Dr. Jimenez: Welcome to the Health Disparities Podcast, our regular exploration of inclusion, diversity, equity, and ally-ship in healthcare. This is presented by Movement Is Life steering committee members in association with our many partners. I am Ramon Jimenez, community orthopedic surgeon of nearly 50 years, founder and past president of the American Association of Latino Orthopedic Surgeons and an active champion of STEM education for Hispanic students in California. This week, it's my pleasure to welcome our special guest, Dr. Adia Wingfield. She is Mary Tileston Hemenway Professor of Arts and Sciences, and the Associate Dean for the Faculty Development at Washington University in St. Louis, Missouri, and author of the book Flatlining. In that book, she explores how hospitals, clinics, and other institutions participate in “racial outsourcing”, which is relying heavily on black doctors, nurses, technicians, and physician assistants to do equity work, which is extra labor that makes organizations in their services to communities of color, but at a cost and often, without recognition, compensation or support. Please say hello, Dr. Wingfield.

Dr. Wingfield: Hi. Thank you for having me.

Dr. Jimenez: And, also joining the discussion from our steering committee is president of the W Montague Cobb NMA Health Institute, orthopedic surgeon, Dr. Randall Morgan.

Dr. Morgan: Good morning.

Dr. Jimenez: And our good friend, Dr. Carla Harwell, internal medicine physician, and community leader from Cleveland, Ohio.

Dr. Harwell: Good morning, everyone.

Dr. Jimenez: Dr. Wingfield, you've always been interested, as a sociologist and a researcher, in trying to better understand how issues related to race, gender, and inequality persistent in professional workplaces. Your influential book, "*Flatlining*", came out early in July 2019, six months before the COVID-19 threat became very real. You know, you talk about the additional burdens being placed on the shoulders of black employees and what you have termed the new economy. And what do you mean by the new economy?

Dr. Wingfield: Great. So, when we talk about the new economy, it's this idea that work has really changed a lot and the economy has shifted to reconstruct how we work in ways that are pretty, dissimilar from what work used to look like. So, there used to be this model where people would go work for one organization for the duration of their career, and they could count on a fairly, generous retirement package from that employer and that was just the way that people experienced upward mobility. And that model is really

gone. We don't really work like that anymore in the 21st century. Instead, what we end up with is a situation where people are more likely to change jobs more frequently. Contract work or precarious work is a lot more commonplace. And that people are in situations where workers have a lot less bargaining power and control over things as basic as their schedules and things as significant as their wages and their working conditions. And one of the things that I wanted to talk about in that context, had to do with what implications that new economy had for questions of race and diversity, particularly for black professionals. Because another part of the new economy and the way that work is structured today is that more organizations are now a lot more focused on saying that they want to have more racial diversity. It's not uncommon to hear industries and organizations say that this is something that they value and prioritize. But in the new economy, we also know that often organizational resources don't really get devoted to making sure that organizations have the space, personnel, support and things that they need in order to make more diversity a reality. So, what I wanted to think about was what position those kinds of contradictory impulses leave for black professional workers who are trying to navigate these new workspaces and what position that puts them in?

Dr. Jimenez: Could you describe the processes by which a select group of employees is expected to take on the burden of additional equity related work in this new economy and how flatlining is the consequence?

Dr. Wingfield: Sure. So, one of the things that I argue in the book is that when we have organizations in the new economy that are focused primarily on their bottom lines, on making a profit, on short-term profits in particular, a consequence of that, again, is often that these organizations are not quite as focused on putting the resources and support and weight behind creating more racial diversity internally. And so, when organizations in the new economy are caught in that tension, what I found that often happens is that it becomes either implicitly or explicitly left up to black professional workers to pick up that slack. And the result of that is that black workers often become responsible for doing what I refer to in the book as this equity work, right? So, in other words, if organizations and when organizations say they want more diversity but aren't really putting the work behind actually creating that. They're saying that this is something that they value, but perhaps they aren't putting in the resources to make that happen. They aren't funding the initiatives that would create more diversity. They're just saying, yeah, we care about this, we really believe in diversity, we want to make this happen, but nothing actually happens to make that a reality. Then I argue that, that becomes a process of racial outsourcing, where that work of making more racial diversity becomes the

responsibility of black professionals. And what this looks like can vary depending on where in the organization these workers are employed. I found that the equity work that black doctors do, looks a bit different from what black nurses do, their equity work is not always synonymous with black technicians. But ultimately across the board, where you have our conditions and circumstances where black professional workers are doing additional labor to try to make the organizations where they are employed more accessible and available to communities of color, they often do so without acknowledgement, without recognition, and maybe most importantly, without compensation. And that creates an additional burden for workers in these environments.

