THE INTERSECTION BETWEEN RACE, CLINICAL RESEARCH, AND MEDICAL EDUCATION WITH EXAMPLES ON STRAGEITES AND POLICES TO UNDERSTAND, IDENTIFY, AND MITIGATE THE EFFECTS OF RACE-BASED MEDICINE / RACISM IN MEDICAL INSTITUTIONS

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Introduction

Various systems and institutions operate as though race is a biological concept – a notion that states there are innate genetic differences among those of different races. These differences are "science-based evidence" that showcases the ability and capabilities of various groups of people. Medicine is no exception. The intersection of medicine and race as a biological construct has brought to light a new area of focus that needs to be addressed: race-based medicine.

Race-based medicine is the belief that people of different races have different biological characteristics that affect the diseases they are prone to, and the types of treatments and procedures that should be used. This belief is reflected in medical education, clinical practice, and research. Race-based medicine is a dangerous consequence of structural racism that can and has already led to subpar care and adverse outcomes for communities of color and other marginalized groups. Race-based medicine was born from slavery. Notions of biological difference between races were used to justify slavery, and the structural racism that was a product of the slavery era gave rise to race-based medicine. The assumption that black and brown people are genetically distinct – and many times considered inferior – to white people. has led to flawed science, biased practices, and increase in health disparities for communities of color and other marginalized groups.

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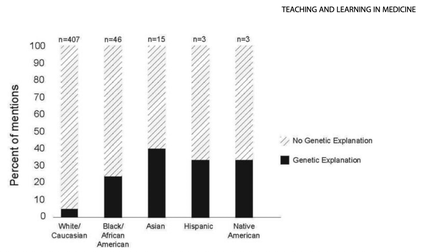
Figure I: Distribution of Mentions that Refer to Genetics in Relation to Race/Ethnicity, by Racial/Ethnic Category.



Effects of Race-Based Medicine

- Delaying treatment/referral for morbidity improving measures
- Increasing morality of minority groups in all clinical scenarios
- Deviating from the standard of care (i.e Calcium channel blockers instead of ACE Inhibitors as a first line treatment for hypertension) based on phenotypical presentation
- Negatively affecting the mental health and academic success of minority students in preclinical and clinical years
- Perpetuating stereotypes that impact the quality of care and in many instances have resulted in death for people of color
- Exacerbating heath disparities by ignoring the influence of social determinates of health and racism

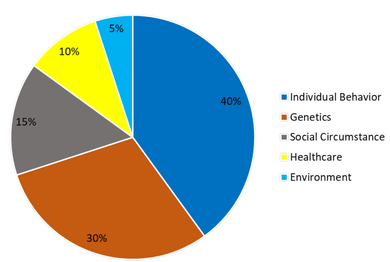


Figure II: Determinants of Health and Relative Impact on Overall Health

Mitigating Race-Based Medicine

Targeting Pre-Clerkship years

- Creating an adjunctive course for students to learn about the consequences of racism and systemic oppression
- Thorough review of curriculum to flag concepts, slides, and pictures that steer the institution away from inclusivity, anti-racism, and anti-bias

Targeting Clerkship Years

- Auditing third year rotation evaluations
- Removing race correction from risk score calculations and medical equations
- Exchanging ideas and strategies through annual Racism in Medicine conferences

Targeting Staff and Faculty

- Implementing continuous educational sessions to acknowledge, recognize, and work against their bias
- Incentivizing anti-racism and anti-bias efforts

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Climate Change and Mental Health
Past and Future Social Justice Considerations

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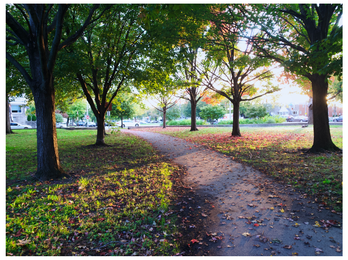

Introduction

Where people live, the foods they consume, and their interaction with the physical environment have significant impacts on their health. Within the area of mental health, the dominant bio-psycho-social model recognizes a person's lived environment has a significant impact on mental wellness and the development of mental illness. Social determinants of health have roots in inequitable access to resources through unjust policy, including healthcare.

