Grabbing the Third Rail: Race and Racism in Clinical Documentation

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Disclosures

None of today's presenters has any conflicts of interest to disclose.

Today's Agenda

Framing the Discussion (Goldenberg)

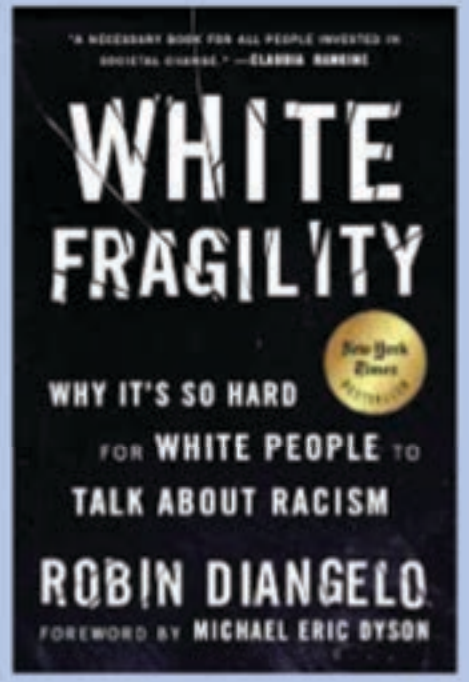
Clinical Case (Williams)

Defining Race and Racism (Isom)

The Problems with Race Medicine (Williams)

A Better Way? Structural Competency (Rohrbaugh)


CNN REPUBLICAN
PRESIDENTIAL DEBATE
6 DAYS
BREAKING NEWS
TRUMP: "I AM THE LEAST RACIST PERSON"
CNN
SITUATION ROOM


WHITE
FRAGILITY
WHY IT'S SO HARD
FOR WHITE PEOPLE TO
TALK ABOUT RACISM
ROBIN DIANGELO
FOREWORD BY MICHAEL ERIC DYSON


WHITE PROVERB
"I DON'T SEE
COLOUR"
MEDIA DIVERSIFIED

Which of the following best describe your program's teaching in terms of mentioning/recording a patient's race as identifying information?

Residents are taught to do so as a matter of routine.

Residents are taught to do so only if relevant in a particular case.

Residents are taught never to mention race.

Residents are taught to do so elsewhere in the patient's chart/EMR.

We have no specific teaching about this issue.

Which best describes your usual practice when colleagues or trainees mention/record race in the patient's medical record?

I don’t usually even notice.

I incorporate it as relevant to the patient’s case.

I wonder why they mentioned it, but don’t discuss it.

I use the opportunity to engage in a discussion of race and its medical relevance.

Identifying info: The patient is a 19 -year-old male recent high school graduate who currently lives with his mother, father, and 13-year-old brother. He has no formal psychiatry history. He has seen a school counselor for anxiety in the past. Currently employed in retail stocking shelves.

CC: “There has been a misunderstanding”

History of Present Illness: The patient is a 19-year-old male with history of asthma, HTN who was brought into the emergency department by police for “bizarre behavior” and making threats towards his co-workers.

According to the police report, on the day of admission, the patient reported to his job at Wal-Mart as usual. He works as a stocker and mostly keeps to himself at work. At lunch break, he was sitting by himself in a corner of the break room. He suddenly started shouting at other co-workers, “What are you saying?!... Stop talking about me! I’m going to f- you up.” He accused his co-workers of talking behind his back and calling him slurs. He did not physically strike anyone. The co-workers immediately reported his behavior to the manager who then called the police. When the patient learned police were being called, he walked out of store down the street. As police approached, he appeared to be talking to himself. Upon being stopped, the patient was irritable and denied anything had happened. He accused the police of following him unfairly. He also claimed that the co-workers were being biased towards him and conspiring to get him fired. Police brought the patient to the ER.

The patient arrived in the psych ER restlessly pacing the unit saying, “There has been a misunderstanding ... I am not supposed to be here!” He was able to be redirected back to his room without the use of physical restraints or medications. Upon exam, the patient is irritable and begrudgingly cooperative. He reports that his co-workers were talking about him behind his back and that he should be discharged. He initially denies any problems other than his coworkers’ behavior and voices frustration that he is being blamed for their harassment. He acknowledges he is sometimes sad but says, “Everyone is.” He reports some problems falling asleep at times.

According to patient’s parents, they have not noticed any acute changes in his behavior or personality. However, they have noticed a progressive increase in social isolation starting around his time of graduation. They attributed this to his feeling sad because his friends went away to college or moved away. He now plays more video games in the basement than usual. The patient expressed little interest in attending college as “school is not his strong suit”. Recently, he did mention that he thinks his co-workers are saying bad things about him and bullying him.

Past psychiatric history: No history of prior outpatient psychiatric treatment, No past history of inpatient psychiatric hospitalizations, No past suicide attempts. No prior medication trials.

Substance use: Regular marijuana use starting at age 16. Smokes 2 marijuana cigarettes a day, says “it relaxes me.” He denies alcohol use. Denies tobacco or any other illicit substances.

Past Medical History: Asthma, HTN, Seasonal Allergies. Meds: Albuterol PRN.

Family history: Mother, maternal grandmother and maternal aunt - depression and alcohol use. Uncle lives in a group home due to chronic bizarre behavior and cognitive limitations.

Social and developmental history: No notable prenatal exposures. Born at term. Slight delay in speech initiation. He received early intervention services as a toddler. Average “C” student in school. Always had 1-2 best friends. Parents are married and generally supportive of him.

Vital Signs: T 98.2º, HR 109, R 20, BP 120/57, O2 Sat 99%

Mental status exam: Appearance: young adult patient appearing stated age, reasonable grooming, casual dress, untucked shirt. Behavior: seated on bed, looks around the room, seems distracted at times, poor eye contact, answers questions tersely. Speech: Sparse, monotone, normal rate/volume. Mood: “Fine.” Affect: Anxious, irritable. Thought content: feelings of being harassed- ?paranoia. Denies SI/HI/AVH. Thought Process: Terse answers but no gross disorganization. Cognition: alert, oriented, recent memory intact, good vocabulary Insight/Judgment: Limited.
Labs: Utox positive for THC

Food for thought…

- Consider the following questions:
  - Is the patient's race relevant to this case?
    - If so, how?
    - If not, why not?
  - Would you document the patient's race in the medical record?
    - If so, where and why?
    - If not, why not?

Which of the following best describes whether and why you would expect trainees to consider and/or document race in this case?

No. They should never consider a patient's race, and this case is no different.

No. They should document a patient's race when relevant, but it doesn't seem to be in this case.

Yes. The patient's race could help the trainee choose the appropriate pharmacologic treatment.

Yes. The patient's race could help the trainee understand the interaction with police.

Yes. The patient's race could help the trainee understand his family's perspective on mental illness.

Learning objectives

During and/or after this session, participants will:

- Reflect on the ways in which they utilize race in their own clinical practice and teach about it in their training programs
- Describe the **historical origins** of using race in the medical chart and make connections to contemporary significance in daily medical practice
- Understand **racial health disparities** as products of social inequality (e.g. housing, education, health care, racism, differential treatment) rather than products of inherent biological differences
- Cite **evidence** of the limited utility of using race in the medical chart and how race is often used to discriminate against and deliver substandard care to racial minorities
- Articulate **specific instances** where using race in the chart might be useful (i.e. structural competency, patient experience, provider bias, advocacy, and activism)

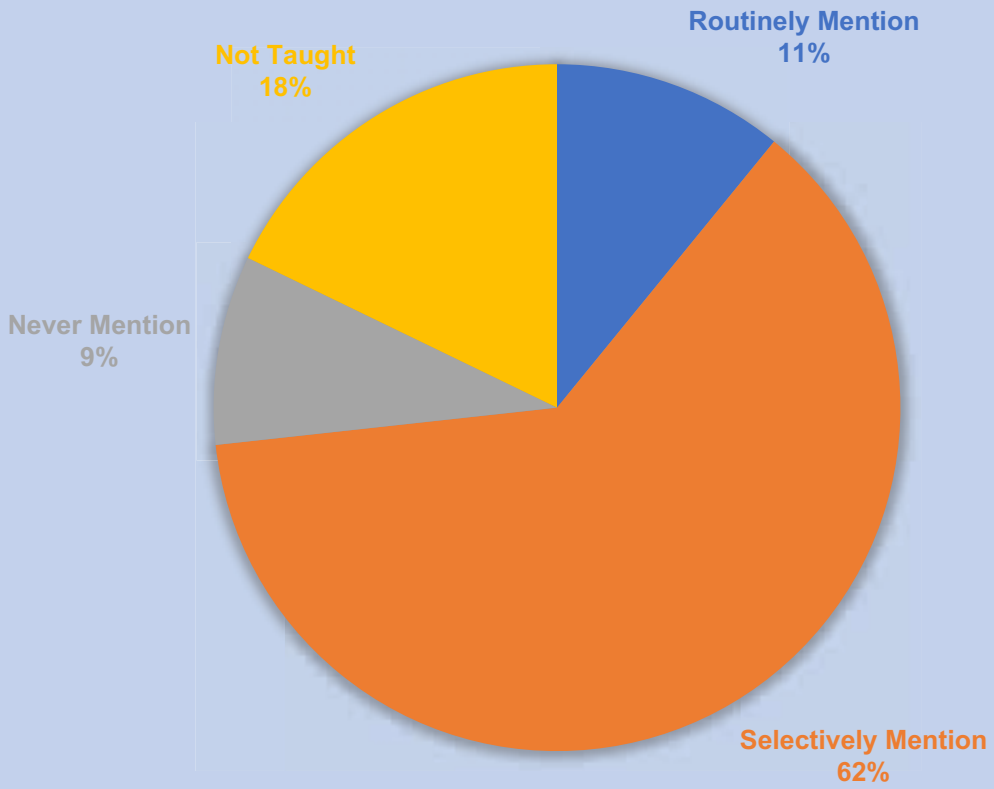
Including Race: Why?

- Custom/Habit
- Assumed relevance
  - Biological
  - Cultural
  - Exposure/Experience
- Check on own implicit bias
- Helps identify the patient on unit

Including Race: Why Not?

- Not relevant
- Activates stereotypes/ problematic heuristics
- Perpetuates idea of races as inherently different
- Makes proper consideration of race/racism less likely
- “My chart”: Patients increasingly with EHR access, worry about mislabeling or appearance of discrimination

What are students being taught about race in clinical presentation?



Nawaz et al. Medical Education 2009: 43: 146–154

Historical origins

- https://www.youtube.com/watch?v=VnfKgffCZ7U

Thinking about the case, I would consider the patient's racial identity, particularly potential minority status, in determining his genetic risk for certain disorders.