Dr. Jimenez: Dr. Harwell, I know that you work with different healthcare delivery organizations. Can you share some of your perspectives on the same issue?

Dr. Harwell: I definitely agree with what Dr. Wingfield is saying. I'm at least happy to say that my organization created and established an office of community, impact, diversity, and inclusion to address many of these issues. And so, I'm fortunate to say that I'm part of an organization that really has put the money and they've really put their actions where things need to happen, and it hasn't just been a lot of words. However, the road traveled to where we currently are, was a road full of a lot of orange barrels, if you will. And

so, I definitely agree with what Dr. Wingfield is saying, because I feel that as a minority physician, that I carried an extra burden to try to make sure that not only were my patients getting equitable care, but also that some of our minoritized workers in our hospital system, that their needs and things were being addressed. It's almost like the black tax that you hear about. It always seems like there's an extra burden on minority healthcare providers, especially, if you're in systems where you aren't getting that help, you know, where you're not getting the things that you need, the resources that you need to not have this flatlining occur. And I feel that as minority healthcare providers, we just sort of take it upon ourselves to fill in these gaps. But again, like I said at first, I'm very fortunate that I believe that my healthcare system really has invested and are invested in addressing the issues of equity and diversity in our healthcare system.

Dr. Jimenez: Dr. Wingfield, now that we're sort of post pandemic - interim pandemic if you would, is it fair to say that we have a new, new economy? I heard you say that the other day. And what are the additional implications of the post pandemic situation?

Dr. Wingfield: Yeah, that's a great question. And as you acknowledged, you know, it's still unfolding. And I don't need to tell you, as medical doctors, that we're clearly not out of the pandemic yet, and we're still in the process of dealing with everything that's happening. But I do think that the aftermath

of COVID is really going to shift a lot of things when it comes to work and the economy and how it is structured and how it's experienced for many workers. And we're seeing some indications of that already with the number of workers who are refusing to return to, or outright quitting certain jobs, particularly jobs in the retail and restaurant industry, because of the accumulation of experiences that they've had and the sense that they don't feel the support, respect, and the wages and compensation that they need in order to do those jobs successfully. But we're also seeing shifts among how necessary in-person work is and how many workers are reconsidering and rethinking whether it's absolutely essential for them to be in-person, along with discussions about what actually makes an essential worker and who is an essential worker. So, I think that the pandemic is going to shift how we are working and how we understand the ways that work needs to be done in a lot of ways. When it comes to the findings that I came up with from the book, I think, again, in the absence of data, this is largely speculative, but I do have questions and concerns about whether, for example, some of the burnout that I described for black healthcare professionals pre-pandemic has probably worsened and more exacerbated in the aftermath or in the midst and in the aftermath of COVID. I think that's likely to be the case, given some of the factors that I observed that led to that burnout in the first place. I wonder if there will be adequate measures in place to make sure that healthcare professionals have the mental health support that they need, particularly through trying

times like these. And again, I can't answer these questions conclusively, because we're still in the midst of these types of issues, but I think that these are things that we want to be attuned to as the pandemic proceeds, and certainly in the aftermath of it.

Dr. Jimenez: I've done some work with burnout in physicians, and I'm sure that the added stress of what you have outlined has some contribution to this increased burnout in these physicians, for sure. Dr. Morgan, can you give us your views on the different health organizations that you have worked with?

Dr. Morgan: Yes. Thank you very much for the question. And I actually represent several organizations, orthopedic surgeons with the J Robert Gladden Society and the American Academy of Orthopedic Surgeons, and then also, our Health Disparities Institute of the National Medical Association, which is the organization that I lead at this time, the W Montague Cobb NMA Health Institute. And I say that because I'm looking at physicians from several different perspectives now. Those who are involved in research in the academic side of medicine, as well as those who, during my first 45 years of practice, were pretty much involved with taking care of patients. And everyone is affected by the increase in stress, I believe, since the pandemic. And I agree with Dr. Wingfield that this was going on

prior to the pandemic and now it's just made it sort of a universal cause for stress.