Those communities who have historically benefitted least from resources gained through climate destruction are now most at risk of harm. Climate stressors interact with other inequities to limit individual and community agency to respond to compounding stressors and leads to less healthy communities. The goal of this work was to examine the intersection of climate change, inequity, and mental health with Philadelphia as an example.

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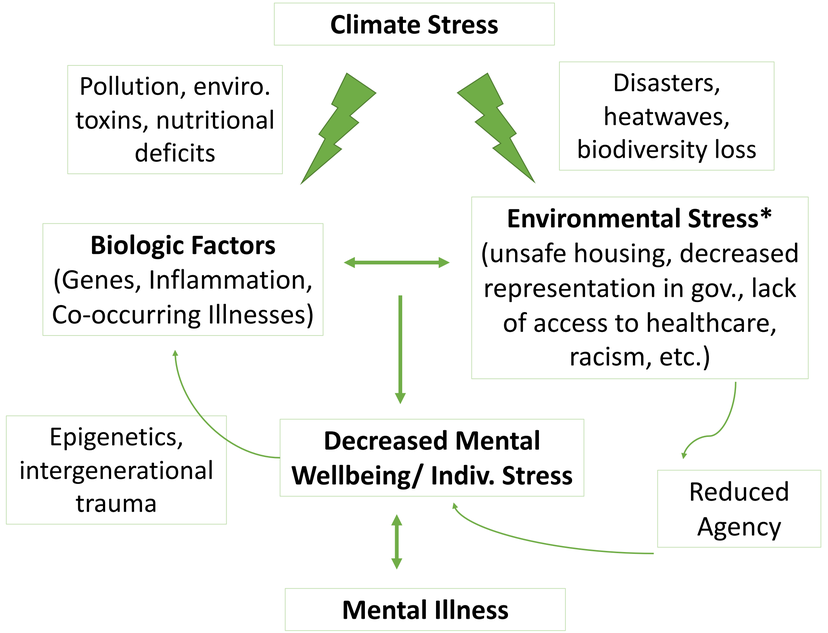

- Climate stress is both an independent source of stress (disasters, resource scarcity) and amplifier of pre-existing inequity in communities already experiencing other sources of stress with limited ability to respond
- External stressors both predispose persons to mental illness and decrease agency to respond to it
- Historic racism and inequitable policy shapes present communities. Stress in one generation can be transmitted through increased disease burden and inequitable access to resources to become healthier

*term environmental used to describe factors outside of an individual related to their physical, social, economic surroundings and situation

Philadelphia

Tree Cover

- The poorest half of the city has only 1/3rd of total tree cover
- 20+ degree difference in ambient temperature between low income N. Philadelphia and wealthier neighborhoods
- Free city tree programs require owner approval, online application, maintenance

Flooding

- Eastwick built on low-lying land for majority persons of color displaced by development
- Army Corps of Engineers working for over decade on plan to mitigate without action
- City investing in public green space, land swap proposals

"If left unaddressed, the hotter and wetter climate will multiply existing risks like poverty, poor health, and economic inequity" -Mayor Jim Kenney

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Envisioning a Feminist Medical Education

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Abstract

The purpose of this thesis is to examine the patriarchal undertones and overt sexism that informs and takes place within undergraduate medical education (medical school). Using a feminist analysis, I will expose some of the ways in which sexism occurs. This includes at the levels of who is given authority to teach medical students, the biomedical research we are using as our primary knowledge source, what material is chosen to be prioritized vs what is left out of the curriculum, how this material is taught and interpreted, and what the larger cultural and value system is that medical education is embedded in. I will demonstrate how the patriarchal values of masculinity, objectivity, heroism, competition, technicality/procedurality, objectivity, rationality, and so on pervade each of these levels, devalue femininity and non-biomedical sources of knowledge, exclude women, and cause harm to all trainees and future patients.

Part 1: Representation

Statistics:

- Women make up 36.3% of US physicians in 2019[1]
- 18% of department chairs and deans are women[1]
- <10% of women in neurosurgery, orthopedic surgery, thoracic surgery, interventional cardiology[2]
- 5.3% of faculty physicians are URIM women[1]
- Fewer than 1% of physicians are TGNB[1]

Standpoint theory suggests that minority faculty physicians can bring in new and insightful knowledge to medical education

However, multiple studies have found all types of demographic groups to have bias.[3,4] Which is why it is also important to continue implicit bias training, engage in reflexivity and make structural changes.