Strongly Agree

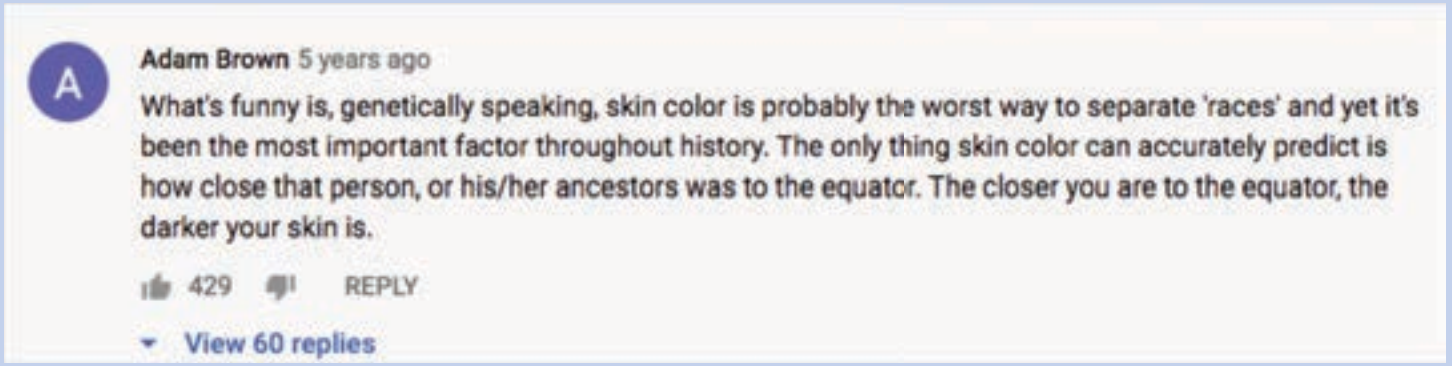
Agree

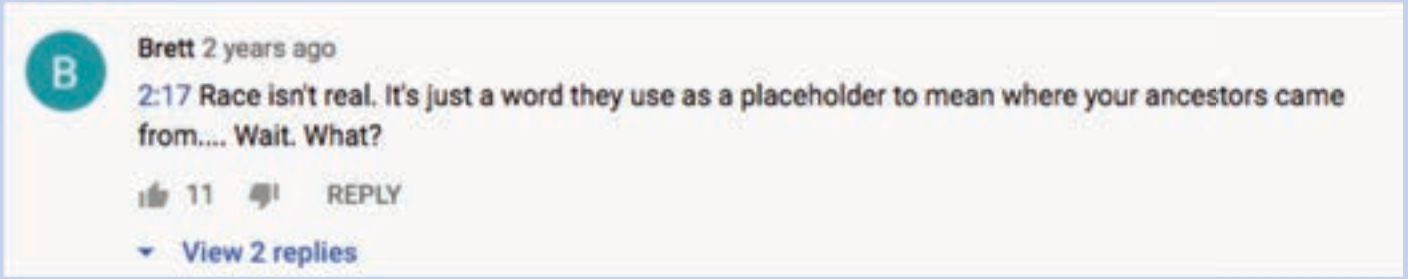
Neutral/Not Sure

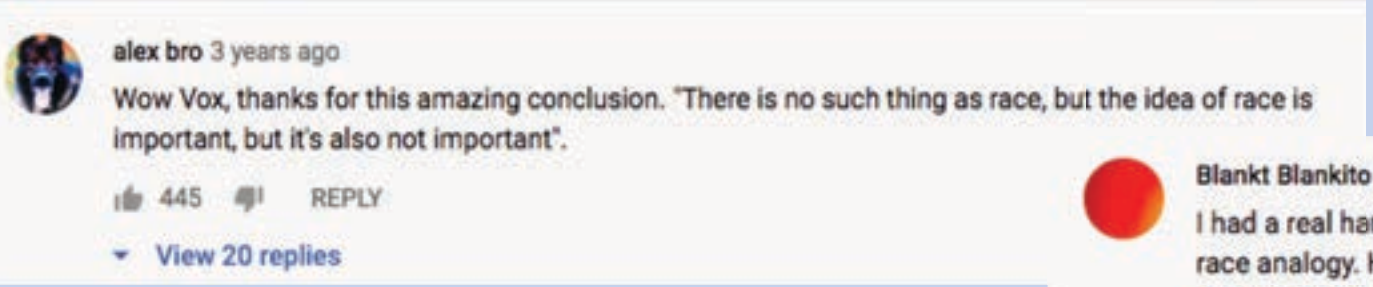
Disagree

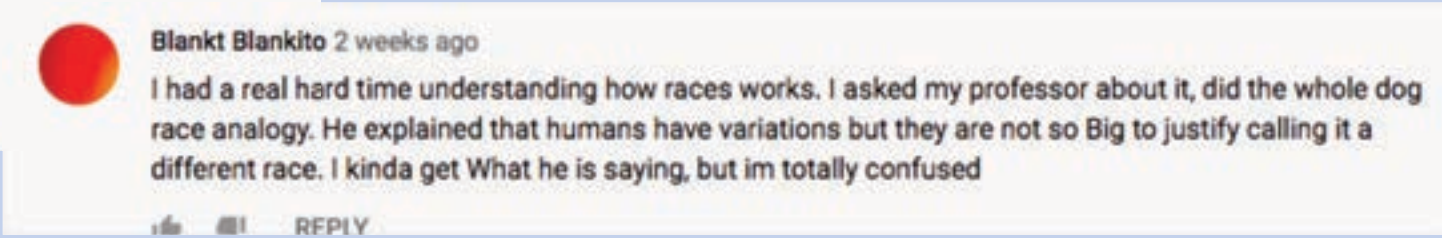
Strongly Disagree

In a nutshell, race is a messy topic to unravel









The creation of race

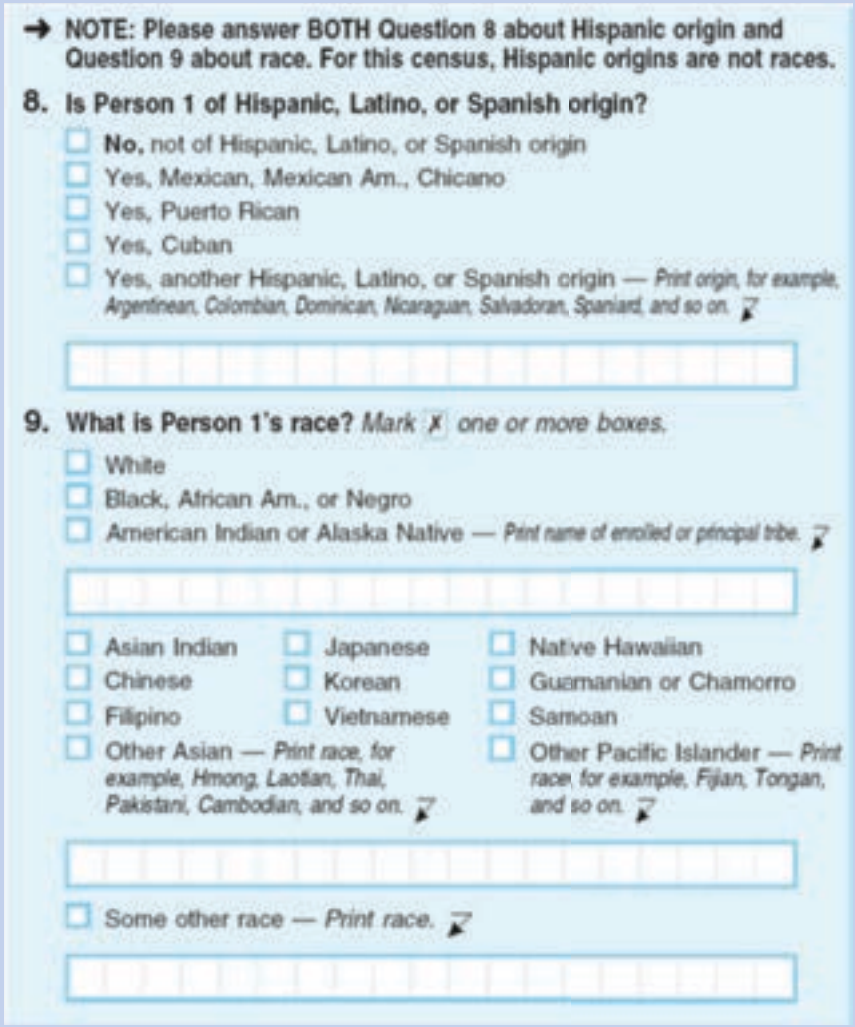
Middle ages: religion and language as identifier; components of ethnicity without physical identifiers
16th Century: race similar to terms type, kind, breed or even species
17th Century: races describes Africans, indigenous peoples and Europeans interactions in North America (and elsewhere)
18th Century: written usage of the term race increases; racial hierarchy is solidified

Race=Static
Ethnicity=Fluid

"**Race**, is the **child** of **racism**, not the father."

Between the World and Me
BY TA-NEHISI COATES

The creation of race



→ **NOTE: Please answer BOTH Question 8 about Hispanic origin and Question 9 about race. For this census, Hispanic origins are not races.**

8. Is Person 1 of Hispanic, Latino, or Spanish origin?

- ☐ **No,** not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican Am., Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin — *Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on.*

9. What is Person 1's race? *Mark ✗ one or more boxes.*

- ☐ White
- ☐ Black, African Am., or Negro
- ☐ American Indian or Alaska Native — *Print name of enrolled or principal tribe.*
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Asian — *Print race, for example, Hmong, Laotian, Thai, Pakistani, Cambodian, and so on.*
- ☐ Other Pacific Islander — *Print race, for example, Fijian, Tongan, and so on.*
- ☐ Some other race — *Print race.*

"Who qualifies as white, black, and Indian has been the matter of countless rule changes and judicial decisions. These racial reclassifications did not occur in response to scientific "advances in human biology, but in response to sociopolitical imperatives. They reveal that what is being defined, organized, and interpreted is a political relationship and not an innate classification."

-Dorothy Roberts, Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-First Century

#BlackLivesTimeline

WHAT 150 YEARS OF SYSTEMATIC RACISM LOOKS LIKE

1863 — Emancipation Proclamation

"All persons held as slaves are, and henceforward shall be free"

1865 — End of Civil War

1865 — 13th Admendment

Freedom from slavery written into the constitution, "EXCEPT as a punishment for crime". This still has not been changed.

1898 — Convict Leasing

The criminal loophole resulted in mass incarceration for minor crimes such as loitering, enslaving Black Americans who were then leased out to work. 73% of Alabama's state revenue came from convict leasing.

1870 - 1965 — Jim Crow & Segregation

Laws were passed creating permanent second class citizenship for Black Americans. Legally separate and unequal transportation, schools, parental rights, public benefits, housing, voting, workplaces etc...

1971 — War on Drugs

John Ehrlichman, chief advisor to Nixon: "We had two enemies, the anti-war left and black people. We knew we couldn't make it illegal to be either against the war or black but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, and vilify them night after night on the news. Did we know we were lying about the drugs? Of course we did." Currently 69% of Americans serving time for a federal drug offense are black or latino.

1986 — Anti Drug Abuse Act

Substances more commonly used by Black Americans had mandatory sentencing 10x higher than similar drugs more commonly used by White Americans.

1988 — Red Lining

Financial services including home and student loans are denied to black americans in both the private and public sector, helping to create and sustain ghettos. Millions of Black Americans live in these redlined areas.

1994 — Federal Crime Bill

Laws & tools such as three strikes for a mandatory life sentence & mandatory minimum sentencing were created and do disproportionately target Black Americans. Prosecutors are 2x more likely to pursue mandatory sentencing for Black Americans compared to White Americans.

2003 — Resume Name

On identical resumes white sounding names will receive 50% more callbacks for interviews than black sounding names.

2015 — Mass Incarceration

Black Americans are nearly 4x more likely to be incarcerated for drug-related offenses than their white counterparts, despite only 13% of Black Americans using illegal substances compared to 32% for White Americans.