Dr. Morgan: And so, I think we have to be mindful of the fact that there are other stressors besides the pandemic. Just as there are other diseases, what we call the other determinants of our health besides the pandemic that if they are not addressed, then ultimately, we won't be in a good place. But I would say that our professionals are certainly feeling additional stress. I think that that is causing a decrease in career spans for many professionals. I think it's being shown, I saw some statistics about the practice life of females in medicine, which is decreasing annually. There are women who have been successful in a career but get to the point where they can't totally balance family versus career versus aspirations. And in many cases, the medical career is the loser. And we know that this is significant because there is a lot of investment in a medical career, in terms of time, in terms of expenses, in terms of getting to the point where you are an effective clinician. And so, if you are burned out, or if you leave that career early, it then causes increased shortages. And the shortages then cause more stress inside of our health system and, also, in our careers. The final thing I would say is that if we are leaving, and I say, we, meaning African American professionals, whether it be females or males - are leaving the field of medicine early, that is a negative factor with regard to our primary health workers, our first responders, our nurses and those

who aspire to take care of people who have not been quite as successful financially as others, because we have led that surge throughout our entire careers and now if we have a disappearance of professionals, it only is obvious that we're going to have a disappearance of the support team as well.

Dr. Jimenez: Great input. Dr. Wingfield, I'm sure you're familiar with the numbers of underrepresented representation of black and brown healthcare workers, but just for the audience, just to say that in orthopedics, that the number of black and Latino orthopedic surgeons, hovers around 3% for each, which shows why there is a real disparity gap between the populations and those who serve them. So, if we are asking them to do more of the equity work, what are some of the solutions that you might propose? Do they need to take steps through clear organizational initiatives in order to bring more resources and ally-ships to the table?

Dr. Wingfield: Well, first I just want to comment on and echo something that Dr. Morgan was just saying about the implications of these disparities, and if people leave the profession. I think this is so key to consider for a couple of reasons. One is that you don't want to see a brain drain in any profession, right? That's just not good on the face of it. But I really want to underscore his points about the implications of having more racial diversity and more doctors of color in the profession and what that means when

those doctors leave. Dr. Morgan is exactly right that the data indicates that workers of color, and black healthcare workers, in particular, are more likely to serve underrepresented communities that are disproportionately low-income, uninsured, underinsured, and/or communities of color. And so given where racial demographics are going in the United States, if we have a situation where the very healthcare providers who are more likely to serve populations of color are leaving the industry just as we're becoming a more racially diverse nation and there are increasing communities of color, we have a huge disconnect in what's going to result in terms of the capacity of the healthcare system to provide care for populations at large. I think that's an enormous problem. That's really critical to think about when we start looking in the long-term about what we are asking healthcare workers to do and what it means for healthcare workers of color, to be in these environments and to be in these situations where not only are they dealing with the baseline levels of stress that all doctors have to, but they are dealing also with being second guessed, with being doubted, with people assuming that they don't really have the training or credentials or skills to be in their profession. And dealing with the expectation that they will do this added equity work of making sure that the organization is more attuned to communities of color. That's just an enormous burden to put on people who are already underrepresented and who are already knowing outsized labor that really has long term implications for the very literal health of this nation. So, to your question

about what can be done differently, I think it's important to emphasize that while I observed a lot and write a lot in the book about the ways that healthcare workers are taking on this additional equity work of trying to make these spaces more available to communities of color, fundamentally, a big part of the problem in my view comes from the fact that you have individuals who are attempting to solve problems that are much more structural than they are individual level. And what I mean by that is that if we really want to be serious about organizations being places that are more available to these communities that they are serving, this can't be the responsibility of a handful of black doctors, nurses, and technicians, who as I just mentioned, are already underrepresented in these spaces in the first place. And we're already serving an additional burden. The solutions have to come from the organizational side. And it has to be up to organizations that are serving communities to say, what can we do to make sure that we are more responsive? Not just to the communities that we serve, but to the practitioners of color who are a critical part of our organizational structure and are doing a certain type and amount of work. How can we make sure that they have mentors? How can we make sure that they are plugged into the networks that they need? How can we make sure that they aren't doing this additional labor of having to correct and challenge their white co-workers when they engage in racial stereotyping or prejudgments about low-income communities of color? How can we make sure that they aren't expected to work extra

shifts and do additional demands, which is something that I heard a lot from black technicians in my sample? Those have to be things that are changed at the organizational level because, again, those are problems that are embedded in the organizational dynamics that are occurring and those are things that a few people can solve. So, I think it's really, important for, and I was really happy to hear Dr. Harwell say that she works at an organization that's thinking along these lines and thinking systematically about how to make sure that this burden doesn't fall solely on black healthcare practitioners. Because it has to be the organization that thinks about these things from an organizational perspective and thinks about how it can marshal its weight and its strength and its resources to make sure that they are attuned to the challenges that black workers are going to face in a very racially stratified society and that the organizational resources are devoted to making sure that those outcomes, for both patients and practitioners, are as optimal as possible, and that they aren't simply leaving that work up to the black practitioners to fix all of these problems.

