Getting to the Root Causes COVID-19 Case Studies

June 6, 2020
2020 AMA Medical Student Section Annual Meeting

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Group Vice President and Chief Health Equity Officer
American Medical Association

African American Case

- Patient: Robert Thomas 56 y/o M
- PMH: Type 2 DM and HTN
- HPI: Presents to ED unconscious after hypoglycemic episode. Vital signs are within normal limits. Tests positive for SARS-CoV-2 upon admission.

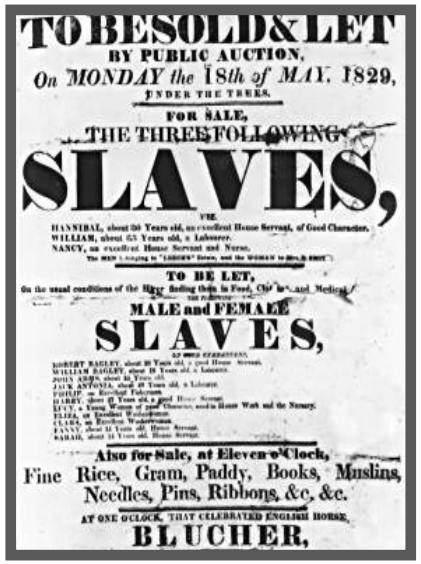
- Personal Factors:
  - Education: Masters in Education
  - Employment: Food vendor
    - Laid off during pandemic
  - Living situation: Travels between two homes - one with 84-year-old father in NYC co-op
  - Transportation: Public
  - Most family members are far away in other states

- ***Magnifiers of Health Inequity:***
  - AA **more likely to have T2DM**
    - Increased risk of contracting COVID-19
    - Increased risk related to higher levels of chronic stress
  - AA **disproportionately affected by layoffs** during the pandemic
  - AA **rely more heavily on public transportation**
    - Increasing risk of COVID-19 exposure
  - AA **more likely to receive poor quality care**
    - Mr. Thomas was not given insulin for 5 days of his hospital stay

Immediate causes and considerations

- Myths, misinformation, and lack of clear messaging
  - Crisis in national leadership and risk communication
  - Invisibility of public health leadership
  - Public health infrastructure fault lines – tremendous disinvestment
- Healthcare system experiences in equities
  - Segregated – affects quality of care, payment types, location
  - In times of ‘rationing’ – physician bias & discrimination exacerbated
  - Lack of trust
- Inequities in health outcomes
- Inequities in social drivers of health
  - Overcrowding, isolation of elderly, reliance of public transportation, more exposure to service jobs

Causes of the Causes Institutionalizing Anti-Blackness

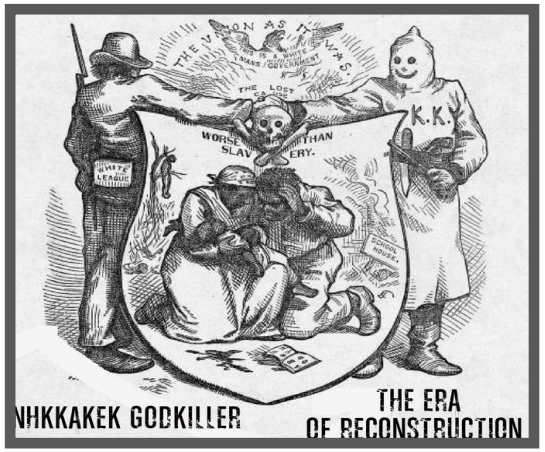

TO BE SOLD & LET
BY PUBLIC AUCTION,
On MONDAY the 18th of MAY, 1829,
UNDER THE TREES.
FOR SALE,
THE THREE FOLLOWING
SLAVES,
TO BE LET,
MALE and FEMALE
SLAVES,
Also for Sale, at Eleven o'Clock,
Fine Rice, Gram, Paddy, Books, Muslins,
Needles, Pins, Ribbons, &c, &c.
AT ONE O'CLOCK, THAT CELEBRATED ENGLISH HORSE,
BLUCHER,

ENSLAVEMENT OF AFRICANS
1619 - 1865

- Dehumanization of people of African Descent
- Chattel property
- 3/5 of a Human
- Established Slave Codes

- Development of Black Codes
- Sharecropping
- Mass Lynchings

RECONSTRUCTION
1865 - 1877



JIM CROW PERIOD
1890 - 1965

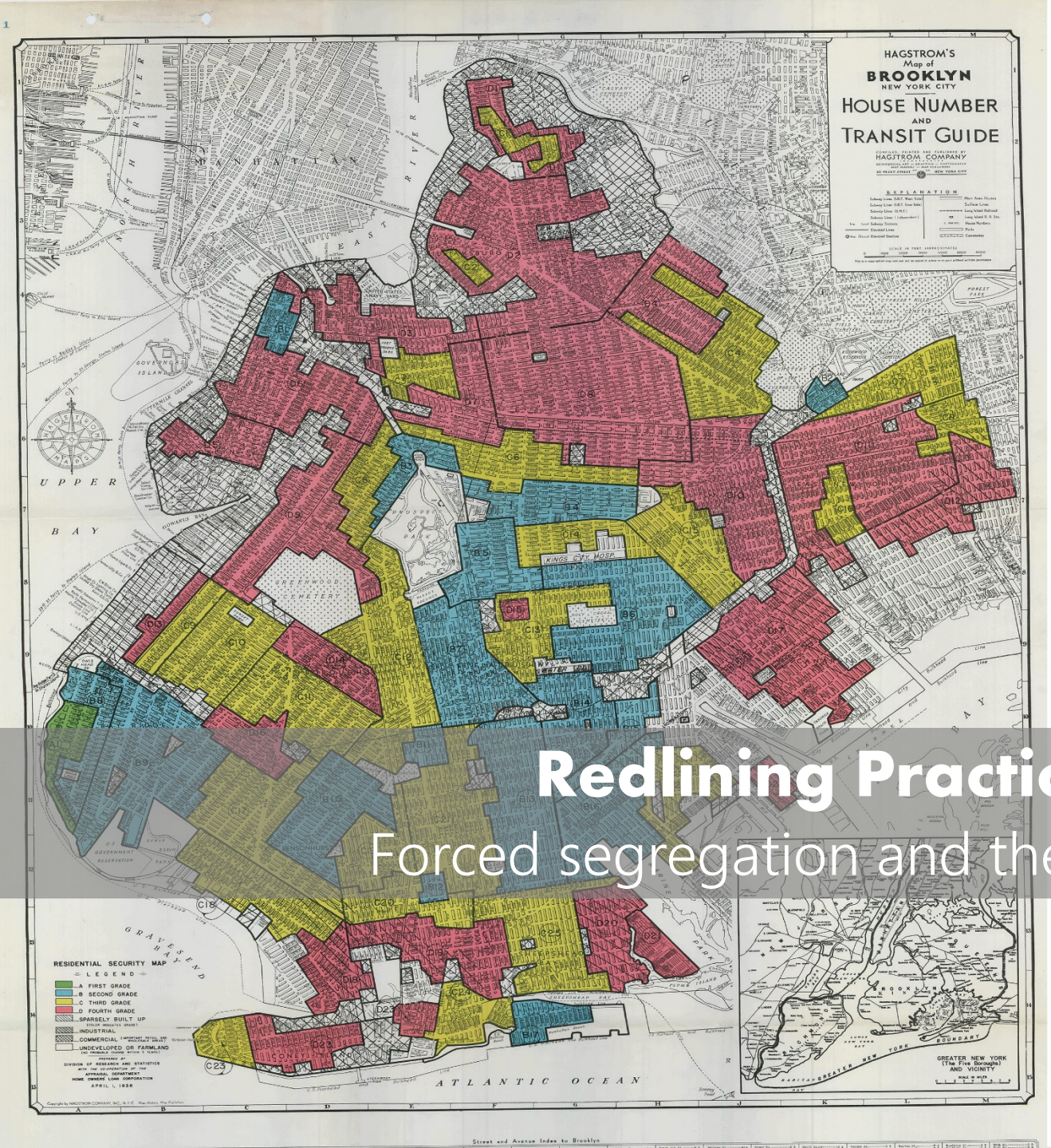
- Codified Racial Segregation in Law
- Developed Institutionalized practices for de jure segregation
- Depictions of Black Caricatures
- Mass Lynching