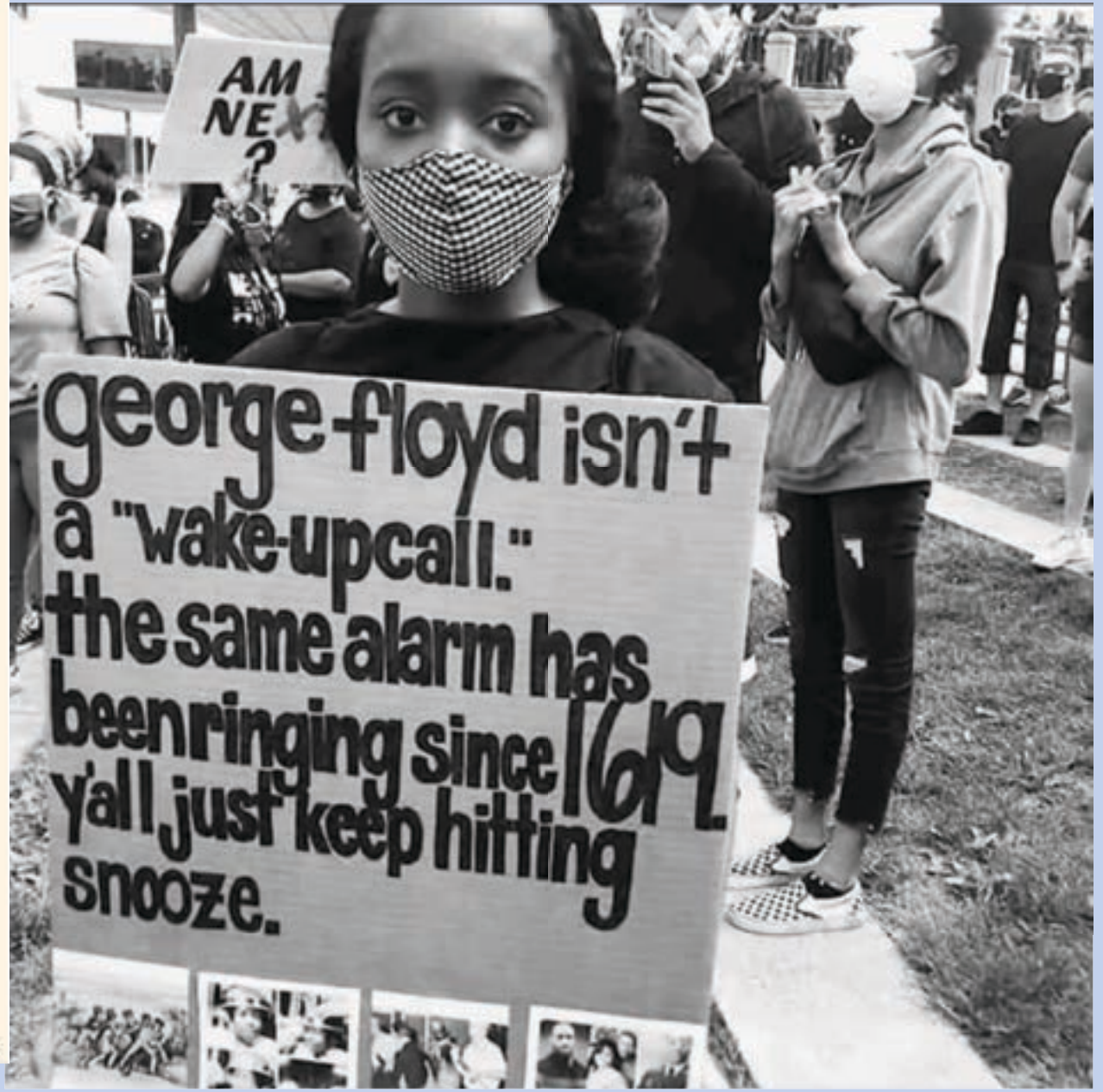
2016 — Enrichment Classes

Black elementary school students with the same test scores are 5x less likely to be chosen for gifted enrichment programs if their teacher is white vs. black.

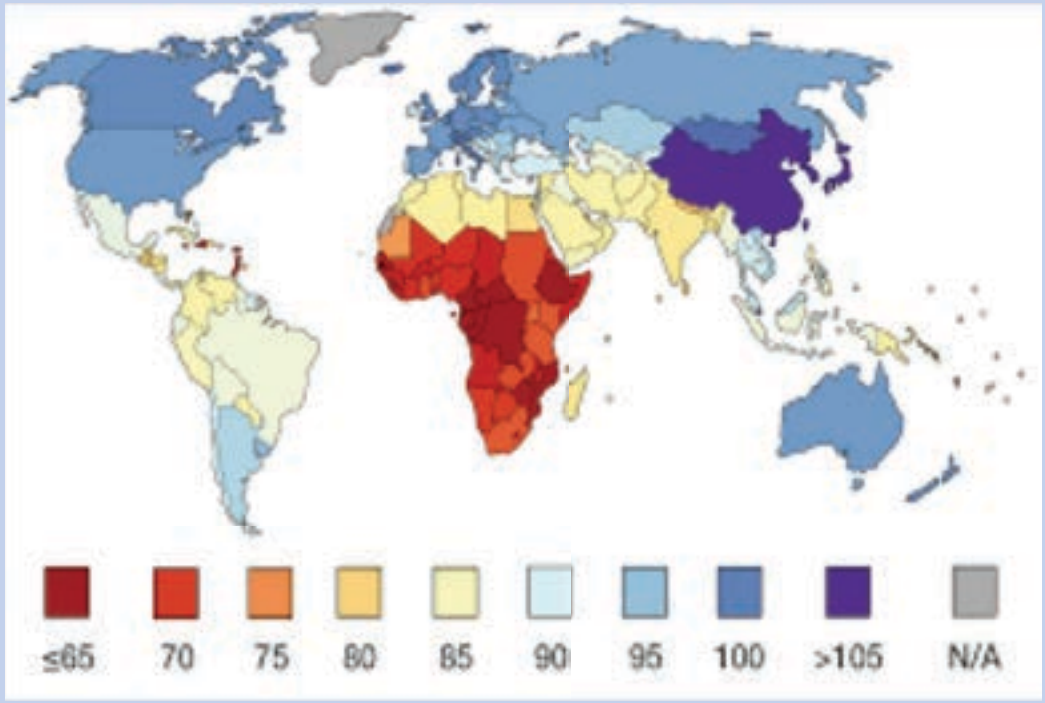
2020 — Lynching to become a federal hate crime

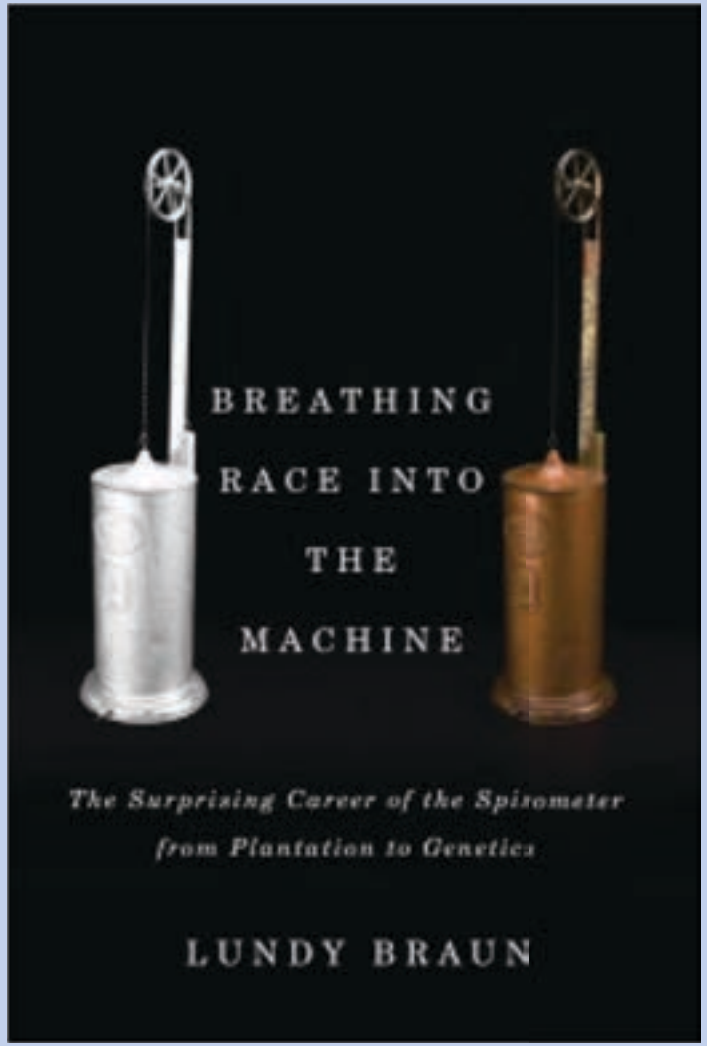
Via the Emmett Till Anti-Lynching Act

By Michael Plater II



Scientific racism: a thing of the past?





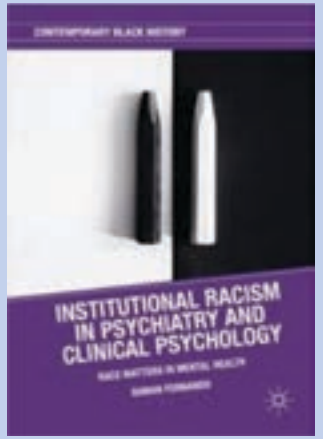
Racial interpretations of human types and traits

Black musical aptitude	"Motion, music, and excitement, or a combination of these make up much of the life of the colored people," a psychiatrist at St. Elisabeth's Hospital in Washington, DC, wrote in the American Journal of Psychiatry in 1921. "Their natural musical ability of a peculiar type, and their sense of rhythm, are too well known to make comment necessary."
Interpretations of readiness for psychotherapy	"Psychotherapy among the Afro-Americans," says Dr. Niles, "is almost like planting good seed in virgin soil," a happy consequence of their "primitively developed mentalities."
Interpretations of the nervous system	The crude, anatomically based neurology of Samuel Cartwright asserted that "the nerves going from the brain, as also the ganglionic system of nerves" in blacks were larger than those of whites, thereby accounting for their mental inferiority and immaturity.
Interpretations of pain sensitivity	James Hunt's "On the Negro's Place in Nature" (1864) repeated this idea that black nerves were thicker, and therefore less sensitive, than those of whites.
Interpretations of heart disease	JAMA reported in 1915, "the natural cardiac strength of the negro enabling him to continue work at very hard labor."

Racial interpretations of human organs and disorders

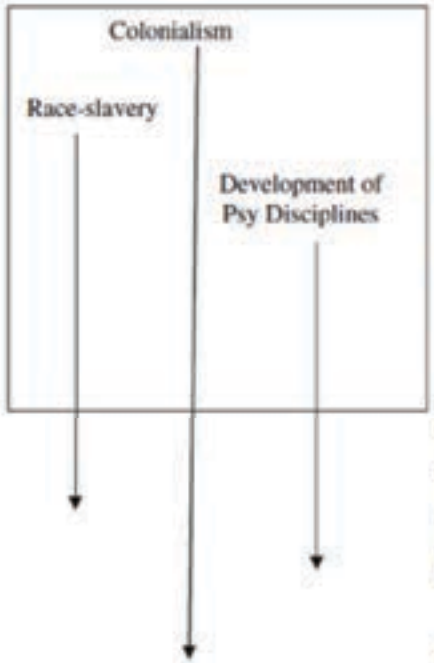
Racial interpretations of the eyes	The allegedly pathological consequences of emancipation were confirmed by one doctor's claim in 1893 that "the eye of the negro had deteriorated since he became free."
Racial interpretations of black skin	"The epidermis of most Afro-Americans is rather thick," a physician wrote in 1913, "while the terminal sensory nerves do not appear to be normally impressionable, as a general rule."
Racial interpretations of human teeth	"The negro teeth," the eugenicist C. B. Davenport wrote in 1919, "are naturally resistant to the organism of tooth caries."
Racial interpretations of "white" and "black" disorders	Dyspepsia, according to the plantation physician Samuel Cartwright, "is, par excellence, a disease of the Anglo-Saxon race. I have never seen a well-marked case of dyspepsia among the blacks. It is a disease that selects its victims from the most intellectual of mankind, passing by the ignorant and unreflecting."
Emotional hardiness	"To suffer from a phobia of Negroes," says Franz Fanon, "is to be afraid of the biological. For the Negro is only biological." "The Negro symbolizes the biological."

