Jeanne Marrazzo, MD, on health equity and the pandemic’s impact

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In today’s COVID-19 Update, Jeanne Marrazzo, MD, an infectious disease specialist, joins us to discuss her experiences during the pandemic as seen through a health equity lens.

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Speakers

Jeanne Marrazzo, MD, director, division of infectious diseases, University of Alabama

Transcript

Unger: Hello, this is the American Medical Association's COVID-19 Update. Today we're talking with Dr. Jeanne Marrazzo, a professor of medicine and the director of the division of infectious diseases at the University of Alabama at Birmingham, who will share her personal experience confronting health equity issues while living in her community and caring for patients during the pandemic. I'm Todd Unger, AMA's chief experience officer in Chicago.

Dr. Marrazzo, I know in the Birmingham area, you've got snow for the first time in a long time. But I want to talk to you today about your experience of being in this community and being an infectious disease physician, caring for patients in the middle of a pandemic. And I know that you're deeply committed to health equity, so when you look at your daily clinical work through a health equity lens,
what do you see?

Dr. Marrazzo: Todd, thanks. It's great to be here and it is great to ask this critical question because when you look at the disparities in outcomes with COVID, I think history is going to judge us very, very harshly. And the issue is that the access to health care and to the best health care has such a long history of discrimination and putting people in a position where they were already at great disadvantage to access the best "health care possible." You add on that a pandemic, you add on that social isolation, you add onto that physical barriers to getting in, and you're asking people to do telemedicine on top of it. You can imagine that these have added up and really exponentially impacted the experience of our most vulnerable patients. So it's been really hard.

Unger: Yeah. I'm curious about history will judge us harshly. In some respects, you're saying like we've known these have existed for a long time, and we should know that faced with a pandemic, it's going to exacerbate that problem. Is there any other thing that you can comment on?

Dr. Marrazzo: I guess I would just say to put it in context, people who like health equity like to do infectious diseases. HIV is a great example, because pathogens, infectious pathogens, are fantastic at taking advantage of our most vulnerable cracks in society. Right? Whether it is happening during migration, war, homelessness, unprotected behaviors that vulnerable people engage in. All those things. So to me, the pandemic is just an example of writ large, where it really has taken advantage of the people who have the least access to health care.

On top of that, there are some indications that there are, of course, all these comorbidities, and that really set people up for the worst outcomes of COVID. So just to set the stage, you've got a bunch of people who lack access to consistent, fantastic health care, who have a lot of comorbidities, who've been escalating for really generations. And this is a generational problem, a societal generational problem. And on top of that, you give them a disease that not only forces them to have it in social isolation, but preys on their biological comorbidities. So it's a recipe for disaster and indeed it has been for our patients.

Unger: Yeah. It's a shame that it took a pandemic to kind of shine a spotlight on what we knew was already there. I mean, for you, you moved from the West Coast to the South here in an entirely new community and a new culture in this transfer. Can you talk about the health equity considerations in the context of your transition?

Dr. Marrazzo: Sure. Actually, I just had my five-year anniversary of my move from Seattle, so I actually feel a little bit more legitimate talking about these things now. Health equity is everywhere. I don't want to paint it as a problem, particularly of the deep South. I think what is so different here to me, again, coming from the metropolitan area of Seattle, where we have lots of people who are living without a home, lots of people who were dealing with substance use challenges, tons of people. I mean, I've worked in the county hospital there. So there was no shortage of people who had experienced all the worst outcomes of being marginalized. I think the difference here, at least in the
deep South, from what I've seen, is that the systematization of rural poverty is so linked to people who have been in racial groups that have been disenfranchised for generations. Right?

When you look at the voting history, the civil rights history, the land ownership history here, the education history here. It hasn't been that many generations since we accepted Black positions at University of Alabama at Birmingham. Now, we have a fantastic African American dean. So, thank goodness for progress. But the systematization, I guess, of poverty that is embodied in even what we call the Black Belt, which is the geographic areas south of Montgomery, so-called because of its agricultural, soil and history. Demographically now one of the poorest and worst health outcomes areas in the country. So, it's different, it's more systematic in a way that you just don't see in some urban settings that I've worked in.

Unger: You mentioned that, your experience coming out of Seattle. How did you originally become interested in health equity and should this be something that's part of every physician's training? How do we do that?

Dr. Marrazzo: Absolutely. It should be part of every physician's training because most physicians in training are very privileged people. You've come from a background, even if you fought to get to where you are, you still have a set of gifts and you have a set of support systems that managed to get you here. I think it's easy to forget along the way that most of your patients, many, let's just say, if not most of your patients, don't have anything near the privilege that you've had. And I think it's this recognition of systemic sustained privilege that we've been talking about more in a different way. We've seen it through the lens of race hugely in the last year, of course, but it's been operative in many, many kinds of settings.

I think my original entree into this space, of course, was with HIV/AIDS when I was a young trainee. It was very clear that not only were young gay men and older gay men, but clearly gay men, being devastated and had been marginalized for obvious reasons. But also I trained in New Haven, Connecticut, and it was really affecting particularly young Black women who were partners of injection drug users, partners of bisexual men. So I think that really woke me up in a way that I kind of knew about, but experiencing that firsthand with patients is always a huge wake up call.

Unger: And we've seen the impact of those kinds of structural issues and biases that people bring in. If you look at the stats on how that impacts then Black population or even LGBTQ patients.

