

# A Third Way: Race-Conscious Approaches to Health Inequities

CERCA Meeting

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Bram Wispelwey (he, him)

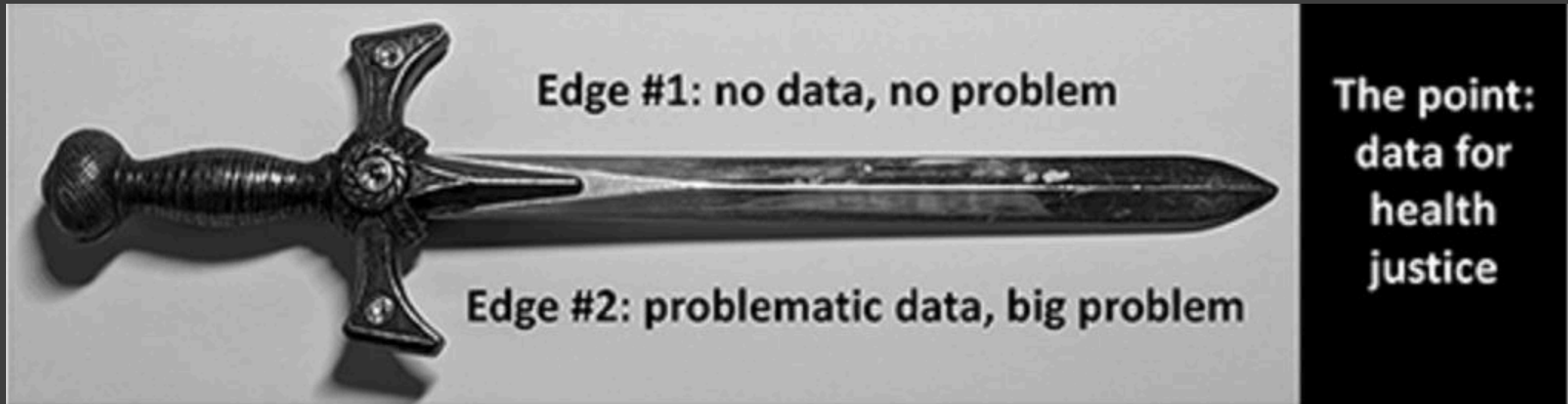
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# The Two-Edged Sword of Data



Nancy Krieger: Frontiers in Public Health:  
<https://www.frontiersin.org/articles/10.3389/fpubh.2021.655447/full>

First edge: ignoring race

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Ideas and Opinions | October 2021

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

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

- The fatal fallacy of race-blind or “equal opportunity” over “equal outcome” approaches is that they fail to account for historical and structural racism and thus can often exacerbate existing inequities by benefitting primarily the most privileged

Second edge: misunderstanding  
and/or misusing race

# Racism

“Racism is the ordinary means through which dehumanization achieves ideological normality, while, at the same time, the practice of dehumanizing people produces racial categories.”

-Ruth Wilson Gilmore

# What does ‘socially constructed’ mean?

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

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

# Medical racism in action

- Racial Essentialism: the belief that socially constructed racial categories reflect “inherent” biological differences
- Implicit & explicit in medical education, training
- Algorithms: kidney function, lung function, VBAC
- Temptation to consider/assume biological cause for inequities



# Medical racism in action

- This is both a moral and an intellectual failing:

Racial essentialism attempts to utilize an oppressive sociopolitical fabrication (**race**) to understand genetic diversity and population distribution of alleles (**ancestry**)

# Consequences of racial essentialism

- Racial essentialism “exacerbates learners’ racial prejudice and diminishes their empathy”
- “Essentialist medical approaches contribute to not only interpersonal racial biases but also *systemic* racial biases that create spurious standards of care for patients of color, delay diagnoses, and inhibit patients’ ability to access surgeries, treatments, and social resources.”