American psychiatry as racial medicine



History of racism

Middle Ages	vague racial awareness
1492	Columbus' voyage to America
	Expulsion from Spain of Jews and Muslims
	Vasco da Gama reaches India
	American Holocaust
1516+	African slaves in South America
1625+	Atlantic slave trade (mainly British)
	African Holocaust
1764	Occupation of Bengal by British
	Plunder of India by British
1807	Abolition of slave trade
1839-42	Defeat of China in Opium Wars
1865	Thirteenth AmendmentUS Constitution
1884	Scramble for Africa
	Plunder of Africa
1947	Liberation of India
1968	Liberation of Ghana
1971	Immigration Act UK

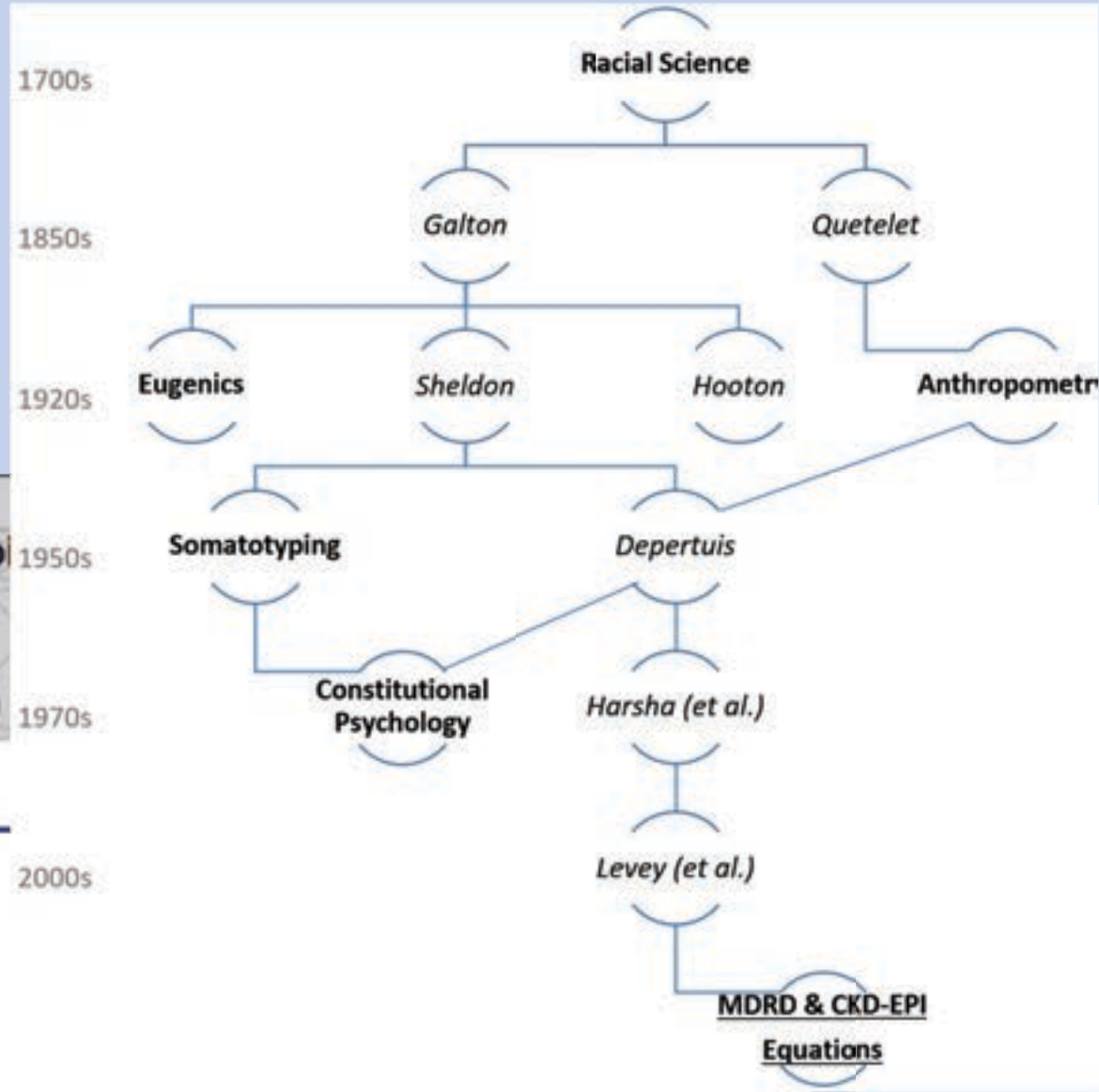


Growth of the psy disciplines

Middle Ages	Madness seen as 'unreason'
	European Renaissance
	Interest in Greek ideas on melancholia
	Medical interest in 'mind'
1586	*Treatise on Melancholy* (Bright)
1621	*Anatomy of Melancholy* (Burton)
1632	Medical Governor of Bethlem Asylum
1713	Hospital for Insane at Norwich
	Public lunatic asylums
1774	Private Madhouses Act
1808	County Asylum Act
1841	Association of Medical Officers of Asylums
1851	'Drapetomania' (illness of runaway slaves)
1901	British Psychological Society
	Kraepelinian diagnoses; eugenics
1962	*British Journal of Social and Clinical Psychology*
1963	*British Journal of Psychiatry*
1971	Royal College of Psychiatrists

Fig. 2.1 Historic context of psychiatry and psychology

Can Medicine Get Rid of The Race Card?



CJASN ePress. Published on May 11, 2020 as doi

Perspective

Precision in GFR Reporting

Let's Stop Playing the Race Card

Vanessa Grubbs

CJASN 15: ●●●–●●●, 2020. doi: https://doi.org/10.2215/CJN.00690120

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE

THE HUB

Towards the Abolition of Biological Race in Medicine and Public Health: Transforming Clinical Education, Research, and Practice

Section 1: Racism, not Race, Causes Health Disparities

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms

Darshali A. Vyas, M.D., Leo G. Eisenstein, M.D., and David S. Jones, M.D., Ph.D.

Table 1. Examples of Race Correction in Clinical Medicine.*

Tool and Clinical Utility	Input Variables	Use of Race	Equity Concern
Cardiology			
The American Heart Association's Get with the Guidelines–Heart Failure† (https://www.mdcalc.com/gwtg-heart-failure-risk-score) *Predicts in-hospital mortality in patients with acute heart failure. Clinicians are advised to use this risk stratification to guide decisions regarding initiating medical therapy.*	Systolic blood pressure Blood urea nitrogen Sodium Age Heart rate History of COPD Race: black or nonblack	Adds 3 points to the risk score if the patient is identified as nonblack. This addition increases the estimated probability of death (higher scores predict higher mortality).	The original study envisioned using this score to "increase the use of recommended medical therapy in high-risk patients and reduce resource utilization in those at low risk."[1] The race correction regards black patients as lower risk and may raise the threshold for using clinical resources for black patients.
Cardiac surgery			
The Society of Thoracic Surgeons Short Term Risk Calculator[10] (http://riskcalc.sts.org/stswebriskcalc/calculate) *Calculates a patient's risks of complications and death with the most common cardiac surgeries. Considers >60 variables, some of which are listed here.*	Operation type Age and sex Race: black/African American, Asian, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, or "Hispanic, Latino or Spanish ethnicity"; white race is the default setting. BMI	The risk score for operative mortality and major complications increases (in some cases, by 20%) if a patient is identified as black. Identification as another nonwhite race or ethnicity does not increase the risk score for death, but it does change the risk score for major complications such as renal failure, stroke, and prolonged ventilation.	When used preoperatively to assess a patient's risk, these calculations could steer minority patients, deemed higher risk, away from these procedures.
Nephrology			
Estimated glomerular filtration rate (eGFR) MDRD and CKD-EPI equations[11] (https://ukidney.com/nephrology-resources/egfr-calculator) *Estimates glomerular filtration rate on the basis of a measurement of serum creatinine.*	Serum creatinine Age and sex Race: black vs. white or other	The MDRD equation reports a higher eGFR (by a factor of 1.210) if the patient is identified as black. This adjustment is similar in magnitude to the correction for sex (0.742 if female). The CKD-EPI equation (which included a larger number of black patients in the study population), proposes a more modest race correction (by a factor of 1.159) if the patient is identified as black. This correction is larger than the correction for sex (1.018 if female).	Both equations report higher eGFR values (given the same creatinine measurement) for patients identified as black, suggesting better kidney function. These higher eGFR values may delay referral to specialist care or listing for kidney transplantation.
Organ Procurement and Transplantation Network: Kidney Donor Risk Index (KDRI)[12] (https://optn.transplant.hrsa.gov/resources/allocation-calculators/kdpi-calculator/) *Estimates predicted risk of donor kidney graft failure, which is used to predict viability of po-*	Age Hypertension, diabetes Serum creatinine level Cause of death (e.g., cerebrovascular accident) Donation after cardiac death Hepatitis C Height and weight	Increases the predicted risk of kidney graft failure if the potential donor is identified as African American (coefficient, 0.179), a risk adjustment intermediate between those for hypertension (0.126) and diabetes (0.130) and that for elevated creatinine (0.209–0.220).	Use of this tool may reduce the pool of African-American kidney donors in the United States. Since African-American patients are more likely to receive kidneys from African-American donors, by reducing the pool of available kidneys, the KDRI could exacerbate this racial inequity in ac-

The evolution in the meaning of race

How Race Becomes Biology: Embodiment of Social Inequality

Clarence C. Gravlee*

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KEY WORDS race; genetics; human biological variation; health; racism

ABSTRACT The current debate over racial inequalities in health is arguably the most important venue for advancing both scientific and public understanding of race, racism, and human biological variation. In the United States and elsewhere, there are well-defined inequalities between racially defined groups for a range of biological outcomes—cardiovascular disease, diabetes, stroke, certain cancers, low birth weight, preterm delivery, and others. Among biomedical researchers, these patterns are often taken as evidence of fundamental genetic differences between alleged races. However, a growing body of evidence establishes the primacy of social inequalities in the origin and persistence of racial health disparities. Here, I summarize this evidence and argue that the debate over racial inequalities in health presents an opportunity to refine the critique of race in three ways: 1) to reiterate why the race concept is inconsistent with patterns of global human genetic diversity; 2) to refocus attention on the complex, environmental influences on human biology at multiple levels of analysis and across the lifecourse; and 3) to revise the claim that race is a cultural construct and expand research on the sociocultural reality of race and racism. Drawing on recent developments in neighboring disciplines, I present a model for explaining how racial inequality becomes embodied—literally—in the biological well-being of racialized groups and individuals. This model requires a shift in the way we articulate the critique of race as bad biology. Am J Phys Anthropol 000:000–000, 2009.