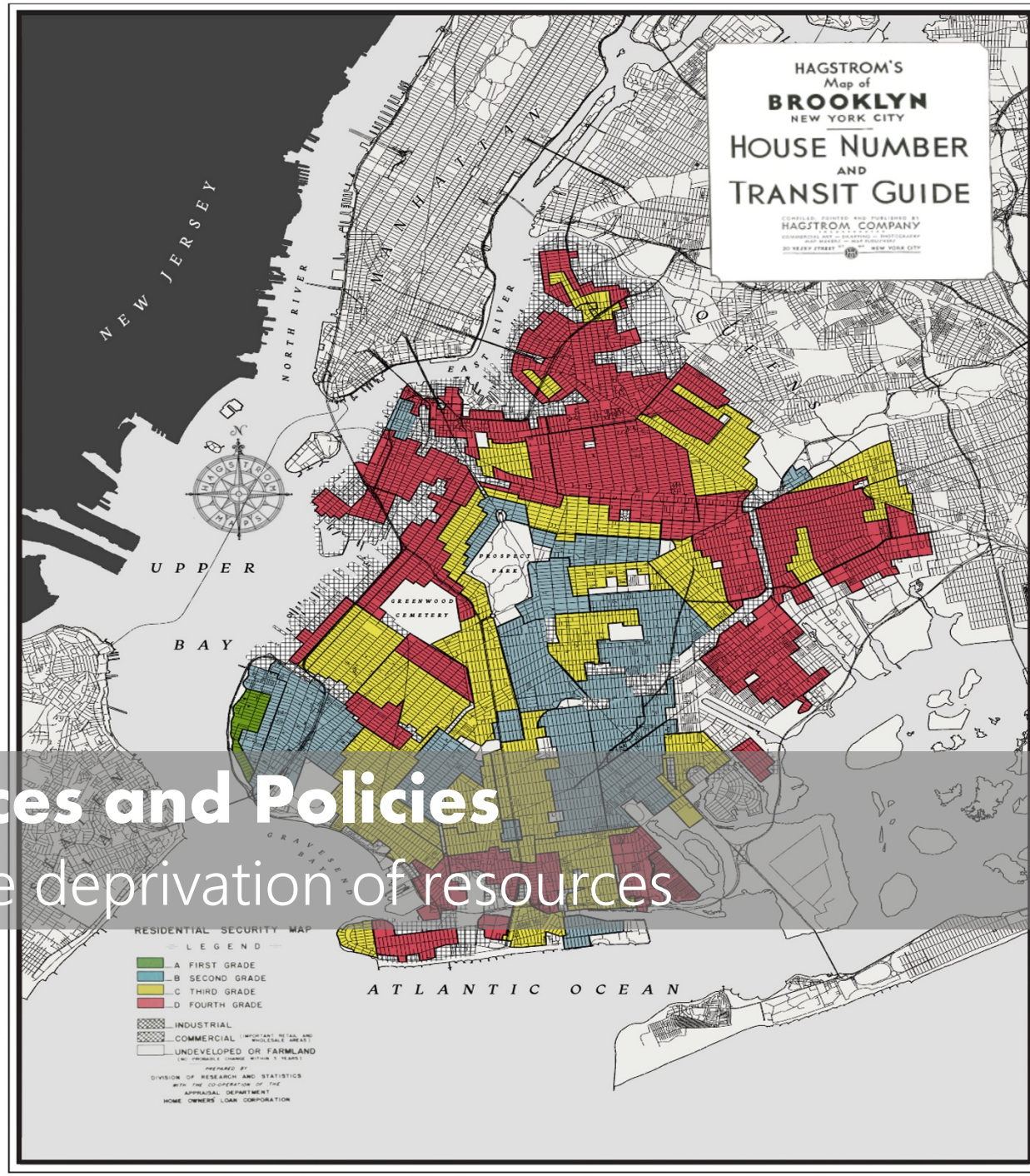
CIVIL RIGHTS
1965 - 1980

- Civil Rights Acts
- Advent of Globalization.
- Systematic Dismantling of Black Power Movement
- Mass Police Killing

PRESENT DAY
1980 – Present

- Mass Incarceration
  - War on Drugs
  - War on Gangs
- Disproportionate Police Surveillance
  - Stop and Frisk
  - Operation Clean Halls
- Mass Police Killings





