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Transcription results:

RK: Rohan Khazanchi

SK: Sudarshan “Sud” Krishnamurthy

UE: Utibe Essien

EO: Ebi Okah

YV: Yannis Valtis

CD: Carine Davila

AM: Audience member

RK 00:00	Hey, y'all. This is Rohan Khazanchi. And welcome back to another episode of the Anti-Racism in Medicine series of The Clinical Problem Solvers podcast, where, as always, our mission is to equip our listeners with the consciousness and tools to practice anti-racism in their health professions/careers. This episode is a really special one for our team. It is our first ever fully live recording. Utibe and Sud spoke with three fantastic health equity researchers at the Society for General Internal Medicine's annual meeting, and I just can't wait for y'all to hear their conversation. Enjoy this recording. And as always, feel free to hit us up on social media, and let us know what you think. [music]
	[silence]
SK 00:48	Hey, y'all. This is Sud Krishnamurthy. And welcome back to another episode of the Anti-racism in Medicine series of The Clinical Problem Solvers podcast. As always, our goal on this podcast is to equip our listeners at all levels of training with the consciousness and tools to practice anti-racism in their health professions/careers.
UE 01:10	So last year, we introduced the live episode concept of the CPSolvers Anti-Racism in Medicine, and it was live and on Zoom, which was the worst, obviously. But we had a wonderful episode, and now, we get to be in person. And this is really awesome, and we appreciate y'all joining us. But we're super excited we got to meet in real life for the first time. Sud and I have been on many of Zoom in the last year along with some of our other team members. And again, super excited to be here with y'all and with our amazing guests today who we'll now introduce.
SK 01:44	So I'll go ahead and start. I'll introduce Dr. Yannis Valtis. Yannis Valtis is a fourth-year med-peds resident at Brigham and Women's Hospital and Boston Children's. He'll be starting a fellowship in medical oncology at Memorial Sloan Kettering Center this summer. Originally, from Greece, Yannis is a graduate of Harvard College and Harvard Medical School. He's worked on global health projects for the Boston Consulting Group, the Global Health Delivery Project, and up to date. His research interest is young adult leukemia, and his career interests lie in the intersection of health equity and health systems management.

UE 02:23 Awesome. And I get to introduce Dr. Ebi Okah who's a family medicine doctor and an NRSA primary care research fellow at the University of North Carolina. Go, Tar Heels, who sadly lost recently. She completed med school at Mount Sinai, along with another one of our fellow guests here today, and then family medicine at the University of Minnesota. Prior to entering medicine, she worked as a associate economist at the New York Federal Reserve Bank and as an analyst for the New York City Department of Health and Mental Hygiene. Her areas of research are in cardiovascular diseases in Black Americans, the use in clinical decision-making, and race. And of course, she is a fellow Nigerian.

SK 03:08 And I get the honor of introducing our third guest, Dr. Carine Davila. She's a palliative care physician at Mass Gen Hospital. She studied public policy at Princeton, received her medical degree from the Icahn School of Medicine at Mount Sinai, like Dr. Okah, completed residency in internal medicine at UCSF, completed the Harvard Interprofessional Palliative Care Fellowship, and then served as a Commonwealth Fund Fellow in Minority Health Policy with Harvard Medical School, where she also received her MPH at the Harvard Chan School of Public Health. She's passionate about palliative care for marginalized populations and has a particular interest in improving care and communication for Spanish-speaking patients. Thank you so much, y'all, for joining us once again.

S4 03:58 Thanks for having us.

YV 04:00 Thank you.

EO 04:00 Happy to be here.

UE 04:01 Yeah, you guys are amazing. So asking folks, literally, the week before the conference to join us on a Friday night podcast is not an easy feat, but Sud's persistence and enthusiasm convinced them. And we, again, appreciate y'all joining us today. We're going to jump right in. Yannis, I'll start with you. So in our very first episode of the podcast back in July of 2020, we discussed policing and health with Doctors Rhea Boyd and Dr. Rachel Hardeman. And one topic that came up was about the presence of police in healthcare and in our education spaces and how they really harm our sense of safety, especially for Black and Brown communities. And discussion-- this discussion, rather, led to one of our co-directors, Dr. Michelle Ogunwole, publishing in a New England Journal of Medicine a piece called Without Sanctuary, where she really reflected on the absence of sanctuary spaces, especially for Black individuals in healthcare. And so we wanted you to, if you could, share with us a little bit about your personal experiences about what really motivated your work at the Brigham, especially to address the complex issues of policing within the hospital.