Part 2: Biomedical Research

- Not neutral/objective since they are influenced by the people creating them and larger society
- Deficient in female animal models[5], women participants[6], women researchers[7], and research topics that relate to women[8] (androcentric)
- When SGBM research is conducted, it interchangeably uses sex/gender, and uses an essentialist and oppositionalist framework[9]

How to improve?

- All genders should be involved in the development, participation and application of research
- This research should incorporate social dimensions of disease, gender similarities along with differences, the interaction between sex and gender, and themes of complexity and plasticity

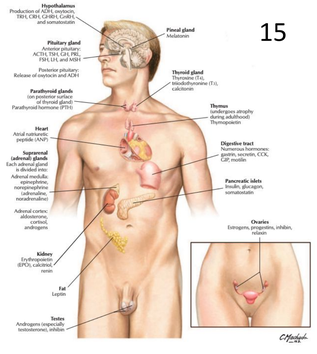
Part 3: Feminist Teaching

- Education not exclusive to biomedical sciences
- Science as a way of thinking, not as content to learn[10]
- Move away from the "banking model" and towards a more collaborative, egalitarian and holistic method like PBLs[11]

Part 4: The Hidden Curriculum

Formal

- Many examples of women being described in derogatory or inferior way, or not at all[12,13]
- White male as standard, bikini medicine for women
- Only 8.1% of medical school classes had in depth discussions on sex/gender[14]



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Informal: mirrors much of the patriarchal/white supremacist/ capitalist values in our society such as maleness, whiteness, competitiveness, emotional detachment, objectivity, rationalism, heroism, toughness, aggression, and antipathy for weakness

> Competition: "You notice that students during the clinical years try to stand out, stabbing each other."[16]
>
> Toughness: "When I come off a service where I've been workin' really hard, I feel like the toughest person. I am so tough; I am so superior to you because I work longer hours than you"[17]
>
> Maleness: "they want you to be a man and act like a man and then when you do, it's like you have some big personality disorder . . . you are not feminine anymore."[17]
>
> Whiteness: "There aren't many of us [Black males] here in the first place…they can't get our names right?!"[18]

Conclusion

Feminist theory is a method in which we can examine and work to correct oppressive practices in medical education via

- Implementing a gender analysis throughout to make sure that women are represented at the level of faculty, to research material, to content in textbooks/lectures.
- Including different forms of knowledge and humanistic perspectives in addition to the biomedicine currently taught
- Challenging our current patriarchal/white supremacist/capitalist system in medicine

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Community-Based Health Interventions: An Ethical Approach to Bringing Healthcare to the Marginalized

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Introduction

The world watched as COVID-19 unearthed an ugly truth—racial disparities existed in healthcare and had negative effects on health outcomes. While the Black Community only makes up about 13% of the United States, they accounted for an astounding 30% of COVID-19 cases (PBS, 2020). In cities like Philadelphia, where Black and Brown individuals are likely to be essential workers, live in densely populated areas, and take public transportation, community members were accounting for even higher percentages of the disease burden in comparison to their white counterparts. With such glaring disparities occurring, community organizations like the Black Doctor's COVID-19 Consortium did their best to focus on communities that were being affected at higher rates. As I watched community-based organizations do their best to fill in the healthcare gaps, it was apparent that community-based health interventions had the potential to be an essential model to decreasing healthcare disparities and increasing access for marginalized communities like North Philadelphia.