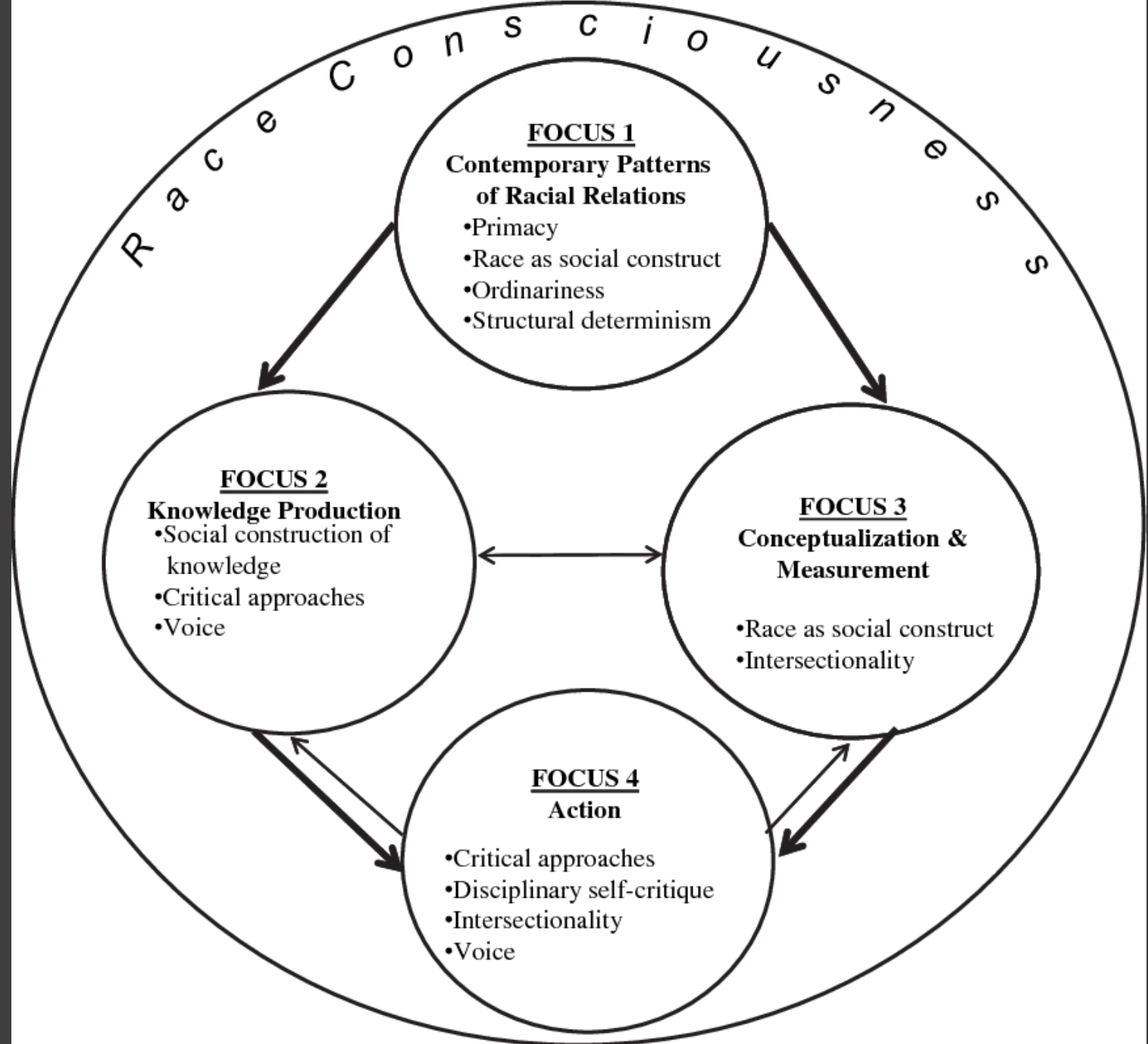
Third way (the point):  
race for health justice

# How to stay on point?

- Race-consciousness
- Targeted universalism
- Equity

<b>Race-Blind/Equality-Driven Approach</b>	<b>Race-Conscious/Equity-Driven Approach</b>
<b>Quality interventions designed to improve care for all</b>	<b>Quality interventions targeting racism directly</b>
<b>Equality (same approach for all)</b>	<b>Equity (differential approaches based on historical injustice and racism experienced by some groups)</b>
<b>Avoid naming race/racism in the intervention</b>	<b>Center the naming of race/racism in the intervention</b>
<b>Assumes racism and bias is exceptional</b>	<b>Assumes racism and bias is pervasive</b>
<b>Using non-race proxies for inequities due to institutional racism (zip code, income, etc.)</b>	<b>Using race as a proxy for inequities due to institutional racism</b>

# Public Health Critical Race Praxis



Ford C and Airhihenbuwa C. Just What is Critical race theory and What's it doing in a Progressive Field like Publichealth? *Ethn Dis.* 2018;28 (Suppl 1): 223-230.