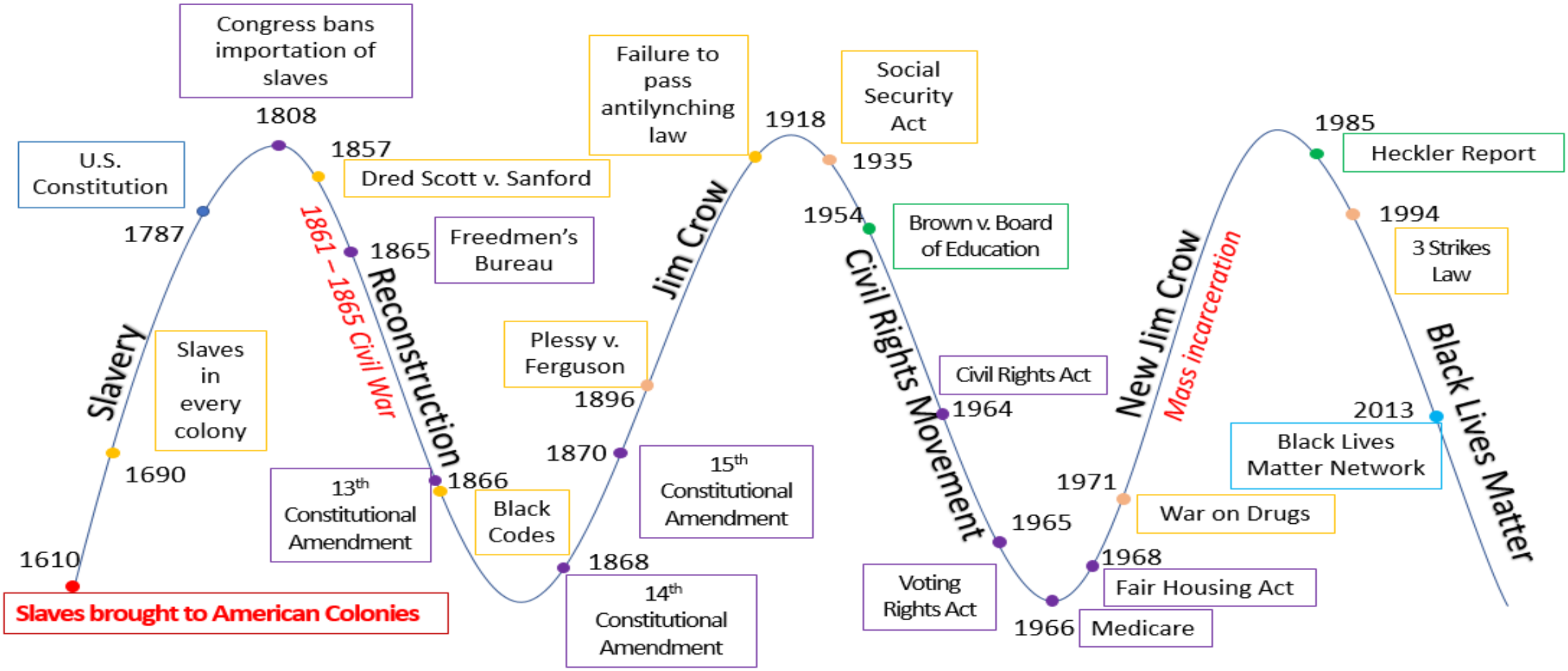
Redlining Practices and Policies

Forced segregation and the deprivation of resources

Forced Segregation and Integration of Health Care

Impacts on the workforce and health outcomes still present

Structural Context: Case 1



Navajo Nation COVID-19 Case

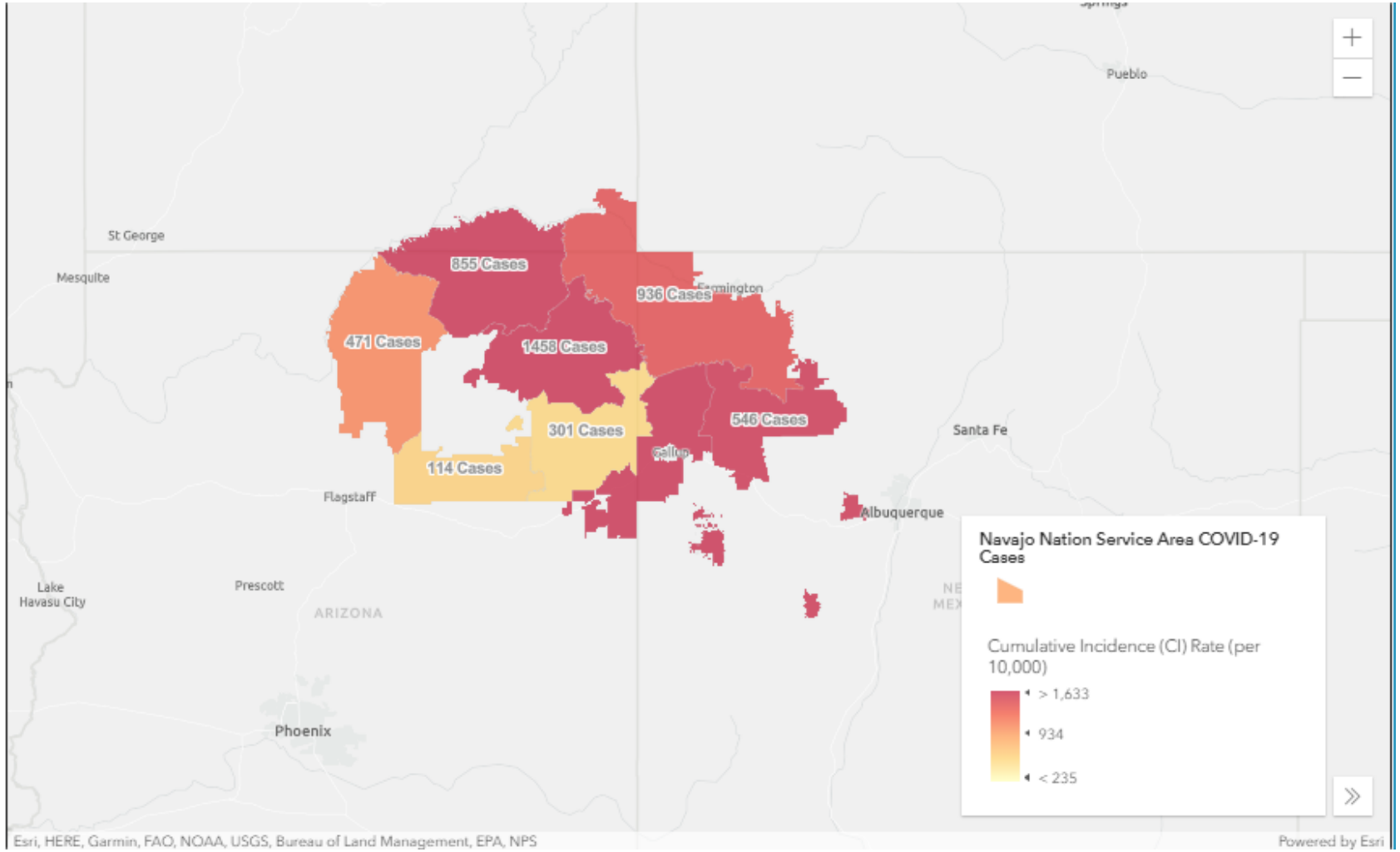
- Patient: Ashley Martinez, 50 y/o F
- PMH: HTN and TYPE 2 DM
- Symptoms: Fever, dyspnea, and anosmia
- Complicating Factors: Deficient access to medicine and continuity of care, two hour drive to and from hospital, need for further transport

- ***Magnifiers of Health Inequity*:**
  - Limited access to fresh foods
  - 10% of NN without electricity
  - 30/40% of NN without running water at home
  - Contaminated water supply and buildings
  - Increased chronic disease burden as a result of these factors

Immediate causes and considerations

- Myths, misinformation, and lack of clear messaging
  - Crisis in national leadership and risk communication
  - Invisibility of public health leadership
  - Public health infrastructure (IHS) fault lines – tremendous disinvestment
  - “Invisibility” in data collection & media
- Healthcare system experiences in equities
  - Affects quality of care, location, shortage of physicians
  - In times of ‘rationing’ – physician bias & discrimination exacerbated
  - Lack of trust
  - Lack cultural responsiveness and relevance
- Inequities in health outcomes
- Inequities in social drivers of health
  - Distant healthcare facilities, transportation, lack of consistent food and water, unemployment

Navajo Nation COVID-19



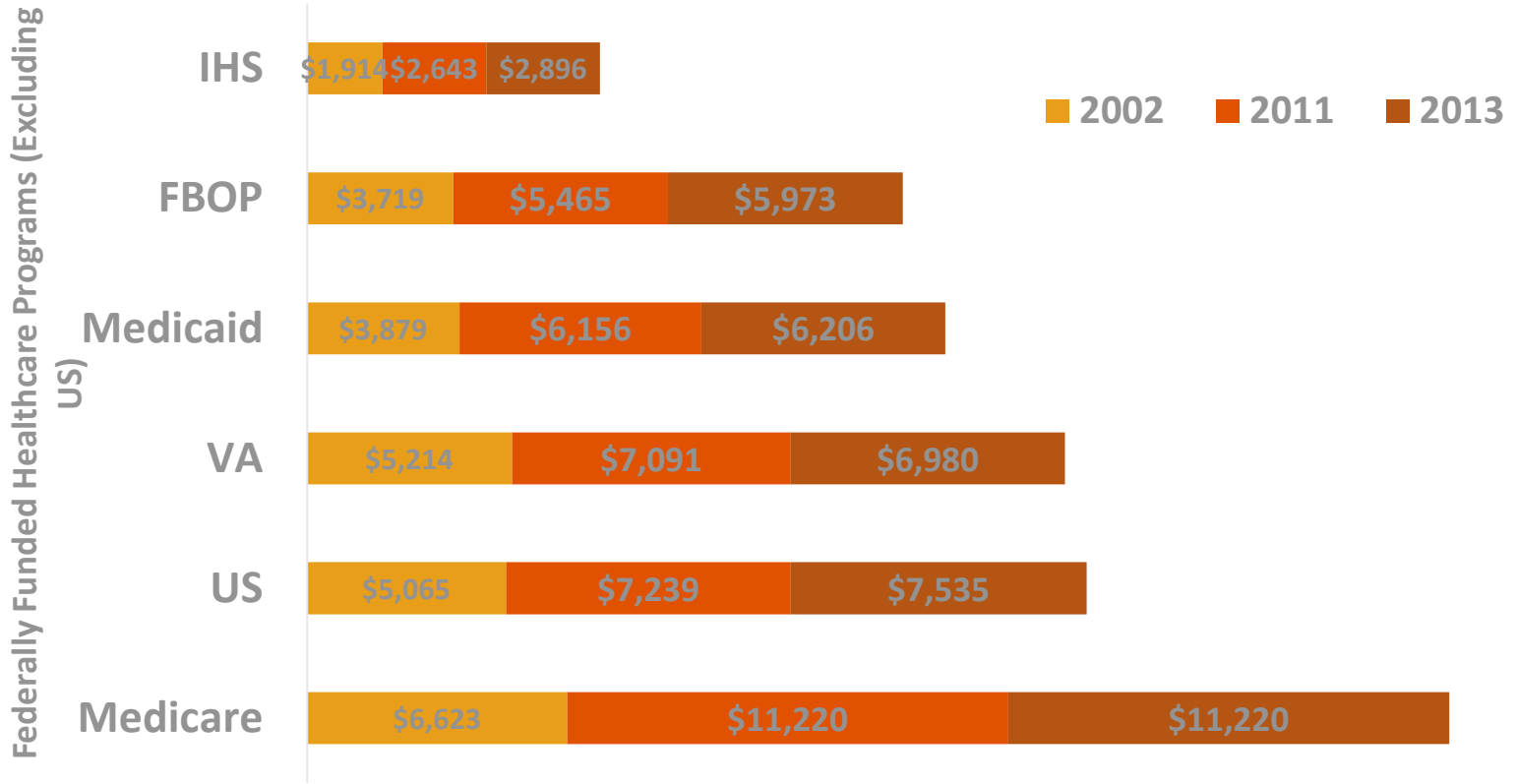
https://navajo-nation-coronavirus-response-ndoh-nec.hub.arcgis.com/