RACE =/= GENES

African & African American Diversity

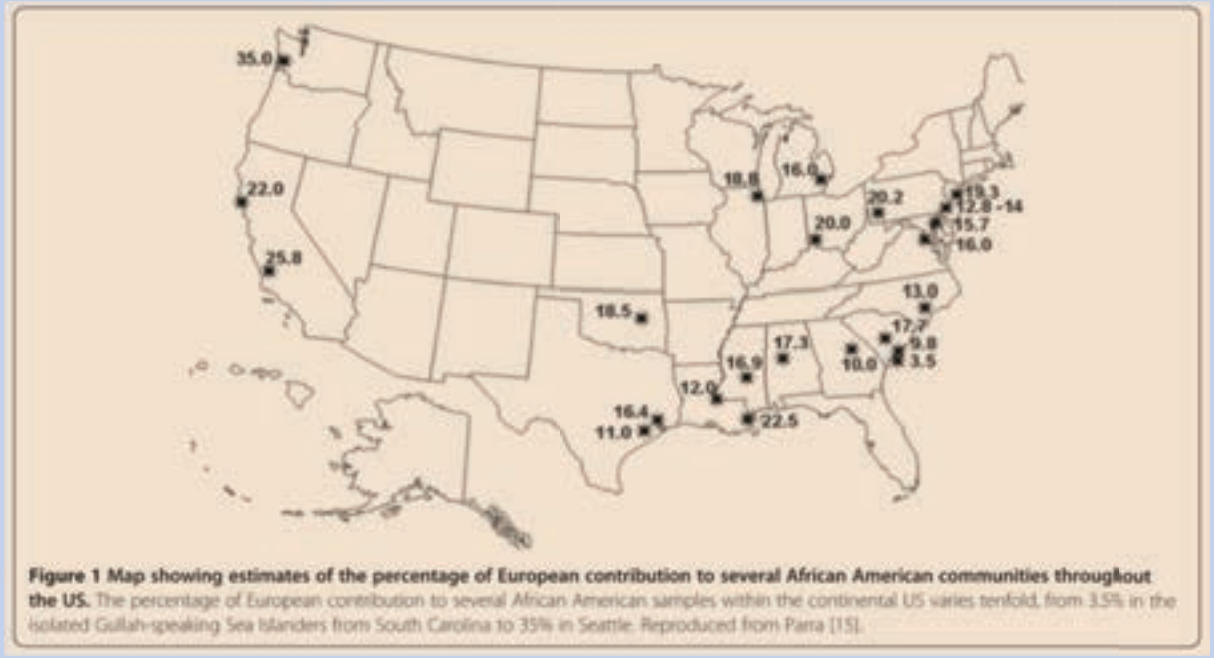
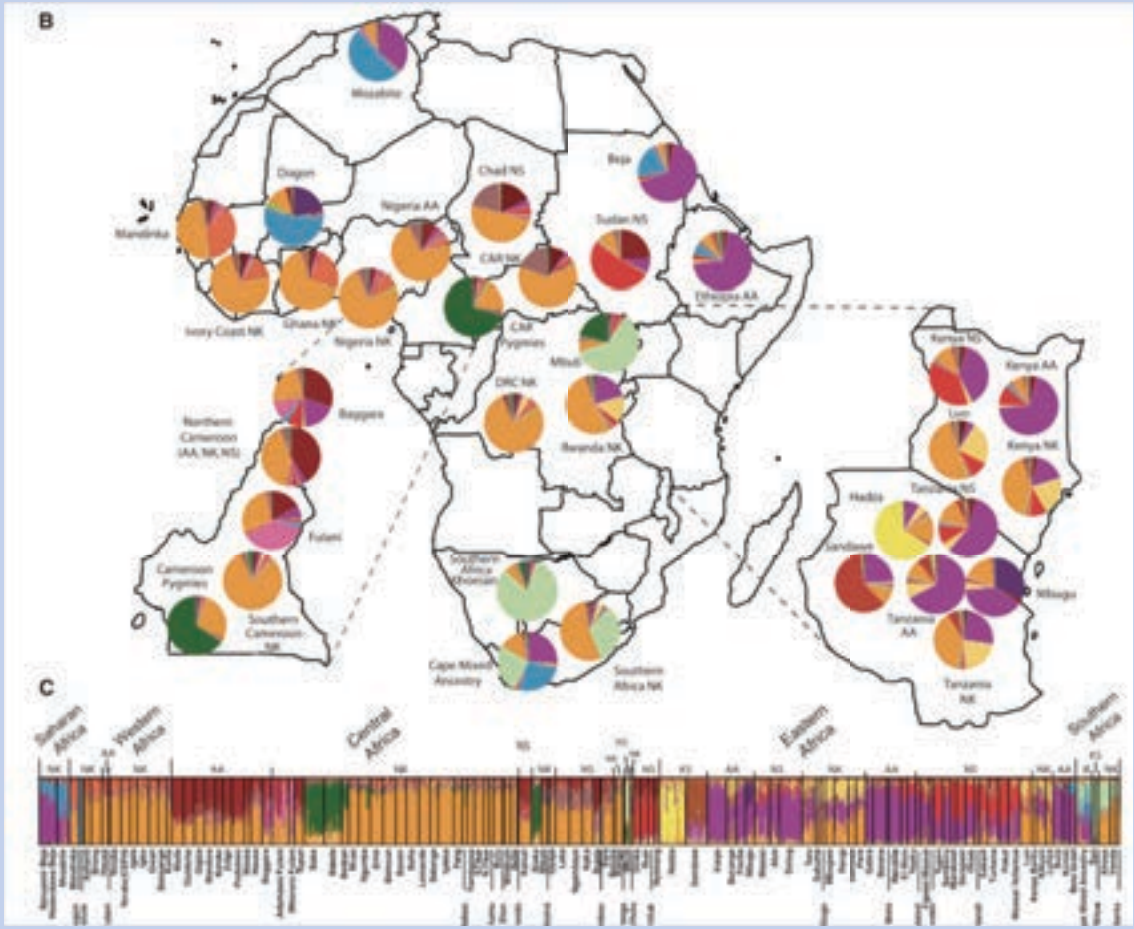


Figure 1 Map showing estimates of the percentage of European contribution to several African American communities throughout the US. The percentage of European contribution to several African American samples within the continental US varies tenfold, from 3.5% in the isolated Gullah-speaking Sea Islanders from South Carolina to 35% in Seattle. Reproduced from Parra [15].



Self-identified race and socially-assigned race

Socially-Assigned Race, Healthcare Discrimination and Preventive Healthcare Services

Tracy MacIntosh, Mayur M. Desai, Tene T. Lewis, Beth A. Jones, Marcella Nunez-Smith

Published: May 21, 201

Medicine · Published in Ethnicity & disease 2008

Using "socially assigned race" to probe white advantages in health status.

Camara Phyllis Jones, Benedict I. Trun

OBJECTIVES

We explore the relationships betwe
race/ethnicity, and excellent or very
identified race/ethnicity and socially
status, even for those who do not s

White et al. International Journal for Equity in Health (2020) 19:25
https://doi.org/10.1186/s12939-020-1137-5

International Journal for Equity in Health

REVIEW Open Access

Socially-assigned race and health: a scoping review with global implications for population health equity

Kellee White[1*], Jourdyn A. Lawrence[2], Nedelina Tchangalova[3], Shuo J. Huang[1] and Jason L. Cummings[4]

Check for updates

Regarding the case, if the patient is identified as a racial minority, he is likely to receive a differential treatment.

Strongly Agree

Agree

Neutral/Don't Know

Disagree

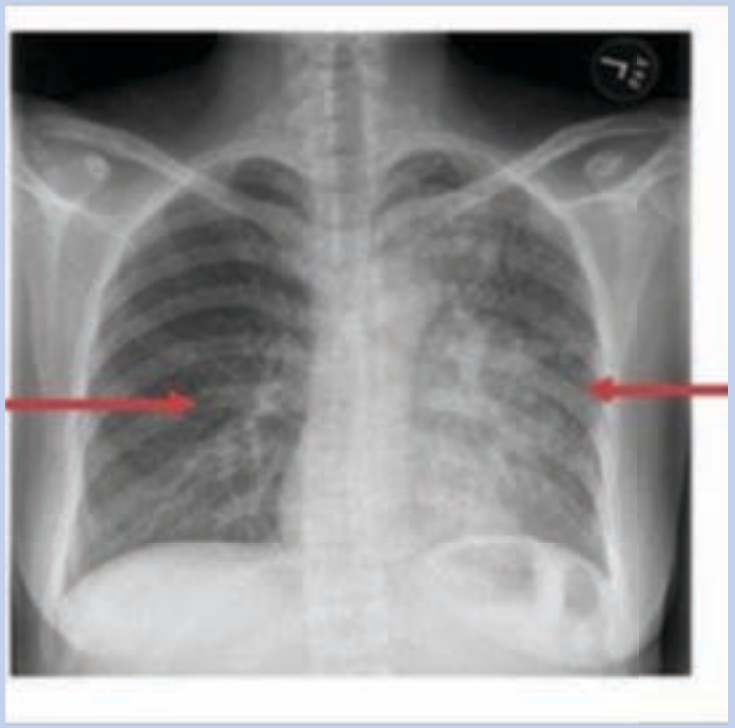
Strongly Disagree

Thinking about the case, I worry that documenting/considering race in the identifying information might activate negative stereotypes or false beliefs about the patient.

Strongly Agree
Agree
Neutral/Not sure
Disagree
Strongly Disagree

Deleterious consequences of using race in the chart…

2 year old African American female with respiratory problems…



https://radio.wpsu.org/post/whats-race-got-do-medicine

CASE REPORT

Sickle Cell Anemia; First Case Reported from Egypt

By A. S. Abbasy, M.B., D.Ch., M.D.

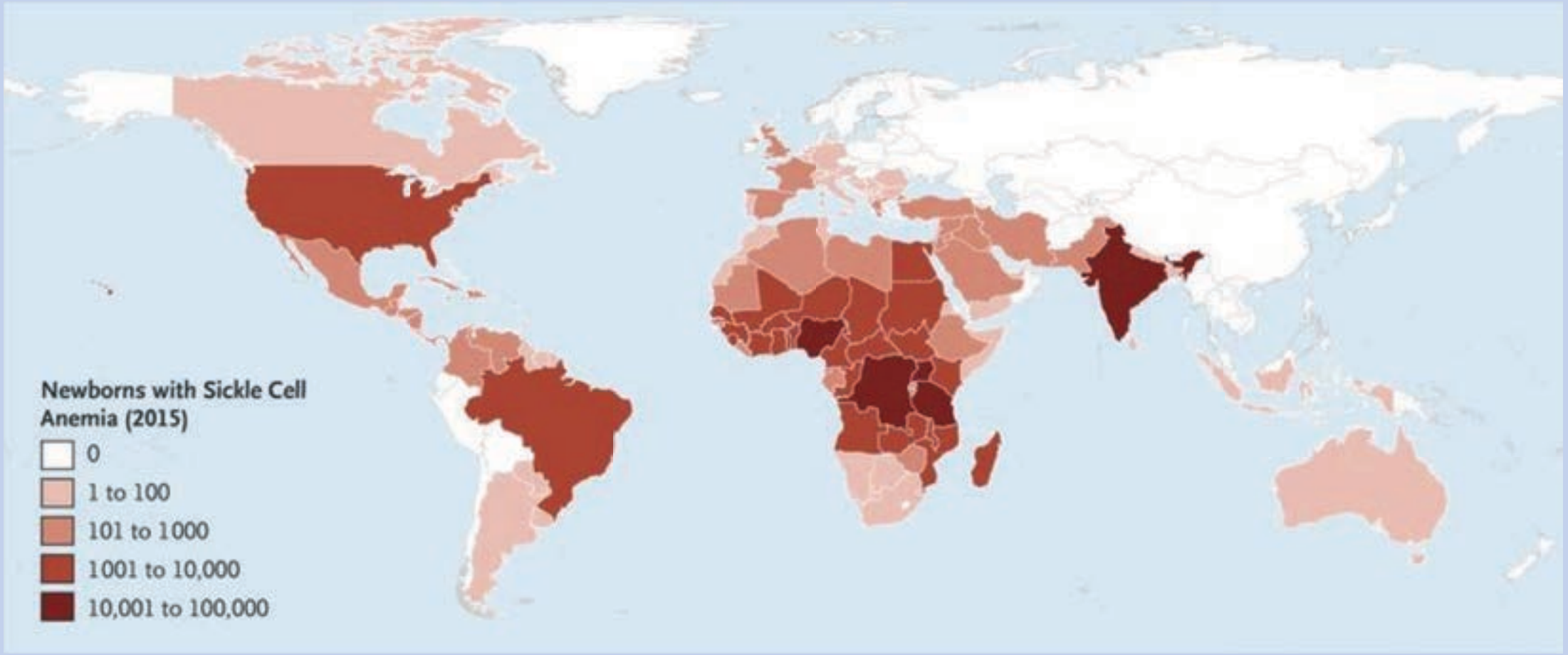
SICKLE CELL ANEMIA, which was first described by Herrick[15] in 1910, occurs almost exclusively in the Negro race. For hundreds of years inter-

A 13 year old white girl from Alexandria, Egypt, was admitted to the Children's Hospital with the chief complaints of pallor and weakness.

underweight for her age (76 pounds). She showed no definitely Negroid features (figs. 1 and 2). Her skeletal measurements in inches were as follows: height, 58; sitting height,

migrated from Algeria to Alexandria three hundred years ago. None of the ancestors is known to have been a Negro. The father and mother, who are second cousins, and five sib-

Sickle Cell =/= Black disease



Racial Bias in Presentation of Cases

THOMAS E. FINUCANE, MD, JOSEPH A. CARRESE, MD

JOURNAL OF GENERAL INTERNAL MEDICINE, Volume 5 (March/April), 1990

Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits

Rachel L. Johnson, MD, PhD, Debra Roter, DrPH, Neil R. Powe, MD, MBA, and Lisa A. Cooper, MD, MPH

TABLE 2—Association Between Patient Race/Ethnicity and Medical-Visit Communication Quality: Baltimore, Md–Washington, DC–Northern Virginia Metropolitan Area, July 1998–June 1999 and January–November 2000