Dr. Jimenez: Great. You know, as you're speaking, it made me think a little bit about my own private, if you would, not public, but private community practice that I had, and it was a single specialty orthopedic group. And I opened my first office in east San Jose, which just happens to be where there was a heavier concentration of the Latino population. And I'm happy to be born

and raised in San Jose. So, I did see, and there was a safety net hospital there and I did see, I guess almost 50% of my patient population was Hispanic/Latino. And then, I moved my practice at an additional office in west San Jose, which was, I guess, about 30% Hispanic. But since I kept both offices open, some patients followed me over there. And I guess the thrust of my question is that I brought in three other physicians, one was Vietnamese and two were Caucasian. And so, the office was predominantly, by the office I meant the 15/20 workers in the office, were multilingual. Workers that spoke Spanish, I paid 20% bonus to, but the whole culture was very inviting, very empathetic. We treated everybody the way they would want to be treated. And so, my point is that, how do we bring majority colleagues, white colleagues, to help us treat these underrepresented populations?

Dr. Wingfield: Yeah, I mean, I think the key is, as you've mentioned, not just treating these populations, but understanding the broader social context and circumstances that many of these populations face. And being a lot more open and transparent about the ways in which racial biases are part of medicine and healthcare, like they are part of every other industry, right? I mean, I think that, and there's been some discussion about this lately. I'm sure you all are familiar with the Journal of the American Medical Association Podcast that was somewhat controversial because one of the podcasters commented that there was no systemic racism in

medicine because doctors aren't racist, so why have conversations about these types of issues anyway? So, I think that indicates that there's a need, at least in some quarters, for a shift in understanding that racial biases and prejudices are part of US society. There aren't industries that are free from these biases and expectations at large, right? Healthcare is not free from these biases. Policing is not free from these biases. I'm an academic and academia certainly is not free from these biases. So, I think a step has to be understanding that these viewpoints are there, they are present, and they can cloud how patients get treated. And then thinking about the types of research that talks about how to create and build racially diverse organizations, even in that context, right? The research shows that when you attempt to tell people that they're wrong about their viewpoints or training that tries to suggest that people are racist, often doesn't work. It makes people more entrenched in their views, and it makes them feel defensive and resistant and not willing to listen to what they're being told. But data does indicate that having more, that there are strategies towards creating more racial diversity in organizations, and that having more racial diversity in organizations can really create certain outputs and create certain end results that are a lot more optimal for those who are in those organizations. So, I think that when it comes to thinking about white practitioners, it's important, one, to acknowledge that there are biases in healthcare, right? And that there are racial biases in healthcare that are sometimes held by practitioners and that these matter, and that

this isn't a space that's just free from these types of issues. But also thinking about, now that we know what are measures that we can put in place; one, to make sure that patients are getting the type of fair, equitable, and compassionate treatment that they deserve. I think often modeling and holding up the experiences of workers of color is key to this because I found that a lot of black providers were very attuned to the social circumstances and broader context of their patients and were very adept at treating all patients very equitably regardless of their background, history, experiences and so forth. But I think apart from that has to be the incorporation of strategies, as I mentioned, at an organizational level so that there is more racial diversity for white practitioners to see how it is possible to think about and be attuned to and aware of the social circumstances of patients of color, to put aside those biases and to try to eradicate those biases as part of the treatment process, to make sure one, as I said, that patients are getting equitable treatment, but two, that providers of color and black providers specifically are not then saddled with the additional equity work of trying to teach their co-workers while they're also treating the patients that they are paid to provide care for.