Across the Navajo Nation

- Total population:
  332,129
- Life expectancy:
  74 years
- Prevalence of diabetes:
  22%
- Population living below national poverty line:
  38%
- Unemployment rate:
  55.9%

https://www.pih.org/country/navajo-nation

Comparison of Per Capita Healthcare Program Expenditures for 2002, 2011, 2013



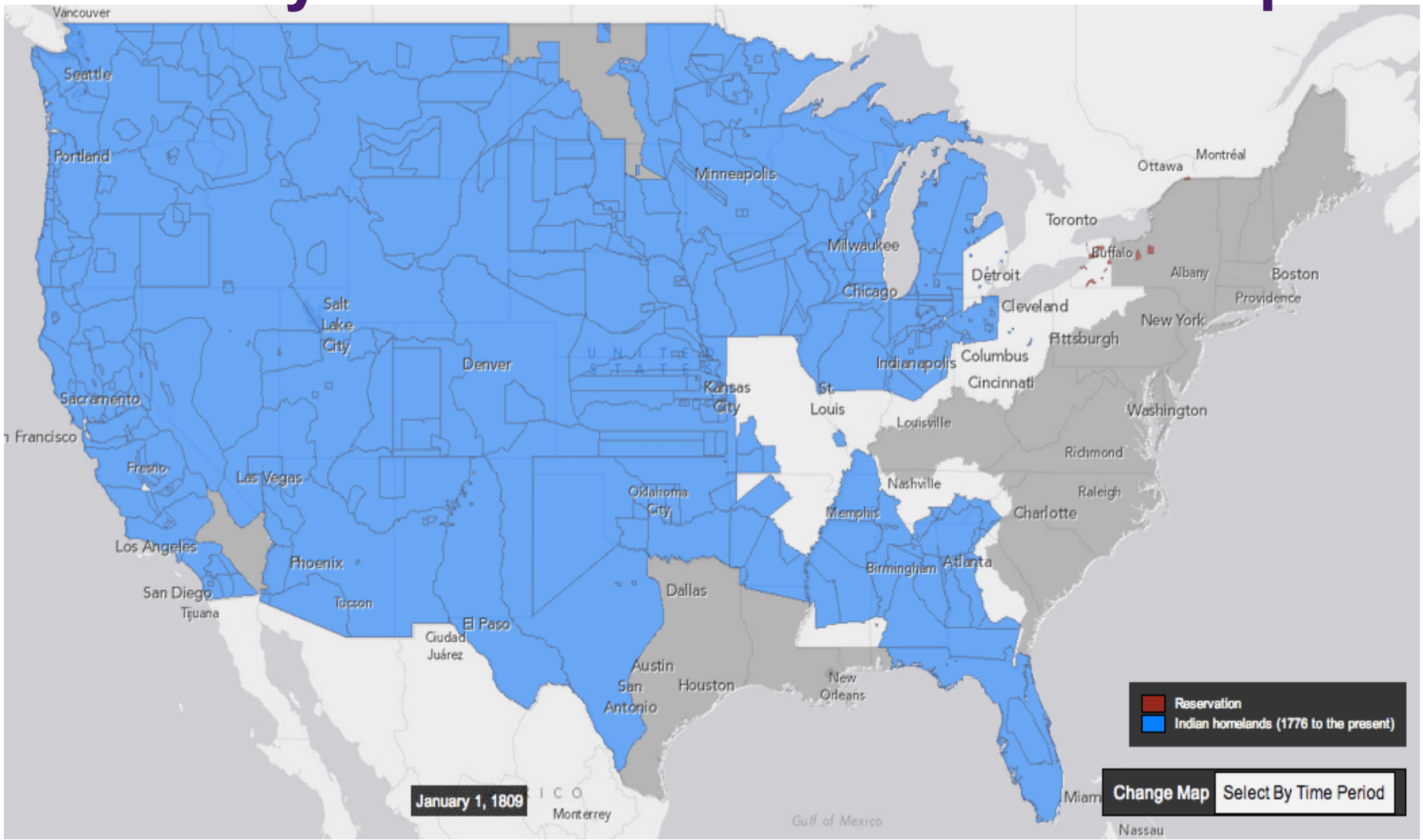
Source: James, Nathan: *The Federal Population Buildup: Overview, Policy Changes, Issues, and Options*; Congressional Research Services, April 15, 2014 (Seconda
A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country. United States Commission on Civil Rights, July 2003 (Secondary Data)
Medicare Enrollment – National Trends 1966-2013, Data accessed from CMS.gov November 2015.(Primary Data)