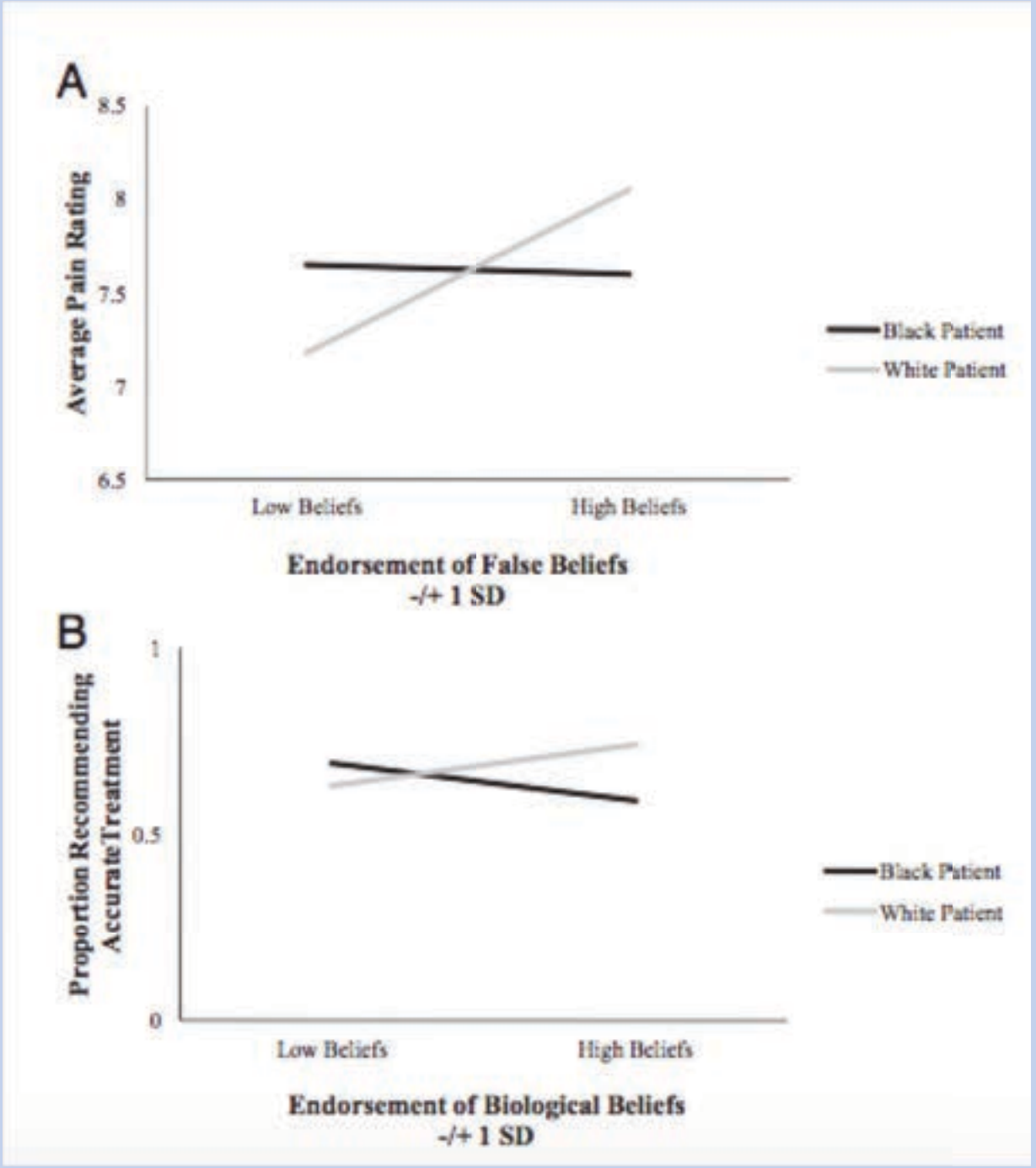
	White Patients (n = 202)[a] Mean (95% CI)	African American Patients (n = 256)[a] Mean (95% CI)	P[b]
Medical-visit communication process measures			
Duration of visit, minutes			
Univariate model	15.91 (14.36, 17.47)	15.27 (13.84, 16.71)	.46
Multivariate model[c]	9.64 (2.01, 17.28)	9.01 (1.97, 16.05)	.59
Speech speed[d]			
Univariate model	23.22 (22.17, 24.28)	22.81 (12.71, 23.90)	.38
Multivariate model[c]	19.91 (14.96, 24.86)	19.90 (15.08, 24.72)	.98
Measures of patient-centered communication			
Physician verbal dominance[e]			
Univariate model	1.24 (1.16, 1.32)	1.43 (1.34, 1.53)	<.001
Multivariate model[c]	1.50 (0.98, 2.01)	1.73 (1.20, 2.26)	<.001
Physician patient-centeredness[f]			
Univariate model	1.31 (1.02, 1.60)	1.02 (0.89, 1.14)	<.05
Multivariate model[c]	1.91 (0.76, 3.07)	1.58 (0.68, 2.48)	.08
Measures of medical-visit affective tone			
Patient positive-affect score			
Univariate model	17.59 (17.23, 17.96)	16.50 (16.09, 16.92)	<.001
Multivariate model[c]	16.65 (14.31, 18.99)	15.77 (13.47, 18.06)	<.001
Physician positive-affect score			
Univariate model	12.68 (11.91, 13.45)	11.90 (11.26, 12.55)	.02
Multivariate model[c]	14.12 (11.48, 16.75)	13.19 (10.56, 15.82)	.02

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

Kelly M. Hoffman[a,1], Sophie Trawalter[a], Jordan R. Axt[a], and M. Norman Oliver[b,c]

Table 1. Percentage of white participants endorsing beliefs about biological differences between blacks and whites

Item	Study 1: Online sample ($n = 92$)	Study 2			
		First years ($n = 63$)	Second years ($n = 72$)	Third years ($n = 59$)	Residents ($n = 28$)
Blacks age more slowly than whites	23	21	28	12	14
Blacks' nerve endings are less sensitive than whites'	20	8	14	0	4
Black people's blood coagulates more quickly than whites'	39	29	17	3	4
Whites have larger brains than blacks	12	2	1	0	0
Whites are less susceptible to heart disease than blacks*	43	63	83	66	50
Blacks are less likely to contract spinal cord diseases*	42	46	67	56	57
Whites have a better sense of hearing compared with blacks	10	3	7	0	0
Blacks' skin is thicker than whites'	58	40	42	22	25
Blacks have denser, stronger bones than whites*	39	25	78	41	29
Blacks have a more sensitive sense of smell than whites	20	10	18	3	7
Whites have a more efficient respiratory system than blacks	16	8	3	2	4
Black couples are significantly more fertile than white couples	17	10	15	2	7
Whites are less likely to have a stroke than blacks*	29	49	63	44	46
Blacks are better at detecting movement than whites	18	14	15	5	11
Blacks have stronger immune systems than whites	14	21	15	3	4
False beliefs composite (11 items), mean (SD)	22.43 (22.93)	14.86 (19.48)	15.91 (19.34)	4.78 (9.89)	7.14 (14.50)
Range	0–100	0–81.82	0–90.91	0–54.55	0–63.64
Combined mean (SD) (medical sample only)			11.55 (17.38)		


A
8.5
8
7.5
7
6.5
Average Pain Rating
Low Beliefs
High Beliefs
Endorsement of False Beliefs
-/+ 1 SD
Black Patient
White Patient
B
1
0.5
0
Proportion Recommending Accurate Treatment
Low Beliefs
High Beliefs
Endorsement of Biological Beliefs
-/+ 1 SD
Black Patient
White Patient

The New England Journal of Medicine

Special Article

THE EFFECT OF RACE AND SEX ON PHYSICIANS' RECOMMENDATIONS FOR CARDIAC CATHETERIZATION

KEVIN A. SCHULMAN, M.D., JESSE A. BERLIN, SC.D., WILLIAM HARLESS, PH.D., JON F. KERNER, PH.D., SHYRL SISTRUNK, M.D., BERNARD J. GERSH, M.B., CH.B., D.PHIL., ROSS DUBÉ, CHRISTOPHER K. TALEGHANI, M.D., JENNIFER E. BURKE, M.A., M.S., SANKEY WILLIAMS, M.D., JOHN M. EISENBERG, M.D., AND JOSÉ J. ESCARCE, M.D., PH.D.

TABLE 4. REFERRAL FOR CARDIAC CATHETERIZATION ACCORDING TO EXPERIMENTAL FACTORS.

EXPERIMENTAL FACTOR AND CATEGORY	MEAN REFERRAL RATE	ODDS RATIO (95% CI)*	P VALUE
	%		
Sex			
Male	90.6	1.0	
Female	84.7	0.6 (0.4–0.9)	0.02
Race			
White	90.6	1.0	
Black	84.7	0.6 (0.4–0.9)	0.02
Age			
55 yr	89.7	1.0	
70 yr	85.6	0.7 (0.4–1.1)	0.09
Risk level			
Low	88.9	1.0	
High	86.4	0.8 (0.5–1.2)	0.31
Type of chest pain			
Nonanginal pain	83.8	1.0	
Possible angina	90.0	1.7 (1.0–3.0)	0.04
Definite angina	89.2	1.6 (0.9–2.7)	0.08
Stress-test result			
Inferolateral ischemia	86.3	1.0	
Anterolateral ischemia	86.7	1.0 (0.6–1.6)	0.89
Multiple ischemic defects	90.0	1.4 (0.8–2.5)	0.20

*CI denotes confidence interval.

TABLE 5. PREDICTORS OF REFERRAL FOR CARDIAC CATHETERIZATION.*

MODEL AND VARIABLE	ODDS RATIO (95% CI)†	P VALUE
Race and sex as separate factors		
Sex		
Male	1.0	
Female	0.6 (0.4–0.9)	0.02
Race		
White	1.0	
Black	0.6 (0.4–0.9)	0.02
Interaction of race and sex		
White male	1.0	
Black male	1.0 (0.5–2.1)	0.99
White female	1.0 (0.5–2.1)	>0.99
Black female	0.4 (0.2–0.7)	0.004

*Both models included all experimental factors as covariates, as well as the probability of coronary artery disease as estimated after the results of the stress tests were known. The first analysis included only the main effects. The second analysis explored a race–sex interaction.

†CI denotes confidence interval.

Racial and Ethnic Differences in Time to Acute Reperfusion Therapy for Patients Hospitalized With Myocardial Infarction

Elizabeth H. Bradley, PhD
Jeph Herrin, PhD
Yongfei Wang, MS
Robert L. McNamara, MD, MHS
Tashonna R. Webster, MPH
David J. Magid, MD, MPH
Martha Blaney, PharmD
Eric D. Peterson, MD
John G. Canto, MD, MSPH
Charles V. Pollack, Jr, MD, MA
Harlan M. Krumholz, MD, SM

Table 6. Differences in Door-to-Balloon Times Between White and Nonwhite Racial and Ethnic Groups*

Characteristic	Difference (95% Confidence Interval)					
	Crude	Model 0†	Model 1‡	Model 2§	Model 3‖	Model 4¶
White, mean time in min	109.4	107.8	107.6	107.4	107.5	105.6
African American	18.9 (16.5 to 21.4)	12.7 (10.3 to 15.1)	13.0 (10.6 to 15.4)	11.2 (8.9 to 13.5)	9.1 (6.9 to 11.2)	8.7 (6.7 to 10.8)
Hispanic	11.4 (8.7 to 14.2)	3.3 (0.7 to 6.0)	4.9 (2.3 to 7.7)	4.5 (1.9 to 7.1)	4.0 (1.6 to 6.5)	3.7 (1.3 to 6.1)
Asian	2.4 (−0.9 to 5.8)	−0.4 (−3.7 to 3.1)	0.9 (−2.5 to 4.4)	1.5 (−1.8 to 4.9)	1.0 (−2.1 to 4.2)	0.7 (−2.3 to 3.9)
American Indian	2.8 (−1.1 to 6.9)	2.8 (−6.5 to 12.6)	3.3 (−5.9 to 13.1)	1.3 (−7.4 to 10.5)	1.1 (−7.1 to 9.0)	1.3 (−6.8 to 9.8)
Other race/ethnicity	−1.3 (−3.7 to 1.1)	−2.6 (−5.2 to 0.0)	−1.4 (−4.0 to 1.2)	−1.0 (−3.5 to 1.5)	−1.1 (−3.5 to 1.3)	−1.1 (−3.4 to 1.3)
R^2	NA	0.14	0.15	0.21	0.30	0.30

Abbreviation: NA, not applicable.
*All estimation models are adjusted for calendar time, fixed and random effects, and hospital random effects.
†Adjusted only for calendar time, fixed and random effects, and hospital random effects.
‡Adjusted for age, sex, and insurance status.
§Adjusted for age, sex, insurance status, and clinical characteristics.
‖Adjusted for age, sex, insurance status, clinical characteristics, time since symptom onset, time of hospital arrival, and prehospital electrocardiogram performed.
¶Adjusted for age, sex, insurance status, clinical characteristics, time since symptom onset, time of hospital arrival, prehospital electrocardiogram performed, and hospital characteristics.