Dr. Marrazzo: Absolutely.

Unger: That's pretty significant. How do we fix these cracks that we've seen in our health care system that the pandemic has really shown a spotlight on? Do you have any sense of steps we can take to fix those problems?

Dr. Marrazzo: So speaking as someone who thinks a lot about this, I think we need more people who
look like the people we're trying to serve. There is no way that someone like me is necessarily going to have automatic credibility, going to a church in Birmingham and trying to discuss vaccine hesitancy with the congregants when I'm not one of them. Now that's not to say I don't do that. I'm not going to do it. I am doing it because I want to try, but having role models and leaders...I just saw this great documentary, "Black Men and White Coats," which is really, really cool. I mean, that power of that is an estimable.

I know some young, black, bisexual, gay men in our HIV clinic. We have a single young black female provider there. They will not see anyone else, but her. And I think that, again, this concept of you look like me, you talk like me. Maybe don't talk like me, but you understand me is, is inestimable just to see someone up there or across the table from you or on the video screen or on any screen, we can't really can't emphasize that enough. And so getting people who look like those people that we really want to take care of in front of the camera, in front of the room, in front of leadership, I think that's just incredibly critical. And that pipeline is not been developed as much as we would like.

**Unger:** I mean, there is a big gap. I mean, if we look in terms of U.S. population, approximately 14 to 15% of the population being Black for doctors and medical students.

**Dr. Marrazzo:** Yep.

**Unger:** It's under 5%. So that's a long-term fix. What can we do now in the meantime?

**Dr. Marrazzo:** It is a long-term fix. I don't know if you've been hearing about some recent discussions with some schools in New Orleans, actually this week. A lot of discussion about how you "rank and decide" who should get into residency. And traditionally that's been a very pedagogical exercise. Right? I mean, you look at people's... I mean, traditionally you look at people's school, you'll look at their curriculum record and you look at this, you look at their letters. That system is rigged. It's really rigged against people who might go to historically Black colleges. It's rigged against people who go to medical schools. Remember the Flexner report actually got rid of Black medical schools. So can you imagine the generational impact that has had on the ability of young Black people to train? I mean, they lost out on two generations. Right? So when you're scoring people on these metrics that are really regressive, you just don't really get the whole picture and I'm guilty myself.

I mean, when I look at fellowship applications for infectious diseases, I can tell who I think, oh, I really want to talk to this person. And then I'll talk to somebody who maybe did not check all those.
But so all these expectations, all these metrics that we have, again, it's implicit bias and explicit bias. I mean, some of is explicit like, "Oh, they went to that great medical school. Oh, I know that person who wrote that letter. He's a good friend of mine." That's explicit. And then implicit is just like, "Oh, this person sounds cool. And I think I know I would be comfortable talking to them." So we've got to break those down and think about how we encourage people to get through our systems and succeed in our systems. That's the main thing.

**Unger:** That's incredibly important. What is your advice for health care organizations now? What strategies can they adopt to improve health equity?

**Dr. Marrazzo:** I think they can walk the walk. There's a lot of talk right now. Right? All these places are developing policies. They're naming chief diversity officers, equity officers. I think those are first steps, but if you don't do the hard stuff and follow up with the meaningful actions that increase representation in the C-suite or in the dean's office or whatever you want to call it, then it's not going to help. You're not going to have young people who need to get in those positions say, "Wow, that person is now the CEO of the hospital. Maybe I want to do that. Or that person's a dean. Maybe I want to do that. Oh, that person's the chief of surgery. She's the chief of surgery. I can do that."

So I worry that there is a lot of sort of piling on, in an effort to look like we're doing the work, but the work is hard. It's uncomfortable. There are a lot of things that come up where people say, you're not doing enough. You're not really listening to me. You're giving me lip service, but you're not really doing the work. So I think you have to be open to discomfort and really get people in there who maybe aren't saying what you want them to hear. And I don't think health care organizations always like that.

**Unger:** Do you have any advice for individual physicians about how to do their part to advance health equity?

**Dr. Marrazzo:** I think it's important to think about your comfort zone. And to recognize what makes you uncomfortable. Maybe it is talking to someone whose educational background is not similar to yours. I mean, that actually happens a lot. It's surprising, but it does happen. And maybe it's a discomfort you don't even recognize. You just assume that person is not as smart as the resident you're working with, who is a graduate of blah, blah, blah. And that is a really dangerous area. Or maybe you're not comfortable talking with a young man who's trying to tell you that he's having sex with other men and at risk for HIV.

So there are these alarm bells that go off in your mind and you sometimes just want to not listen to them. Important to listen to them. And if you're uncomfortable, talk about it, not to the person, necessarily the patient, but think about talking about it with your peers. Maybe somebody who can really help you about that. So the first step I think, is just self-recognition of our biases, whether they're subtle or whether they're not so subtle. And again, I'm as guilty as anyone. So that's so much
of the reason why I've been thinking about this because it's so easy. We are a product of our culture. We're a product of our environment. We're a product of our training. So it's a challenge, but we've got to work hard.

**Unger:** Well, thank you so much, Dr. Marrazzo. I really appreciate you being here today and sharing your perspective with us. That's it for today's COVID-19 update. We'll be back with another segment tomorrow. For resources on COVID-19 visit ama-assn.org/COVID-19. Thanks for joining us today. Please take care.

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