Dine' Cultural Context of Well Being

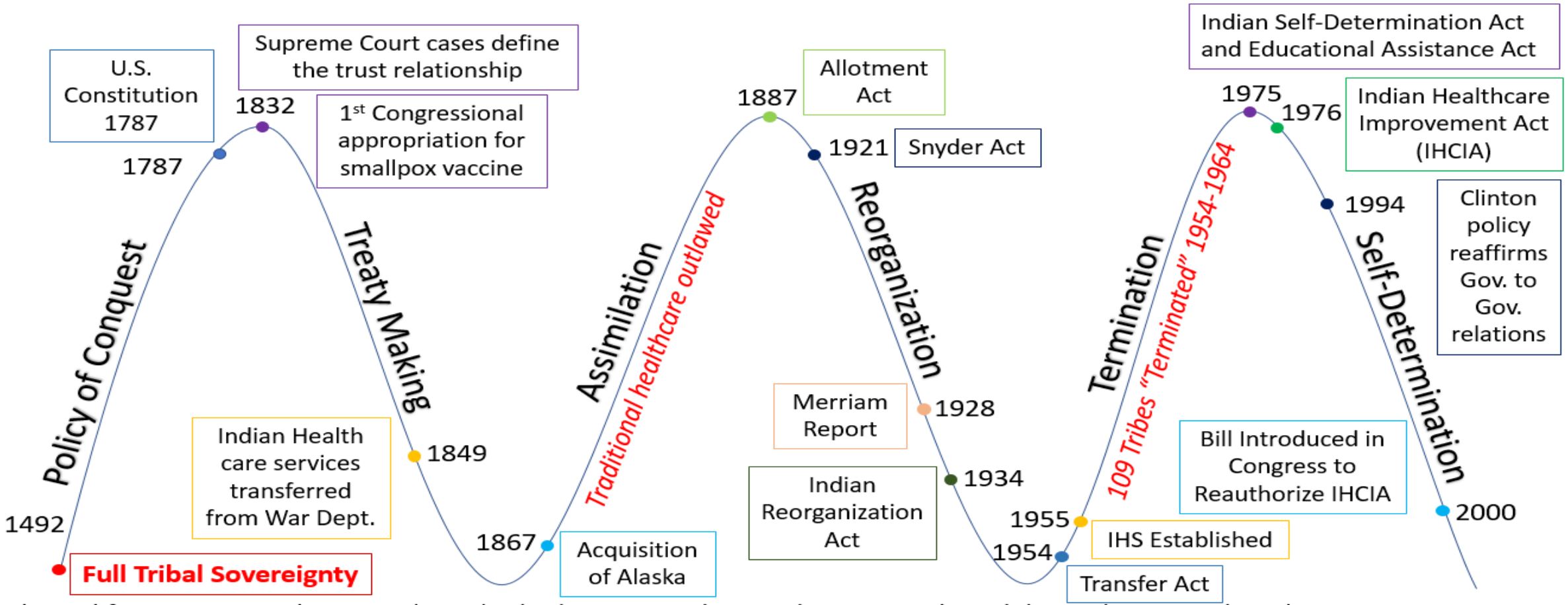
- Individual's actions and behaviors influence the balance of the intrinsic core values tied to the domains of knowledge or their internal constitution; nitsahakees (mental), ats'os (body), ani'(heart, mind) and hoghan haz'angi (home-place). Balance is characterized by a person's thinking free from stress, being in line with the morals placed in the four areas of knowledge, the body nurtured with health, being secure in their sense of belonging in a family, community, and comfortably secure in their home and environment. This balance is called hozhoogo na'adah being able to walk in the light of the Holy Ones with health, peace and harmony in the family, community and home-place.

From OUR VOICE: IMPLEMENTATION RESULTS OF HEALTHY DINÉ NATION ACT 2016 – 2018 https://www.nec.navajo-nsn.gov/Portals/0/Projects%20Webpage/HDNA%20Webpage/HDNA%20Report%20July%202018%20FINAL.pdf?ver=2020-01-31-155901-920

Time-Lapse of United States land seizure of approximately 1.5 billion acres from 1776 to present



Structural Context: Case 2



Adapted from image. Jude, Mary. (2016). Thinking Beyond an Evidence-Based Model to Enhance Wabanaki Health: Story, Resilience and Change.

https://www.researchgate.net/publication/309564779_Thinking_Beyond_an_Evidence-Based_Model_to_Enhance_Wabanaki_Health_Story_Resilience_and_Change