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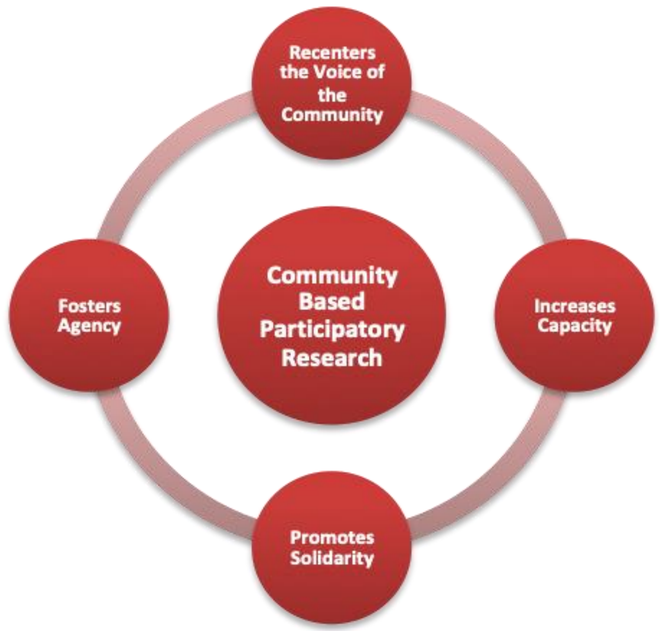
Community Based Participatory Research



- Using Community Based Participatory Research (CBPR) creates a mutually beneficial partnership between academics and the community.
- CBPR allows communities to form research questions around what issues are important to them and increases their capacity to explore possible solutions (Suarez-Balcazar, 2020).
- CBPR fosters agency by taking into consideration the context of the individual, including one's experience and intersectionality, when developing an intervention for the community.
- CBPR should be regarded as the most ethical model for research because of the role it has in increasing a community's capacity.
- As a principle, solidarity binds two or more stakeholders together; because of this, in its essence, CBPR promotes solidarity through partnership.

Community Health and Bioethics

I believe implementing community-based interventions to meet the need of marginalized communities is rooted in utilitarianism. Utilitarianism focuses on achieving the greatest amount of good for the greatest amount of people. Through using community-based health interventions to increase access to healthcare access to the marginalized, in conjunction with standard healthcare that is accessible by the majority, a wider net is cast, allowing for a greater amount of people to access health care. If one is truly trying to do the greatest good for the greatest amount of people, the main focus should be how to make things accessible to the masses. This requires considering barriers that prevent individuals from accessing the care that they deserve. Intentionality and inclusivity are imperative to implementing interventions that truly decrease barriers and increase access for marginalized communities.

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COVID-19 AND ITS IMPACT ON ASIAN AMERICAN AND PACIFIC ISLANDER (AAPI) MENTAL HEALTH

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https://medicineatmichigan.org/feature/2020/fall/covid-19-hurting-our-mental-health-what-can-we-do-about-it

Introduction

There is growing research on how pandemics affect marginalized groups

- Xenophobia, stigmatization, discrimination
  - 60% of Asians had personally witnessed someone blaming Asians for COVID-19
  - Hate crimes targeting Asians and Asian Americans have risen by 150% in 2020 and 194% in the first quarter of 2021

COVID-19 related discrimination was significantly associated with an increased level of symptoms of post-traumatic stress disorder

The biopsychosocial model can be used to understand patients in a more holistic way

- Can be applicable to AAPIs in the current pandemic

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Biopsychosocial Model

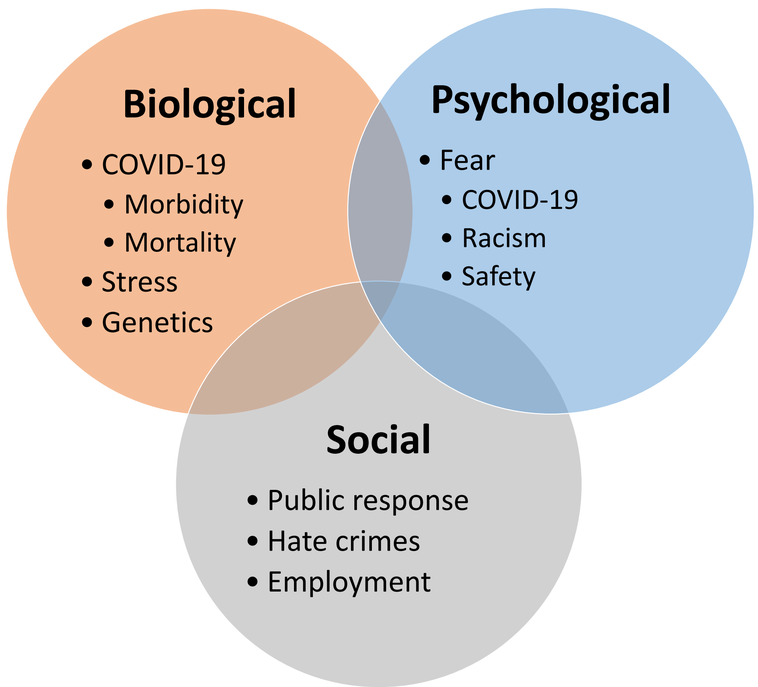
Invented by Dr. George Engel in 1977 to humanize care