Fig 1. Race consciousness, the four focuses and ten affiliated principles

**ORIGINAL ARTICLE**

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

- Study was guided by Public Health Critical Race Praxis: an approach utilized by researchers to study and ameliorate instances of structural racism and resultant health inequities and developed out of the legal framework of Critical Race Theory
- Considered race to be a social construct that captures the impacts of racism rather than innate biological differences and, therefore, hypothesized that differences in HF outcomes were due to structural drivers rather than biological causes.

# Heart Failure: Study Outcomes

## Raw data:

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

## Primary Outcome, multivariate analysis:

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

## Secondary Outcomes, Cardiology admission associated with:

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

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

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



So what are steps we can take to improve investigation and address inequities?

- What's the fundamental action approach that adheres to Public Health Critical Race Praxis and avoids both edges of the sword?

# Healing ARC: reparative approach to institutional racism

- 1) *Acknowledgement*: the institution voices ownership and responsibility for inequities to the communities impacted
- 2) *Redress*: a compensatory step in addressing patients and communities harmed by institutional racism
- 3) *Closure*: explores community oversight as a means of ensuring fair restitution for inequities

## Healing ARC



### A Reparative Approach

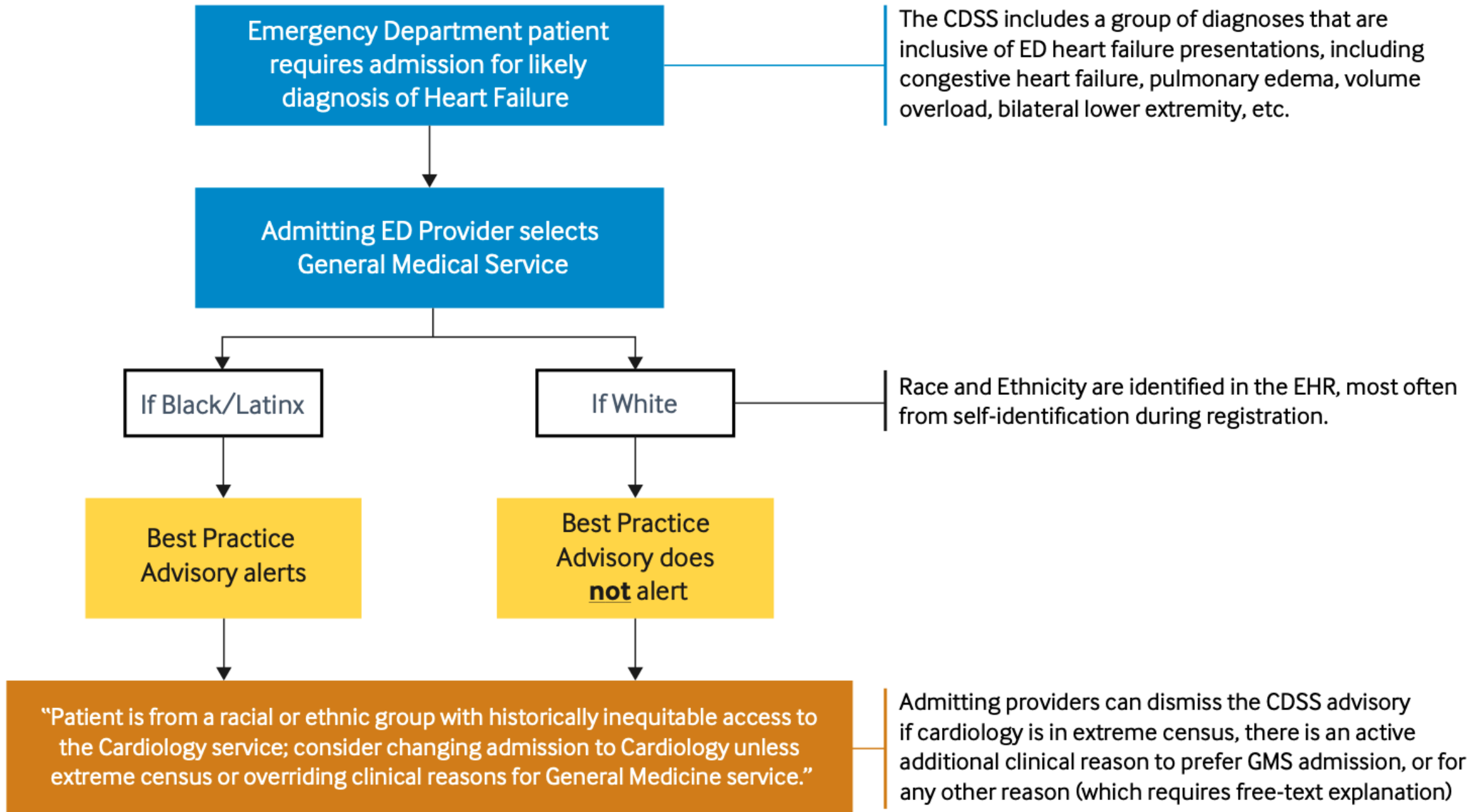
The outstanding debt from the harm caused by our institutions, and owed to our BIPOC patients, is long overdue: now is the time to start settling it.