CONTEXT

Historical, political, and cultural

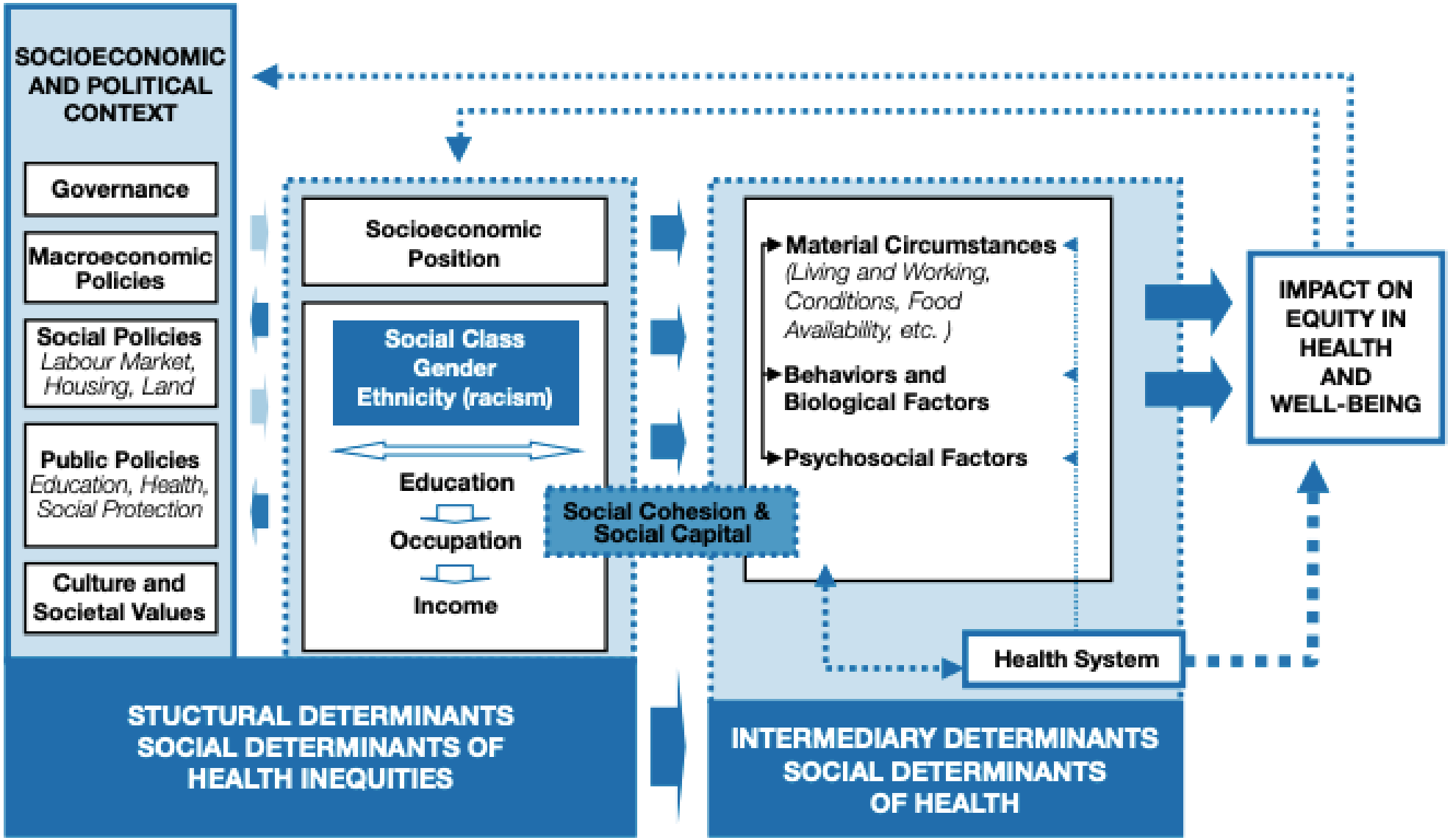
Lack of proximity to the injustice

Not visible to CEOs, physicians, C-suite occupiers

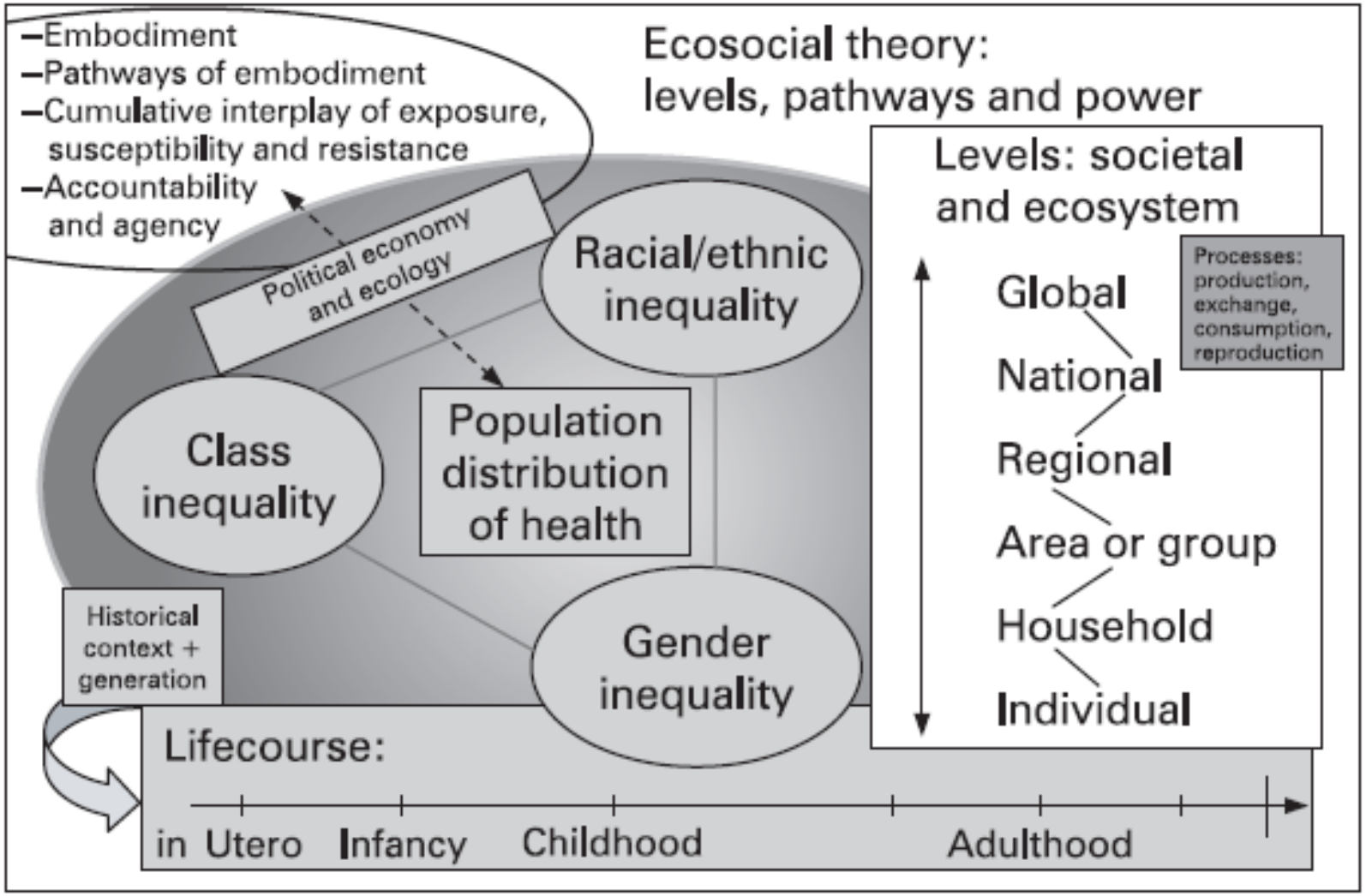
“Because of advances of medical knowledge, the medial school curriculum has become so crowded that the social importance of preventive medicine and public health is seldom emphasized. This creates a blind spot which often persists throughout professional life and results at times in misunderstanding between the practicing physician and the constituted health authorities of the community.”

J. A. Miller, George Baehr, and E.H.L. Corwin, 1942

World Health Organization



Ecosocial Theory
Nancy Krieger, PhD



America: Equity and Equality in Health 3

Structural racism and health inequities in the USA: evidence and interventions

Zinzi D Bailey, Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, Mary T Bassett

Despite growing interest in understanding how social factors drive poor health outcomes, many academics, policy makers, scientists, elected officials, journalists, and others responsible for defining and responding to the public discourse remain reluctant to identify racism as a root cause of racial health inequities. In this conceptual report, the third in a Series on equity and equality in health in the USA, we use a contemporary and historical perspective to discuss research and interventions that grapple with the implications of what is known as structural racism on population health and health inequities. Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources. We argue that a focus on structural racism offers a concrete, feasible, and promising approach towards advancing health equity and improving population health.

Introduction

Racial and ethnic inequalities, including health inequities, are well documented in the USA (table),[1–5] and have been a part of government statistics since the founding of colonial America.[6–8] However, controversies abound over explanations for these inequities.[6–8] In this report, we offer a perspective not often found in the medical literature or taught to students of health sciences, by focusing on structural racism (panel 1)[9–11] as a key determinant of population health.[9,10,12,13] To explore this determinant of health and health equity, we examine a range of disciplines and sectors, including but not limited to medicine, public health, housing, and human view—one that identifies and seeks to alter how such racism contributes to poor health—is required to understand, prevent, and address the harms related to structural racism. There is a rich social science literature conceptualising structural racism,[8–10,19] but this research has not been adequately integrated into medical and scientific literature geared towards clinicians and other health professionals.[9,10,12,13] In this report, we examine what constitutes structural racism, explore evidence of how it harms health, and provide examples of interventions that can reduce its impact. Our central argument is that a focus on structural racism is essential to advance health equity and improve population health.

Lancet 2017; 389: 1453–63

See Editorial page 1369

See Comment pages 1376 and 1378

This is the third in a Series of five papers about equity and equality in health in the USA