Dr. Morgan: I think what Dr. Wingfield has said was exactly what I was thinking that my career mirrors your career. I went back to practice in my hometown. I built a practice that at one time had 11 orthopedic surgeons and 11 orthopedic specialty related patients. And we treated multiculturally, a practice across

two or three counties in Northwest Indiana. And certainly, our problem was not one of being culturally competent. We were very culturally sensitive to our patients because we were emotionally sensitive to them. Perhaps, we had difficulty sometimes when we had people who spoke Spanish and we didn't have adequate employees to help us with language, that was a problem. But same with Eastern Europeans, that was somewhat of a problem. But it wasn't a problem that we had to constantly worry about adjusting our style of practice to make sure that we were culturally sensitive. When you look at the majority physicians, many of them, I think, still are resistant to the idea that you have to adjust the way you practice based on the patient who is before you. And when you're in a smaller practice or even some of our orthopedic group practices that are very autonomous, and if they decide that they don't wish to enforce truly culturally sensitive care, then it becomes the norm. And the doctors won't go out of their way and the staff won't go out of their way to make a difference and be more inviting for patients. Now, when we look at Carla's situation, where if you're at a prestigious center that has more patients than they can take care of and has a stellar reputation, they're able to have an edict that says our employees, our physicians, everyone's going to do certain things. And so, it's easier to instill diversity, equity, inclusion, solutions sometimes, into what goes on in those organizations. And really, that's just kind of what clicked when I listened to both of you speak. You know, I mean, this is something that we need, but something that is

extremely difficult to control if the system doesn't make it happen from top down.

Dr. Harwell: Yeah. This is Dr. Harwell. And I definitely agree with everything you said because when systems don't acknowledge, first of all, that systemic racism even exists, then there'll be no movement of the needle towards some true equity. And when institutions, and even when in non-minority healthcare providers, don't recognize that unconscious bias exists. We all have that. We all, you know, have some unconscious biases that obviously, you know, we're not even aware of. And as an associate program director for our internal medicine residency program, I teach and make sure that the residents are aware that the social determinants of health that plague so many of our minoritized patients, you have to address these issues. I tell them all the time, no one wakes up and says, “Oh, I want to be as sick as I possibly can be.” “Oh, you know, I don't want good healthcare.” No one wakes up and says that. And when the patient doesn't show up for an appointment, is it a transportation issue? You know, what else is going on? Because I don't believe that, that patient just doesn't want to be seen or doesn't want their medical needs addressed. And so, for our up and coming, physicians of the future, I'm glad that as an associate program director, that I have the opportunity, to teach and precept these up and coming, residents to understand that when you're dealing with minoritized populations, you have to consider that, A, you are

bringing some unconscious biases to the table. B, that you have to address, not just the person just as a person, but look at the big picture, look at what else is going on in that patient's life. If there's a pattern that, you know - Mrs. Jones is always admitted for a congestive heart failure exacerbation towards the end of the month, that if you pry a little bit deeper, you may discover that she's out of money, that she lives in a true food desert, that as her resources become limited, she turns to ramen noodles, you know, salty things that don't cost her as much to buy, so that she can just make it until she gets her check, you know, that next month. So, you have to look at all those things. Again, as Dr. Morgan said, you know, I'm lucky. I think that my organization really has tried to address these issues. We have employee resource groups, or like an affinity group where we're voices are heard. We have an African American one, we have a Hispanic one, and we have an LGBTQ employee resource group. And these are safe places where employees can come and vent and recognize and bring to the table issues that they're having so that these can be addressed on a higher level. But as I think we all are in agreement with here, these sort of things, these changes, these things have to come from the top down. You know, this has to be a system approach to addressing these issues. So, I think as we all have quite eloquently said here, and all agree, that until it's even recognized and acknowledged by these systems, that systemic racism exists, and even as individual providers. No one thinks of themselves as being racist but the

unconscious biases that I think we bring to the table and to not recognize that, you know, none of us are above not being judgmental and having stereotypes, that that does not impact how we provide care to our patients.

Dr. Jimenez: Well, to repeat your words, Carla, eloquently said. You know, we see safety net hospitals closing. That kind of shuts out the opportunities where a lot of the under-representative healthcare workers work, and also shuts out patients. And so, what are your thoughts about that in this new economy?