- Used to understand mental illness

Different from the biomedical model

- Disease does not occur in a vacuum
- Illness is a dynamic process
- Mind, body and environment are linked

AAPI Stressors During the Pandemic



Psychological Stressors

Fear has played a big part in people's mental health throughout the COVID-19 pandemic

- Basic emotion that is activated in response to perceived threat

Integrated model of understanding fear

- Conceptualize fear that have been experienced by the AAPI community

Bodily
- Asian features
- Perpetual foreigner

Interpersonal
- Racism in community
  - Friends/Family
  - Workplace

Cognitive
- Fear of knowing/not knowing
  - Hate crimes

Behavioral
- Fear of action/inaction
  - Mask wearing
  - Public transportation

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An Ethical Recovery from Breast Cancer: an examination of disparities in breast reconstruction and a discussion about rectifying these disparities

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Introduction

Black women are most likely to receive mastectomies, yet the **least likely to have** receipt of **breast reconstruction**. This disparity in breast and plastic surgery care is unethical and has been documented in the literature and has been witnessed clinically, but far most importantly, it is continued to be lived by Black women all over the nation. The bioethical principles of **agency** and **social justice** are called into question as Black women are not given an adequate understanding of their reconstructive options and are not being treated equally or equitably by the healthcare system. As noted by **literature, race and ethnicity, socioeconomic and insurance status as well as comorbidities** are contributing to this gap in care. As far as solutions go, there must be a multifaceted approach to mitigating this disparity. I have adopted Dr. Butler's categorization of **solutions** to understand the exact approach we need to have, which includes **patient education, legislation and academic medical institution**, to make the recovery from breast cancer ethical for all women.

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Contributors to the Disparity

In a brief literature scope using a self generated search query (Figure 1), 186 articles were resulted and 26 were chosen as pieces to inform this thesis. Out of the chosen articles, 18 (69%) of the articles focused on the disparity as an issue. Dating back to the mid-1990s, it was clear that this persistent disparity has been a gap of care in the Black community for years. The major themes uncovered in the literature are found below.

Race & Ethnicity

- Minority women are less likely to receive breast recon
  - Theories for this factoid – lower health literacy, lack of access and referral to a plastic surgeon, low socioeconomic status & un-/underinsured status
  - Race = proxy for racism/racist systems
- Plastic surgeons' explanations of the surgery are vague
- Breast surgeon referral patterns
- Cultural perspective

Socioeconomic & Insurance Status

- 1998: Women's Health and Cancer Right Act (WHCRA) passed → insurance required to cover breast reconstruction for patients receiving mastectomies
- Black women continued to be the only group with lack of significant improvement in receipt of reconstruction
- Insurance status = proxy for socioeconomic stability

Comorbidities

- Patients have been omitted from breast recon if they have more than one chronic comorbidity
- No statistically significant difference in postop morbidity between White and Black patients with the same comorbidities

Solutions

Dr. Paris Butler published an article regarding disparities in breast reconstruction and offered a three-tiered solution model (Figure 2) for plastic surgeons to utilize when attempting to mitigate the barriers to breast reconstruction.

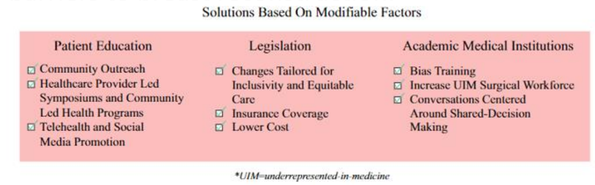

Figure 2. Adopted from Persistent Disparities in Postmastectomy Breast Reconstruction and Strategies for Mitigation by PD Butler et al. published in Annals of Surgical Oncology in 2021.