Table 5. Differences in Door-to-Drug Times Between White and Nonwhite Racial and Ethnic Groups*

Characteristic	Difference (95% Confidence Interval)					
	Crude	Model 0†	Model 1‡	Model 2§	Model 3‖	Model 4¶
White, mean time in min	33.8	34.6	34.5	34.5	34.4	34.1
African American	7.3 (6.4 to 8.3)	6.3 (5.4 to 7.3)	6.5 (5.6 to 7.5)	5.5 (4.6 to 6.4)	5.3 (4.4 to 6.1)	5.1 (4.2 to 5.9)
Hispanic	2.3 (1.4 to 3.3)	1.6 (0.6 to 2.6)	2.4 (1.4 to 3.4)	1.7 (0.7 to 2.6)	1.4 (0.5 to 2.4)	1.3 (0.4 to 2.3)
Asian	3.6 (2.2 to 5.1)	2.3 (0.8 to 3.7)	2.8 (1.4 to 4.3)	2.1 (0.8 to 3.5)	1.9 (−2.7 to 4.3)	1.7 (0.4 to 3.0)
American Indian	2.7 (−1.1 to 6.8)	0.9 (−2.7 to 4.9)	2.3 (−1.5 to 6.3)	1.2 (−2.4 to 4.9)	0.6 (−2.7 to 4.3)	0.8 (−2.6 to 4.4)
Other race/ethnicity	0.1 (−0.8 to 1.1)	−0.7 (−1.7 to 0.3)	0.2 (−0.9 to 1.2)	0.0 (−0.9 to 1.0)	0.0 (−0.9 to 1.0)	0.0 (−1.0 to 1.0)
R^2	NA	0.09	0.12	0.17	0.21	0.21

Abbreviation: NA, not applicable.
*All estimation models are adjusted for calendar time, fixed and random effects, and hospital random effects.
†Adjusted only for calendar time, fixed and random effects, and hospital random effects.
‡Adjusted for age, sex, insurance status.
§Adjusted for age, sex, insurance status, and clinical characteristics.
‖Adjusted for age, sex, insurance status, clinical characteristics, time since symptom onset, time of hospital arrival, and prehospital electrocardiogram performed.
¶Adjusted for age, sex, insurance status, clinical characteristics, time since symptom onset, time of hospital arrival, prehospital electrocardiogram performed, and hospital characteristics.

“I am not colorblind. I always take note of my patient's race. So do many of my colleagues…When it comes to practicing medicine, stereotyping often works… When I prescribe Prozac to a patient who is African-American, I start at a lower dose, 5 or 10 milligrams instead of the usual 10-to-20 milligram dose.”

ORIGINAL ARTICLE

National Patterns in Antidepressant Medication Treatment

Mark Olfson, MD, MPH; Steven C. Marcus, PhD

Table 4. Number of Antidepressant Prescriptions in Persons Treated With Antidepressants in the United States, 1996 and 2005, Total and Stratified by Sociodemographic Groups[a]

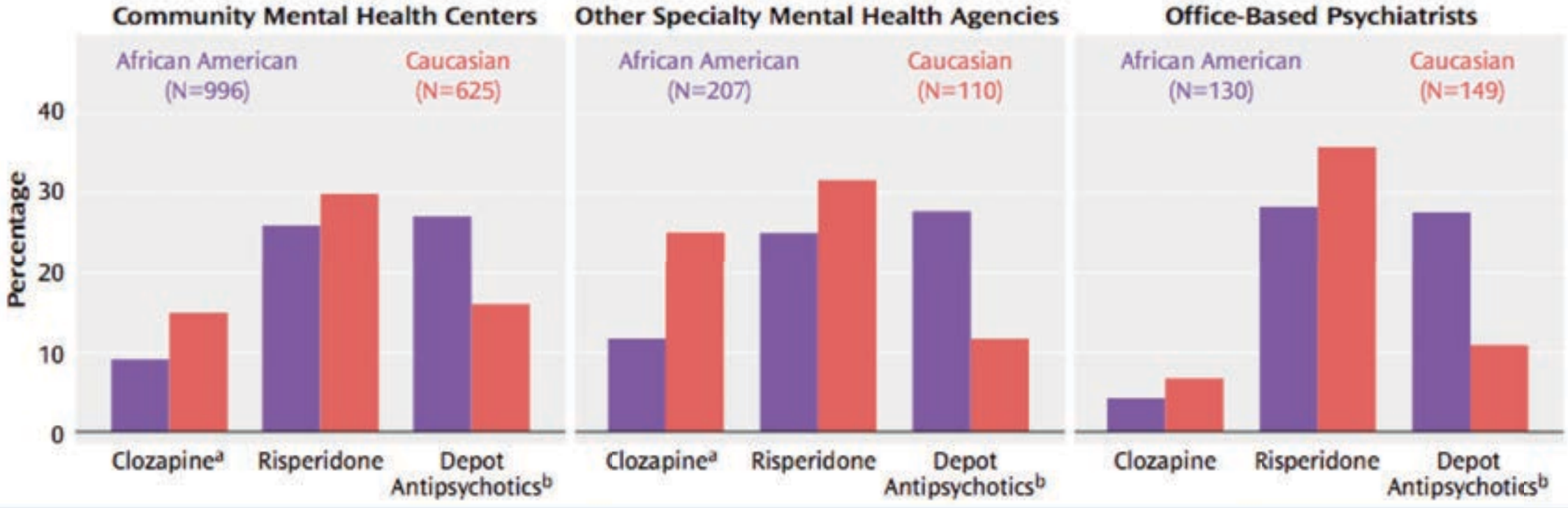
	No. of Antidepressant Prescriptions		Statistics		Adjusted Year Effect[b]	
	MEPS 1996 (n = 1029)	MEPS 2005 (n = 2602)				
Group Characteristic	Mean (SE)	Mean (SE)	*t*	*P* Value	β	*P* Value
Total	5.60 (0.17)	6.93 (0.15)	5.93	<.001	1.41	<.001
Sex						
Male	5.27 (0.24)	6.61 (0.21)	4.13	<.001	1.49	<.001
Female	5.76 (0.21)	7.09 (0.17)	4.89	<.001	1.30	<.001
Age, y						
6-17	4.95 (0.75)	6.51 (0.56)	1.66	.10	1.11	.23
18-34	5.09 (0.34)	5.34 (0.26)	0.57	.57	0.54	.20
35-49	5.75 (0.28)	7.57 (0.28)	4.59	<.001	1.97	<.001
50-64	5.53 (0.29)	7.44 (0.24)	5.11	<.001	1.95	<.001
≥65	6.04 (0.37)	6.63 (0.31)	1.21	.23	0.73	.13
Race/ethnicity						
White[c]	5.73 (0.19)	7.08 (0.16)	5.46	<.001	1.39	<.001
Black	4.88 (0.47)	6.48 (0.42)	2.53	.01	1.43	.02
Hispanic	4.69 (0.44)	5.45 (0.39)	1.28	.20	0.81	.16

Racial Disparities in Antipsychotic Prescription Patterns for Patients With Schizophrenia

Eri Kuno, Ph.D.

Aileen B. Rothbard, Sc.D.

FIGURE 1. Antipsychotic Prescription Patterns for African American and Caucasian Patients With Schizophrenia Followed for 1 Year After First Antipsychotic Prescription in 1995, by Outpatient Care Provider Setting



Race as a Factor in Inpatient and Outpatient Admissions and Diagnosis

William B. Lawson, M.D., Ph.D.
Nancy Hepler, Ed.D.
Jack Holladay, M.S.
Brian Cuffel, Ph.D.

ences in hospitalization were found to persist even in state hospitals that admit only committed patients, indicating that some of the increased utilization of inpatient mental health services by African Americans was

The most useful place to identify a patient's race in the medical chart is:

Demographic Information (by Registration)

Identifying Information/HPI

Social History

Mental Status Exam

Formulation

Nowhere

Utilizing Race in the Medical Record

- Self Identified Demographic Information
- Research purposes
- Social History: Improving understanding of the patient's experience in their body as they move through society
- Developing a cultural and structural formulation

Cultural Formulation Interview, DSM V

"Sometimes aspects of people's background or identity can make their (problem) better or worse. By background or identity I mean the communities you belong to, the language you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation…"

Using the Cultural Formulation Interview to Build Culturally Sensitive Services

Esperanza Díaz, M.D., Luis M. Añez, Psy.D., Michelle Silva, Psy.D., Manuel Paris, Psy.D., Larry Davidson, Ph.D.

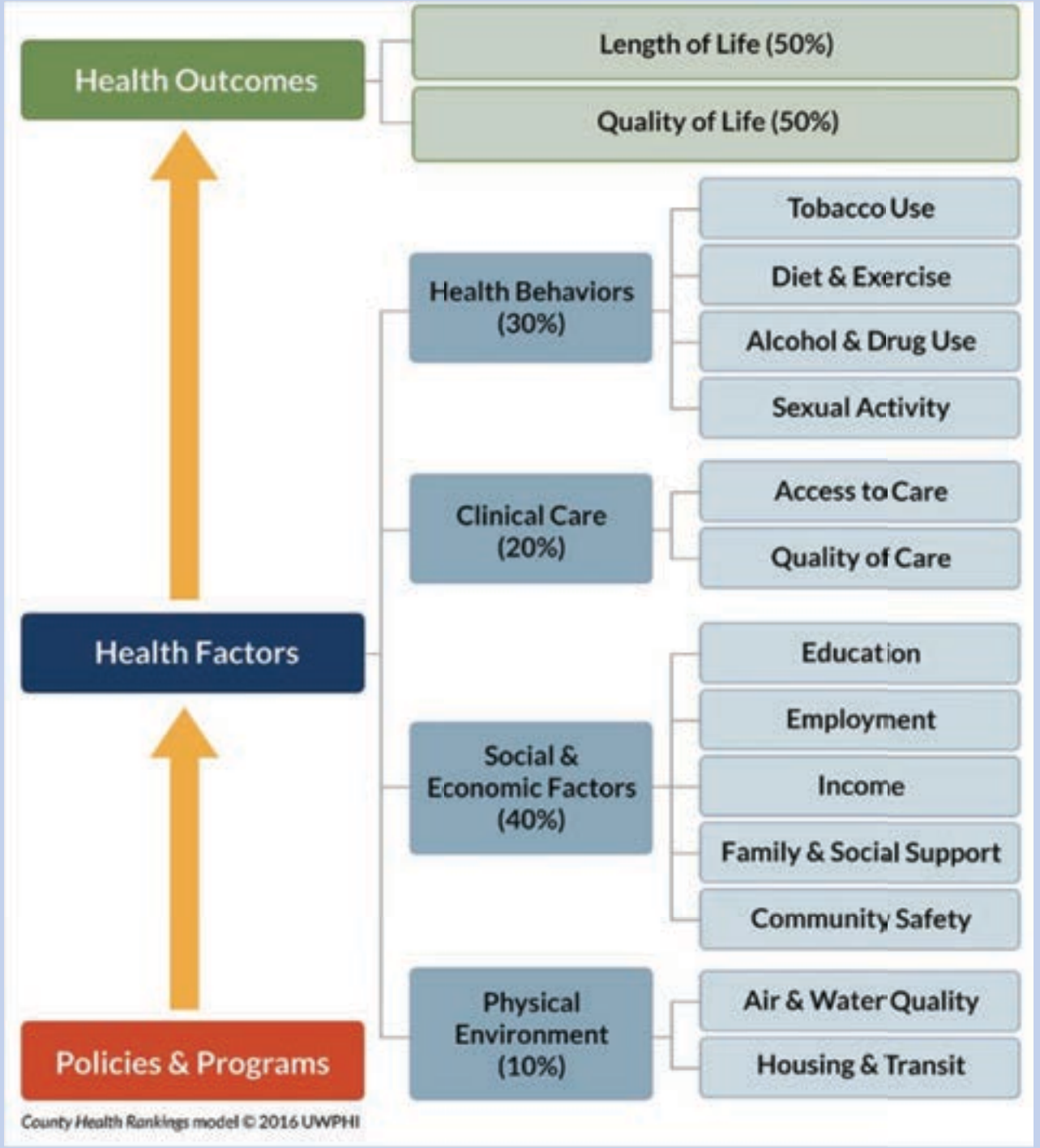
Published Online: 1 Nov 2016 | https://doi.org/10.1176/appi.ps.201600440

Cultural Formulation Interview Questions

Cultural Definition:	Sometimes people have different ways of describing their problem. How would you describe your problem to your family, friends, or a member of your community?
Cultural Cause:	Why do you think this is happening to you?
Cultural Identity:	For you, what are the most important aspects of your background or identify? Are there any aspects of your background or identity that make a difference to your problem?
Past Help Seeking:	In the past, what kinds of treatment, help, advice or healing have you sought?
Current Help Seeking:	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anythings that we can do to provide you with the care you need?