Dr. Wingfield: I think that that's really concerning. And I have a chapter in the book where I talk about the particular implication that the shrinking public sector has for black workers who are employed in those spaces. And one of the things that I found from the book was that for many black workers, part of how they end up in the public sector is by deliberate and intentional choice. They see the public sector as a space where they can really make a difference. They know either from personal experience or from observation that public facilities are going to be those that disproportionately treat, again, communities of color, often those that are low income, often those that are un- or under-insured. And so, wanting to have a real impact is what draws many black healthcare workers to those public facilities. But again, maybe somewhat paradoxically, or maybe not,

as those facilities are really under siege in many ways by the lack of resources and the lack of state support and the lack of public support that goes into healthcare and health education, that really takes a toll on many of these workers. Because they find themselves in situations where they are doing an enormous amount of the equity work that I described, in terms of not just providing care to these patients, but often challenging their white coworkers' biases about those patients. So, Dr. Harwell was just talking about the ways that people may not understand the social determinants of health and the challenges that people may face in accessing comprehensive and complete healthcare. For many healthcare workers who are employed in public facilities, many of their patients come from environments like this, where they are dealing with economic challenges, social challenges, challenges that have to do with violence in their neighborhoods and so forth. And all of those things have implications for the ability to achieve good health and to maintain good health and to be compliant with medical recommendations and suggestions. But when black healthcare workers are employed in environments where their coworkers don't see that and their coworkers make assumptions about these patients and assume that they just are lazy or they're just looking for drugs, or they just don't care about themselves. They don't understand why these patients are so difficult about being compliant. That not only, again, has implications for the type of care that these patients are going to receive, that's difficult for black healthcare workers in these workspaces to

have to hear because this becomes another type of the equity work that they have to do. Responding to those types of statements, making sure that patients of color get adequate, compassionate, respectful, and fair treatment, despite knowing that they are going to encounter stereotypes and biases from some of their very colleagues. For black women doctors, in particular, I found that it really creates a certain emotional toll, where there's a level of emotional labor that these black women doctors ended up doing. Feeling as though they are being exploited and taken advantage of, because there's a sense that the institutions want these outcomes, and they want to see black healthcare workers devoting as much as they can and knowing that they will devote as much as they can to these communities, without the type of support and care and consideration that they earn and deserve for doing this additional level of work. So, to me, this points to a bigger picture that goes back to what I was saying before about the new economy, right? If we know that we have a system of healthcare where, essentially, if you can afford good health insurance, you can get a certain level of care. If you can't afford good health insurance, you're dependent on public care facilities that are subject to declining resources, and the communities of color are more likely to be subject to that public care. To me, that points to this bigger issue where it's incumbent and critical that if we want to think about having a healthy society, where healthcare is something that's available to most populations, and that we want to actually see people in America live and

be healthy and be well, that's going to underscore the necessity of reinvesting and re-supporting our public facilities and not just treating them as an afterthought, and not just treating them as things that we can treat cavalierly and without attention, and that we cannot care if they shut down.

And the last thing I'll add, just to this point, I wrote this book and I focus, in this book, a lot on the experiences of black healthcare workers. But when we talk about the experience of public care facilities, there are ways in which that stretches across racial lines that I think warrant a lot of concern that are critical for people of all stripes and all backgrounds to take into consideration. And I think that's another thing that was really highlighted with the COVID epidemic that we are still living in. If you live in a rural area, if you live in a rural, predominantly white community, where there is one facility that's located two hours from where you live, that is a crisis. And we've seen that, that is a crisis of care for the way that people have opportunities or don't have opportunities to get treatment and get care in the midst of this pandemic. And I think that when we think about the shrinking number of resources that go into public facilities, I think often there's a mental image that people have of these facilities being located in urban inner-city communities that are then coded black and Latino. And they often think, well, you know, we don't have to care about those populations, but even if that is your orientation and you don't care about those populations, the lack of public support going to healthcare facilities

is affecting communities that you do care about, and that you may not be thinking about. Because that also has impacts for rural healthcare and rural communities that are not getting the resources in public facilities that are serving communities that aren't really in these areas that are as populated. So, it matters across the board is my point, for thinking about how the lack of support for public facilities is having a really depressing impact on the ability to provide care for communities across the board.