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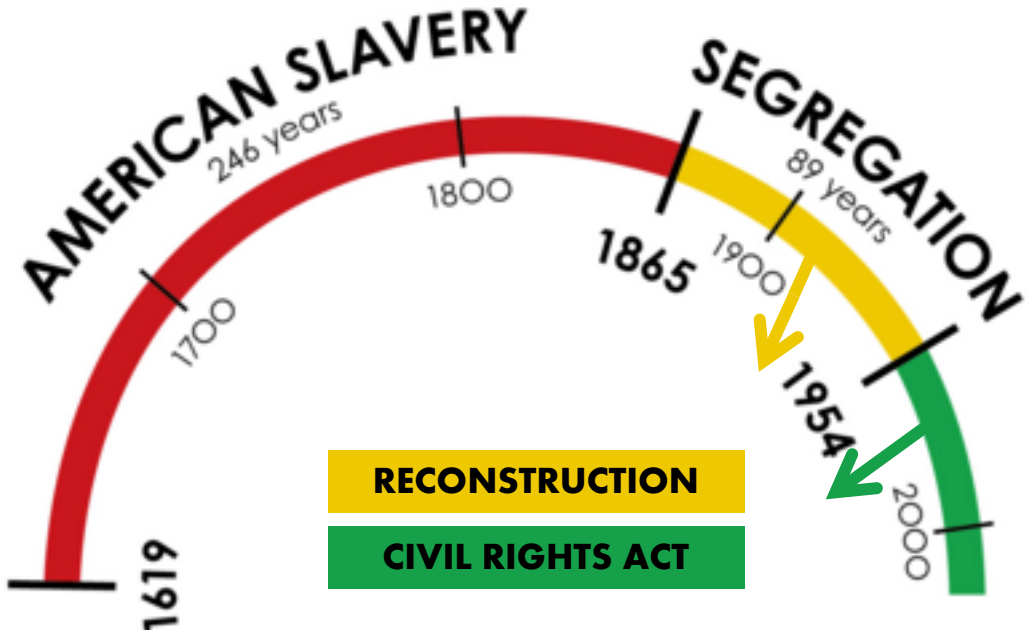
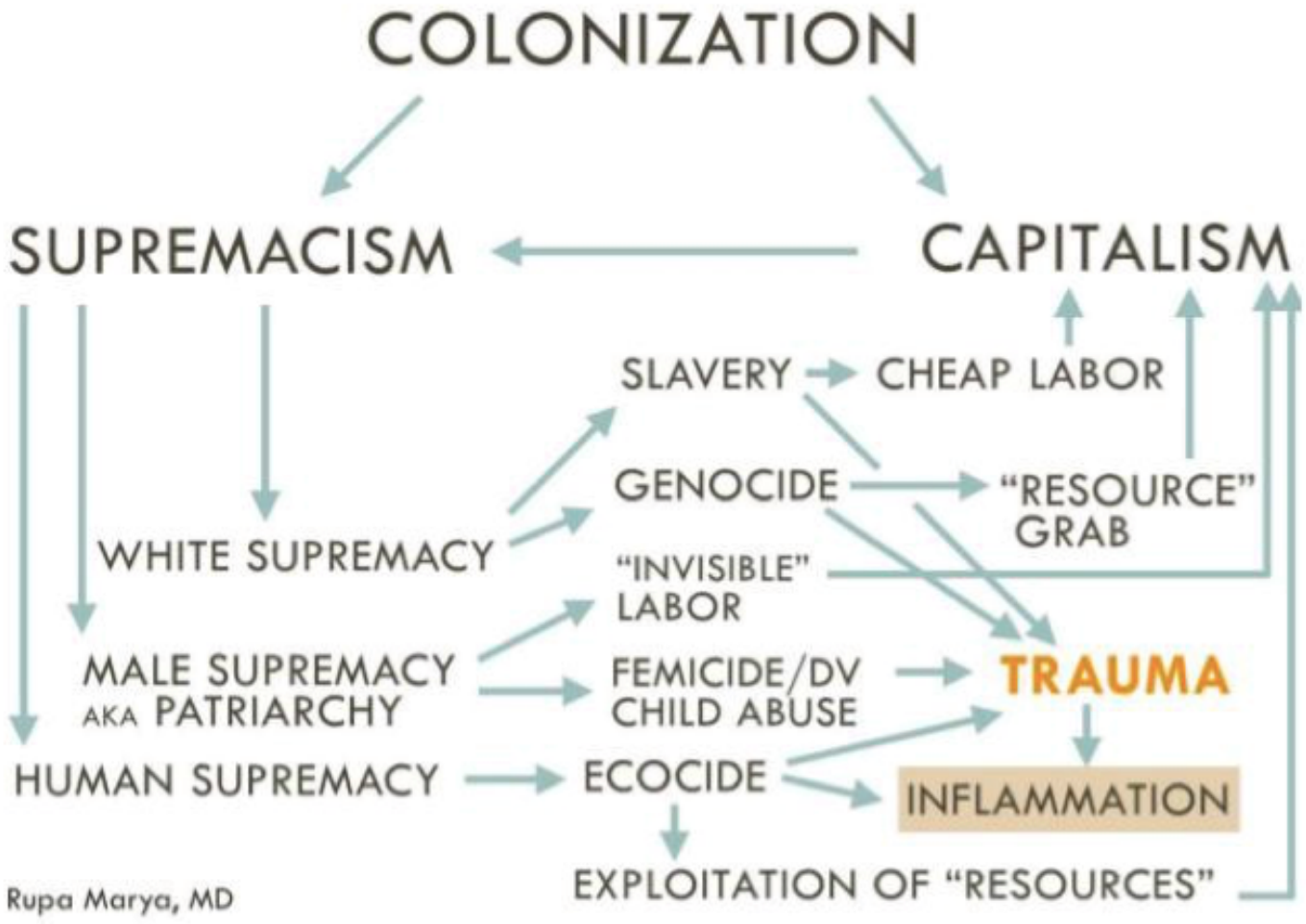
See Online for infographic www.thelancet.com/

Racism is a System of power and oppression that **structures opportunities** and **assigns value based on race**, unfairly disadvantaging people (racial oppression), while unfairly advantaging others (racial privilege & supremacy)
Internalized-Interpersonal-Institutional-Structural



"To understand the root causes of the pathologies we see today, which impact all of us but affect Brown, Black and Poor people more intensely, we have to examine the foundations of this society which began with COLONIZATION…. Colonization was the way the extractive economic system of Capitalism came to this land, supported by systems of supremacy and domination which are a necessary part to keep wealth and power accumulated in the hands of the colonizers and ultimately their financiers." — Dr. Rupa Marya



The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Case Studies in Social Medicine — Attending to Structural Forces in Clinical Practice

Scott D. Stonington, M.D., Ph.D., Seth M. Holmes, Ph.D., M.D., Helena Hansen, M.D., Ph.D., Jeremy A. Greene, M.D., Ph.D., Keith A. Wailoo, Ph.D., Debra Malina, Ph.D., Stephen Morrissey, Ph.D., Paul E. Farmer, M.D., Ph.D., and Michael G. Marmot, M.B., B.S., Ph.D.

Many clinicians and trainees see the social world as a messy, impenetrable black box: they may acknowledge its influence on their patients' health, but they lack the understanding and tools for incorporating it usefully into their diagnostic reasoning and therapeutic interventions. But the social sciences of health and medicine provide such tools — theories and methods for understanding social processes and intervening to effect change. Leading organizations in medical education have recommended providing additional training in social medicine, which deploys these approaches to improve health.[1,2] In this issue, the *Journal* launches Case Studies in Social Medicine, a series of Perspective articles, to highlight the importance of social concepts and social context in clinical medicine. The series will use discussions of real clinical cases to translate these tools into terms that can readily be used in medical education, clinical practice, and health system planning.

In their first year in medical school, all students learn to take a social history. As they transform their eyes, ears, and hands into sensors for detect-

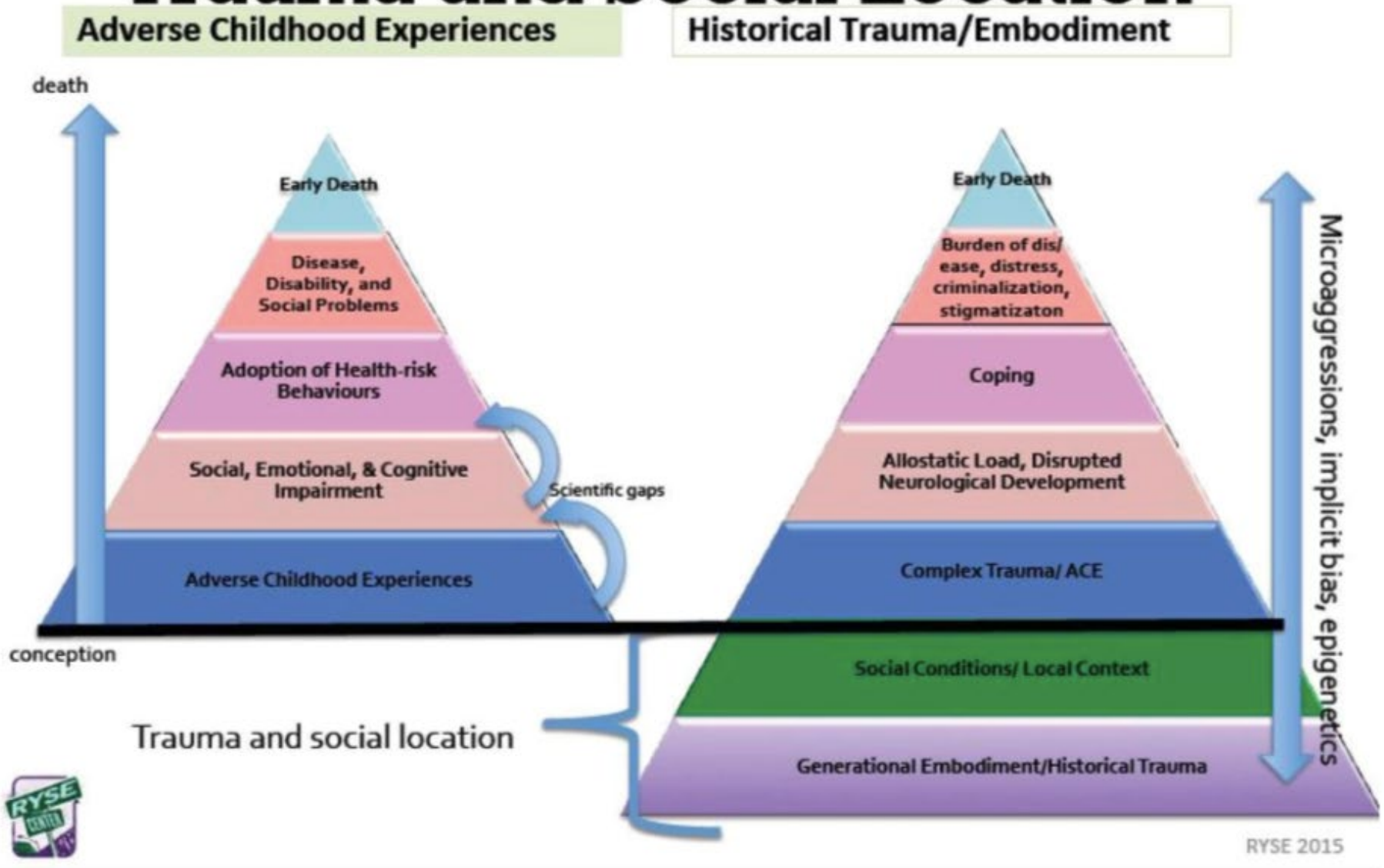
in clinical medicine, the biologic and behavioral world of a patient's body is more important than the social world outside it.