COMMENTARY

# **Leveraging Clinical Decision Support for Racial Equity: A Sociotechnical Innovation**

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DOI: 10.1056/CAT.22.0076



# Wisdom Councils Guide Healing ARC Implementation for Institutional Accountability

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





November 7, 2022

# Association Between Racial Wealth Inequities and Racial Disparities in Longevity Among US Adults and Role of Reparations Payments, 1992 to 2018

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JAMA Netw Open. 2022;5(11):e2240519. doi:10.1001/jamanetworkopen.2022.40519

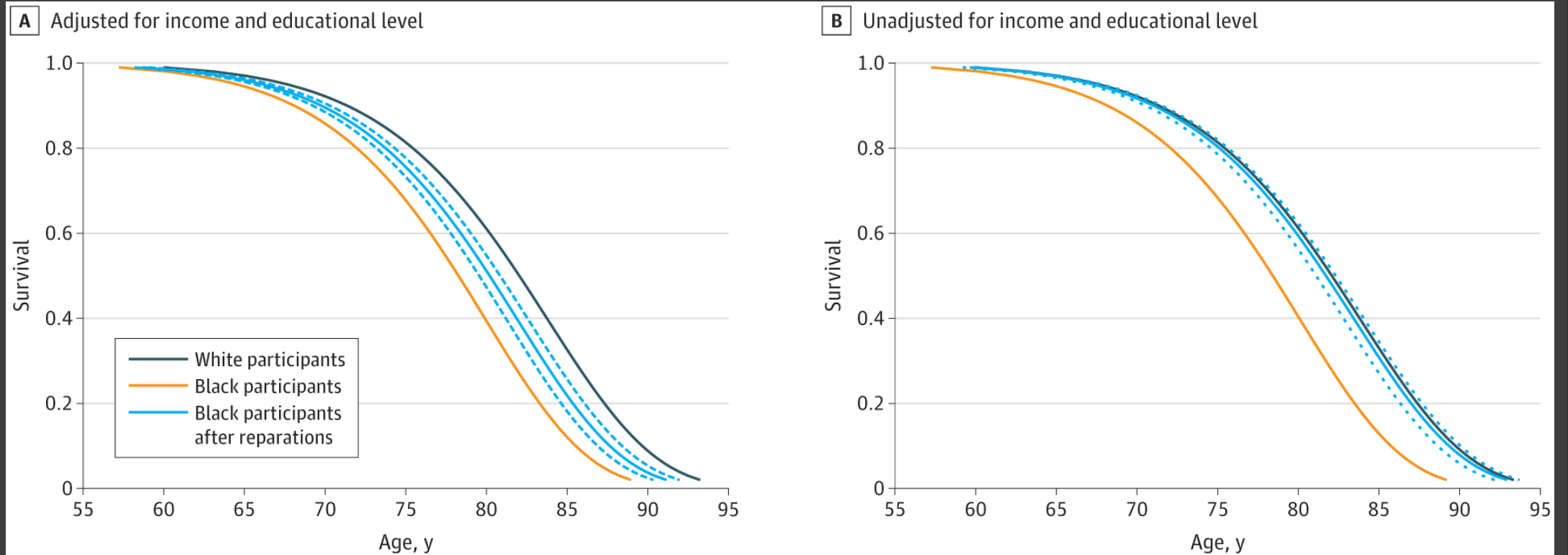


Figure Legend:

Survival of White and Black Participants and Projected Survival of Black Participants After Reparations Payments. Data are from the Health and Retirement Study. Survival curves are drawn for an individual with the mean value of all covariates and using the Weibull survival models from Table 2. Dashed lines represent 95% CIs.

What inequities are you uncovering in your work and how might you take a reparative approach to address them?



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