Dr. Jimenez: Well, it was easy for me as a Latino, as the president and founder of this five-man group, that I could direct more of what we're going to practice, etcetera, in order to garner patients, treat patients and how to treat them, etcetera. But I want to give an example of an individual who is a white majority physician, orthopedic surgeon, who had the common, hopefully all physicians have that, empathy, and he treated patients as they wanted to be treated. And so, he built his practice. He did not speak Spanish, but he built his practice by staffing. And I was in his office for about 10, 12 years, but we had about 18 employees and 16 of the 18 were bilingual by culture. The patients, they didn't care. All they wanted to know was how much their doctor kind of cared for them, whether he was white, black, brown, yellow, it didn't make any difference. But the environment, the milieu, which they could go in and they spoke primarily Spanish, be greeted in Spanish by a receptionist, all these things just led to the fact, a tremendous practice. Carmel Pebble Beach patients, which were

predominantly white, and we had Hispanics all in the same waiting room, etcetera. And so, it really meant success in practice, and satisfaction in practice and good service to all patients.

Dr. Morgan: I think, again, if it's in your DNA to be accommodating and to be thankful that you have the opportunity to be a physician and to serve, you value each and every patient that you have and you're not into making judgment about who should be treated and who you shouldn't be. But I think sometimes if that's not the way you think, then it becomes a burden and not only for an individual, but for a system. So, one thing I was thinking, I know we're sort of getting toward the close here, but I think that we should offer, Adia certainly should offer her book to many of the hospital systems. I see all the systems now trying to still deal with the diversity, inclusion, and equity equations. But I think understanding what happens when a large part of your workforce is not functioning as effectively as they could and how systematic changes could maybe make a difference, I think is something that could be offered to many of our systems. These are some of the things that, you know, were done when we had solo practices and like, you took care of people, and they took care of you, but now when there's not the impetus to do that from their employer, I think they need to be reminded of how much more efficient their systems would be and provide a higher level of care if maybe they had a chance to think about some of the points that Dr. Wingfield has raised.

Dr. Jimenez: Who are the decision makers we need to reach, if we have a call to action and what do we need to say to them?

Dr. Wingfield: That's a great question. I mean, from my view, I think that people who are in leadership at healthcare facilities and the hospital facilities have to be the people who are at the forefront of these conversations about change. To them, I would say, you know, if you're in a leadership role at a hospital then presumably, you know, you want to see your hospital do well, you want to see patients served well, you want to see your organization succeed. And my view has always been that organizations are structures, but they are structures that are populated by the sum total of the people that work within them and the people who work for them. And that your organization can always do better if you are fully leveraging everyone's talent. And what I learned from my research and what I learned from this book is that many organizations are not doing that in an effective fashion when it comes to their black employees. So, I would say to people who are in leadership roles in the organization, that, it's critical to think about how there might be organizational changes that allow you to maximize your employees of color and leverage the position, the skills and the talent of the employees of color in your organization. And that doing so has implications for the organization’s success, it has

implications for patient care, and it has long-term implications for your ability to be a thriving organization in the future.

Dr. Harwell: Yeah, this is Dr. Harwell, and I totally agree with that Dr. Wingfield. I, personally, have tried to make sure that I insert myself on as many, you know, search committees that I can try to bring in more diversity to our organization, or, you know, many other leadership roles and positions, like you said. I think it's key that we have a voice at the table. And until we are in some of these leadership positions and are really, able to be at the table when these sorts of decisions are being made or the wrong decisions are being made, again, you know, it's just going to be tough to move that needle. So, definitely I agree with everything that you just said.

Dr. Jimenez: One final thought, Dr. Morgan.

Dr. Morgan: I think we need to think about who are the most powerful allies that we can communicate with who can recognize that in spite of pipeline activities and the like, for the past 50 years, we are losing brains, as Dr. Wingfield says. We're losing primary providers of care at all levels, including the professional level, in healthcare and that this is a crisis. And we need to figure out a way to reestablish the reason for being. Because we can't just look at fitting in young people in the pipeline at one end, and they're seeping out at the other end because of systemic factors. And it's not just

the hospital nurses and therapists, it's the professionals as well. And I think that's what I've sort of tried to allude to in this discussion today and Dr. Harwell as well. So, it's very frustrating to be on all these committees, serving the black tax, making sure that you have adequate workforce in place, and then see them be dissipated because of systemic issues. So, we need the type of ally that maybe can reverse that. And I don't know exactly who that is, but I think we need to have some discussions about it.

Dr. Jimenez: In closing, I want to thank each and every one of you - Dr. Wingfield, Dr. Harwell and Dr. Morgan for joining us today. It's really been, I think, a terrific discussion. So, Dr. Wingfield, we hope you'll come back and join us when your next book is published or even before then. So, please keep in touch and thank you everyone for joining us today for this episode of the Health Disparities Podcast. Adios.

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