Patient perspective

- Supportive environments are key to having a better breast cancer journey (i.e. family, social media, etc.)
- Black women have work on their mind while making decisions about life postmastectomy
- Demystifying plastic surgery in the Black community would prove to be beneficial

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Unsafe, Inhumane, and Preventable: The COVID-19 Pandemic in U.S. Prisons and Jails and Decarceration as a Bioethical Imperative

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Introduction

When the COVID-19 pandemic erupted in 2020, public health experts immediately pointed to jails and prisons as likely vectors of community spread. With population reduction theorized to be the most effective method to combat the novel virus, the United States, with 25% of the world's incarcerated population despite making up just 4.2% of the general population faced a particularly daunting challenge. Policymakers and prison officials elected to forego extensive population reduction in favor of draconian lockdowns, isolations, and quarantines that resulted in countless human rights violations but also resulted in an infection rate 5.5 times that of the general population and a mortality rate 3 times higher.

How did we get here? What could we have done differently? How can we not only prevent the next public health crisis within this population but also rethink our correctional system to be one that focuses on rehabilitation and equity?

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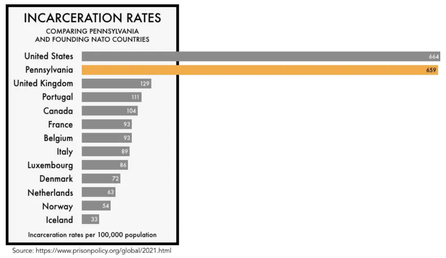
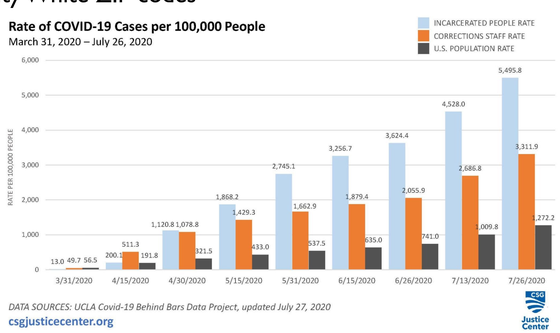


Key Findings

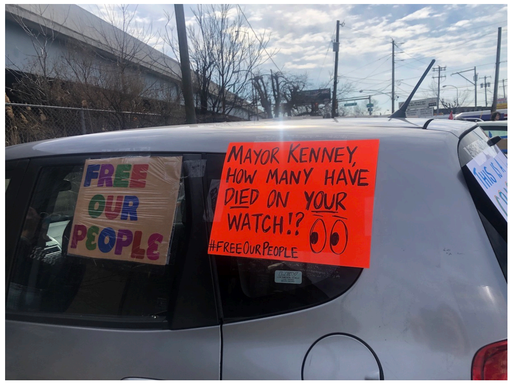
- In March of 2020, the Pennsylvania Department of Corrections issued recommendations indicating that an estimated 12,000 individuals would need to be released from state correctional facilities to adequately limit the spread of COVID-19 . By August 2020, only 741 inmates had been released
- With draconian lockdowns, lack of PPE, staffing shortages, and increased time in solitary confinement, violence increased with homicides within local prisons and jails in late 2020 and early 2021 exceeding the previous 8 years combined
- Inmates convicted of violent crimes are often excluded from temporary or permanent release measures even though they have overall lower rates of recidivism compared to individuals convicted of non-violent crimes
  - Poverty is the highest predictor of recidivism rather than category of previous conviction
- A 2016 study of mass incarceration found that for 39% of individuals in US prisons there is no public safety justification for their incarceration
- Analysis in Cook County and Chicago found that of the additional disease burden associated with jail cycling, 86% of that burden would be borne by Black and/or Hispanic-majority ZIP codes thus making up 17% of total cumulative cases within those ZIP codes compared to just a 6% effect in majority White ZIP codes



Recommendations

To prevent continued inequity and deleterious outcomes within this population we must:

- Immediately and urgently: reduce the incarcerated population at the federal, state, and municipal level
- End pre-trial detention and cash bail to prevent the continued influence of jails as racially and socioeconomically inequitable vectors of community spread
- Reallocate funding designated for new carceral facility construction towards reentry programs and public health investments that bolster the social safety net



Emily Rizzo/WHYY

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