This erasure flies in the face of increasing evidence documenting the role of social forces in determining health, disease, treatment, and recovery. Noncommunicable diseases, including coronary heart disease, stroke, lung cancer, chronic obstructive pulmonary disease, and mental health disorders, remain major global causes of illness and death, and their prevalence is increasing.[3] The likelihood that these conditions and the prognoses and treatment outcomes associated with them will develop are strongly predicted by social factors, including income, race, ethnicity, immigration status, and place of residence: they cluster in social networks and are exacerbated by social inequalities.[4] The fundamental causes of health and disease, however, are not these seemingly static characteristics that mark inequalities, but rather the social, political, and economic forces that drive these inequalities in the first place — what we would call the structural determinants of the

Structural Violence

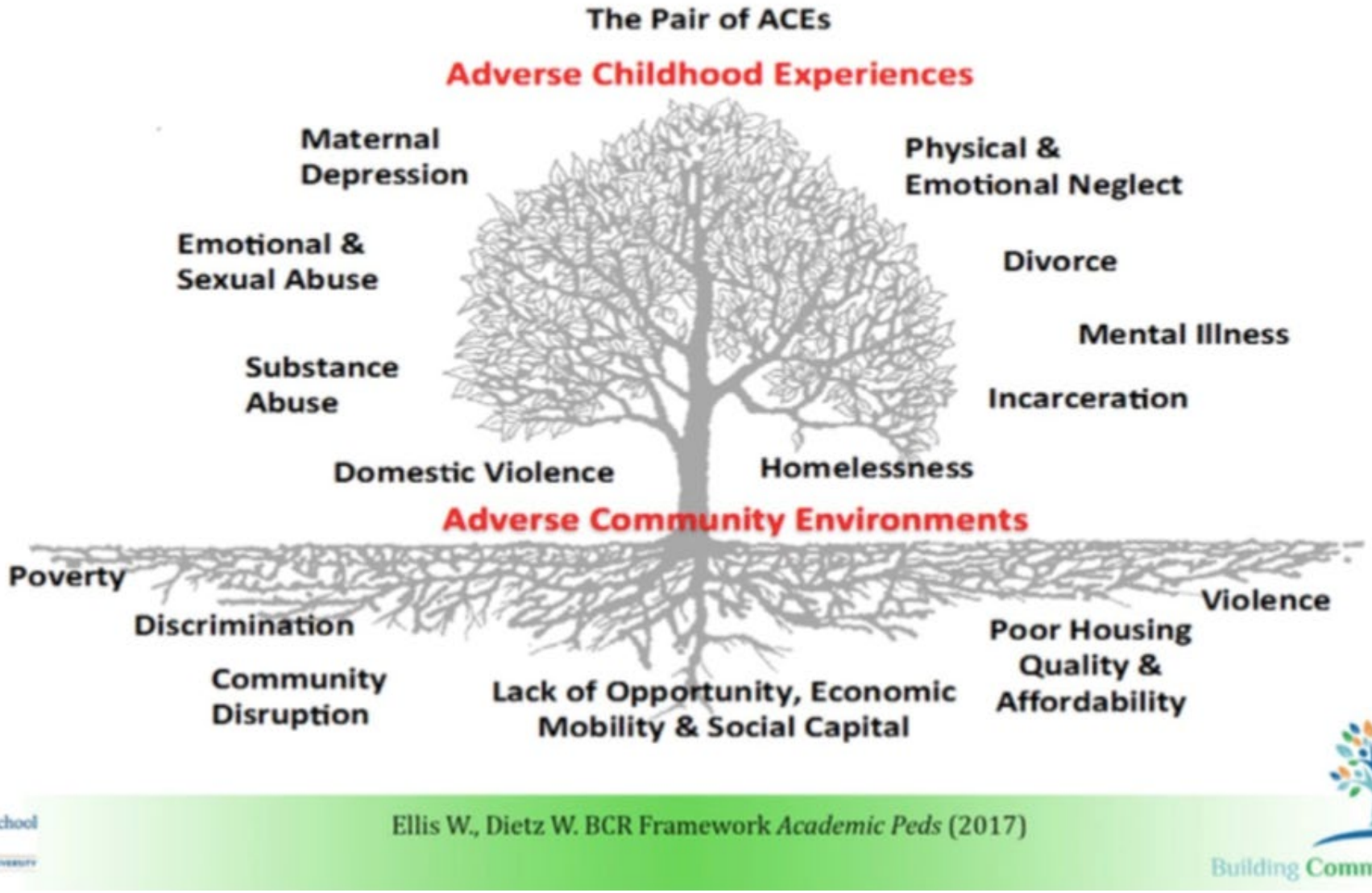
"Johan Galtung introduced the term "structural violence" in 1969 to explain the process by which social institutions caused harm to individuals or groups by preventing them from reaching their potential or by depriving them of the resources they need to survive."

Trauma and Social Location



8 of the 10 Leading causes of death linked to early traumatic exposure…

As are over 40 health conditions



Participants who suffered <u>three</u> or more adverse childhood experiences had much higher rates of:

Substance abuse
Domestic violence
Suicide attempts

Were more likely to have:

Dropped out of school
Divorced
Diabetes
Obesity
Cancer
Heart disease

Dominant narratives, embedded in our institutions and culture, represent voices reinforcing social relations that generate social, political, and economic inequality and racial injustice marginalizing or silencing the voices of social groups with limited power. These narratives shape consciousness, meaning, and explanations of events.

Narrative

Their effect is to obscure power (and responsibility), divide populations with common concerns, enforce compliance, and ensure that opposing visions of society's future do not become reality.

Narratives Shape Our Beliefs
...dominant narratives undermine health equity

- Racial and class inequities are “unfortunate, but not necessarily unjust”
- Self-determining individuals make right or wrong “lifestyle” choices (Rendering political, structural, and social determinants of health inequities invisible)
- Cultures of oppressed and marginalized racial and ethnic groups are responsible for and blamed their own poorer health outcomes
- Pick ourselves by our bootstraps
- Creates ”othering” and “belonging”

Use Power and Privilege

Advocate to create narrative, structural, and policy change

#NYCHealthEquity

NYC Health
Center for Health Equity

To move forward, it is important for our leaders to understand the ubiquitous nature of racism and its historical lineage across all nations. The devastating effects of slavery, colonialism and resource-driven conflict have been well-documented, yet we have not done enough to challenge the ideology of racial hierarchy that supported and sustained these ills. To this day, we still see a world where the nations that benefitted the most from the slave trade and colonial ambition remain the most economically and technologically developed. These countries, paradoxically, are often the most reluctant to confront or discuss the impact race has on the day-to-day lives of their citizens.

Physicians' powerful ally in patient care