initiatives that are bringing about reformation and are part of creating a roadmap towards ending health disparities. Until then, I want to say thank you to Dr. Harwell, Dr. Wiznia, we want to say I really appreciate the robust conversation.

Dr. Harwell: Thanks, Christin, it's been a great conversation and see you next time.

Dr. Wiznia: Thank you, Christin, for having me. I really enjoyed the discussion.

Christin: I'm Christin Zollicoffer saying thank you for listening to the Health Disparities Podcast. Be safe and be well.

(End of recording)