People live in communities with these social determinants:

Discrimination or Bias	Discrimination or bias on basis of ethnicity, gender, race, sexual orientation, etc.
Environmental	Green space, wilderness, landfills, pollution from factories
Financial	Employer, banks, pay-day lending, check cashers
Healthcare Access	Doctor's office, hospitals, clinics, pharmacies
Housing	Upkeep, crowding, exposures, (lead paint, pipes) neighborhood safety
Legal	Police interactions, jails, courts
Nutrition	Grocery Store, corner store, restaurant, food panty
Recreation	Parks, playgrounds
Transportation	Access to car, public (bus/train), biking, walking


Health Outcomes
Length of Life (50%)
Quality of Life (50%)
Health Factors
Health Behaviors (30%)
Tobacco Use
Diet & Exercise
Alcohol & Drug Use
Sexual Activity
Clinical Care (20%)
Access to Care
Quality of Care
Social & Economic Factors (40%)
Education
Employment
Income
Family & Social Support
Community Safety
Physical Environment (10%)
Air & Water Quality
Housing & Transit
Policies & Programs
County Health Rankings model © 2016 UWPHI

Social Determinants to Structural Competency

Five Core Competencies:

1. Recognize the structures (economic, physical, and sociopolitical forces) that influence medical care.
2. Develop extra-clinical language of structure by infusing the language into case formulations.
3. Rearticulate “cultural” formulations with “structural” language
4. Create structural interventions
5. Develop Structural Humility

Metzl, J.M. & Hansen, H. 2014. Structural competency, *Social Science and Medicine*, 103:126-133.

Structural Vulnerability Assessment Tool

Structural Vulnerability Assessment Tool[a]

Domain	Screening questions and assessment probes[a]
Financial security	**Do you have enough money to live comfortably—pay rent, get food, pay utilities/telephone?** • How do you make money? Do you have a hard time doing this work? • Do you run out of money at the end of the month/week? • Do you receive any forms of government assistance? • Are there other ways you make money? • Do you depend on anyone else for income? • Have you ever been unable to pay for medical care or for medicines at the pharmacy?
Residence	**Do you have a safe, stable place to sleep and store your possessions?** • How long have you lived/stayed there? • Is the place where you live/stay clean/private/quiet/protected by a lease?
Risk environments	**Do the places where you spend your time each day feel safe and healthy?** • Are you worried about being injured while working/trying to earn money? • Are you exposed to any toxins or chemicals in your day-to-day environment? • Are you exposed to violence? Are you exposed regularly to drug use and criminal activity? • Are you scared to walk around your neighborhood at night/day? • Have you been attacked/mugged/beaten/chased?
Food access	**Do you have adequate nutrition and access to healthy food?** • What do you eat on most days? • What did you eat yesterday? • What are your favorite foods? • Do you have cooking facilities?
Social network	**Do you have friends, family, or other people who help you when you need it?** • Who are the members of your social network, family and friends? Do you feel this network is helpful or unhelpful to you? In what ways? • Is anyone trying to hurt you? • Do you have a primary care provider/other health professionals?
Legal status	**Do you have any legal problems?** • Are you scared of getting in trouble because of your legal status? • Are you scared the police might find you? • Are you eligible for public services? Do you need help accessing these services? • Have you ever been arrested and/or incarcerated?
Education	**Can you read?** • In what language(s)? What level of education have you reached? • Do you understand the documents and papers you must read and submit to obtain the services and resources you need?
Discrimination	***[Ask the patient]* Have you experienced discrimination?** • Have you experienced discrimination based on your skin color, your accent, or where you are from? • Have you experienced discrimination based on your gender or sexual orientation? • Have you experienced discrimination for any other reason? ***[Ask yourself silently]* May some service providers (including me) find it difficult to work with this patient?** • Could the interactional style of this patient alienate some service providers, eliciting potential stigma, stereotypical biases, or negative moral judgments? • Could aspects of this patient's appearance, ethnicity, accent, etiquette, addiction status, personality, or behaviors cause some service providers to think this patient does not deserve/want or care about receiving top quality care? • Is this patient likely to elicit distrust because of his/her behavior or appearance? • May some service providers assume this patient deserves his/her plight in life because of his/her lifestyle or aspects of appearance?

Bourgois et al. (2016) Acad Med.

Structural Vulnerability Assessment Tool

Structural Vulnerability Assessment Tool[a]

Domain	Screening questions and assessment probes[a]
Financial security	**Do you have enough money to live comfortably—pay rent, get food, pay utilities/telephone?** • How do you make money? Do you have a hard time doing this work? • Do you run out of money at the end of the month/week? • Do you receive any forms of government assistance? • Are there other ways you make money? • Do you depend on anyone else for income? • Have you ever been unable to pay for medical care or for medicines at the pharmacy?
Residence	**Do you have a safe, stable place to sleep and store your possessions?** • How long have you lived/stayed there? • Is the place where you live/stay clean/private/quiet/protected by a lease?
Risk environments	**Do the places where you spend your time each day feel safe and healthy?** • Are you worried about being injured while working/trying to earn money? • Are you exposed to any toxins or chemicals in your day-to-day environment? • Are you exposed to violence? Are you exposed regularly to drug use and criminal activity? • Are you scared to walk around your neighborhood at night/day? • Have you been attacked/mugged/beaten/chased?
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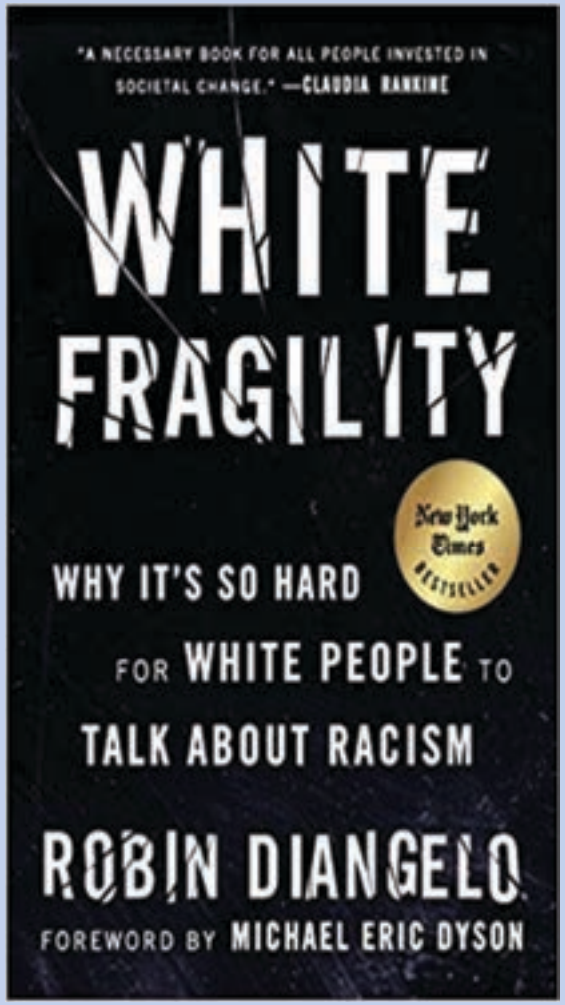
Bourgois et al. (2016) Acad Med.

How does considering race Impact the provider?



- Know your vulnerabilities (Implicit Association Test) and adjust practice with patients
- Educate yourself and talk about race and racism: challenging for white people
- Learn about effects of structural racism, look for it in your institution, and address it
- Advocacy and Activism to dismantle white supremacy


Perspective

Racist Like Me — A Call to Self-Reflection and Action for White Physicians

Deborah Cohan, M.D., M.P.H.

Stamped from the Beginning : The Definitive History of Racist Ideas in America

by **Ibram X. Kendi**

How Might This Impact Patients?

- Understanding/connection with their clinician
- Trust/Investment in their treatment
- Increased Agency
- Better outcomes through development of a cultural formulation and a structural formulation

Returning to the case...

Social history: The patient self-identifies as African-American, and recently he has felt racially targeted at his place of employment. He reports having been called racial slurs on multiple occasions. Most of colleagues are white, and he feels that they exclude him from social activities. In addition, the patient reports he was recently pulled over by the police and subject to a random search.

Breakout Group...

- Within your breakout room, discuss the following questions:
    - What would be your formulation of this case?
        - What structural elements might you consider?
        - How would you incorporate data about the patient's race?

Structural Formulation: The patient describes his symptoms as stemming from his experiences of racial discrimination at his place of employment and from law enforcement. The experience of racial discrimination is a risk factor for a variety of mental health outcomes. As many of these communities have been historically targeted by law enforcement, his recent interaction with the police prior to admission may have triggered a highly anxious, agitated state, which might be seen as a reasonable, non-pathological response. While admitted, feelings of anxiety were exacerbated by armed hospital security who patrolled the unit.

Breakout Group Activity

- Within your breakout room, discuss the following:

How would you incorporate this content into your training program?

What resources would be helpful?

What barriers do you imagine encountering?

QUESTIONS? COMMENTS?

National Social Justice Curriculum Collaboration

- Recruit and develop a team of multi-disciplinary, multi-institutional scholars and medical educators dedicated to teaching medical trainees vital concepts related to social justice in medicine
- Develop high quality curricula for medical students and trainees that can be disseminated across programs nationally. Host national conferences that focus on social justice education initiatives in medical education.
- Offer monthly to bi-monthly case-conferences and workshops to enhance learning for medical students, trainees, and faculty
- For more information or to join, please visit: https://forms.gle/4LnUSSKqNfGFWS7u7

Activity Preview

Responding to Racism from Patients, Families, and Guests Towards Residents and Practicing Psychiatrists

ACTIVITY TYPE: On Demand

RELEASE DATE: 7/7/2020
EXPIRATION DATE: 7/7/2023
AMA PRA CATEGORY 1: 1
PARTICIPATION: 1

Register

Overview

Psychiatrists, and particularly psychiatry residents, are ill-equipped in recognizing and responding to racial discrimination from patients, families, and guests. The treatment settings within which they practice often fail to respond adequately and risk legal ramifications of failing to protect their employees against Title 7 violations. The module will address these gaps by providing guidelines, recommendations and case studies to address such discrimination.

Pricing

FREE - $0

Estimated Duration: 60 minutes
Begin Date: July 4, 2020
End Date: July 4, 2023

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