YV 05:08 Yeah, thank you so much for inviting me. I'm really excited to be here. And thank you for wanting to hear about this project because it is something that is very close to my values and what I care about. So the inspiration for this project really was born after George Floyd's murder. And a group of us at the hospital got together and started having weekly meetings to discuss what we thought our role as physicians and clinicians was in protecting our patients and specifically our Black patients from police brutality and police murdering. And as we were having these conversations about police outside the hospital, we realized that our mindset was completely outside the hospital, and we weren't turning our eyes inward to say, "What is happening here in our own professional home?" And we decided that we wanted to change that. And so we said, "Okay. What is happening here at the Brigham? Do we call police and security

more frequently on our Black patients? If we do that, what happens then? Do we restrain them more frequently? Do we give them medications against their will more frequently? And then what is the patient experience through all of this? And then ultimately, what can we do about it?"

YV 06:26 So the work that I'm presenting here at SGIM really only gets to the first part of that, which is, "Is there an inequity here?" And we found that there is. And of course, I can tell you more about it. But the inspiration for the project was what happened around that time. At the same time, as we started working on that, and we started talking about this project to other residents, it became obvious that it was a little bit of a common secret within the Brigham. We all knew that when we heard the Code Gray bell go off - Code Gray is the security code - we all knew that if we ran into that room, it was a very high likelihood that we would walk into the room of a Black patient. So everyone was already thinking that and was aware of that, but we weren't measuring it and kind of putting it on paper and in a way that hospital leaders can see and can respond to with an intervention.

SK 07:24 I think that's really powerful. I think always hearing this story that kind of inspired the work that researchers are working on always goes a long way in kind of showing the impact of that work. Thank you so much for sharing that. I think we're going to switch gears a little bit. My next question is for you, Ebi. To give you a little bit of background, we focused three episodes of the Anti-racism in Medicine series on interrogating and dismantling race-based medicine. Much of what we've talked about was the historical and structural underpinnings of racial essentialism in medicine and how that's really spilled over into modern-day clinical algorithms. Ebi, you have studied this issue in frontline clinical care. Your presentation at SGIM showed that the use of race in clinical care is associated with the belief that genetic or cultural differences in racial groups explained racial differences in health outcomes. Could you tell us a bit more about your research and what your team found?

EO 08:28 Absolutely. And I also want to say thank you for inviting me here to speak. Since you gave such a enthusiastic response to giving our history, I'll give you a history of how I got here. So I went to medical at Mount Sinai, as you mentioned, and there are a lot of students who were actively involved in work to change the curriculum and to challenge race-based care or race-based medical education, which is essentially using race as a risk factor for disease. And I also went to this talk by Dorothy Roberts, and she talked about race in medicine and how we shouldn't use race in medicine. And one of the things that immediately came to mind for me was sickle cell disease, and I feel like that's something that comes to the mind of a lot of people. And when I really looked into it, I saw that, "Okay. Yes, the prevalence of sickle cell carriers was higher in lots of regions in the African continent, not as much in the south, a little bit less in the east, but also was prevalent in parts of the Middle East and parts of India. And so I think thinking about race and the narratives that we create to explain why we see what we're seeing, essentially, that's what motivated me to want to study this question more.

EO 09:45 And then I went to residency, and I think in that space, practicing as a clinician, I got to see how critical race seemed to be for so many decisions. I think we're all very familiar of the Black/non-Black eGFR estimations for renal function but also actually in risk calculators and in algorithms, where race just kept popping up. And the part that confused me, in some ways, is the fact that-- my ancestry is in Nigeria. I was born there. And I know the African continent is the most genetically diverse continent in the world, and I felt that it didn't make sense to me that all these things were being

attributed to blackness, especially poor health, which a lot of times connected people to the idea that this group of people are the way they are because of some unknown reason that we're not really sure about, but that's sort of just the way it is; that is some sort of innate risk instead of thinking about the society that assigns privileges and benefits by race that then results in these different health outcomes. And so that was the motivation for me to do this work.

UE 11:07

Thank you so much. And again, shout out to-- I think it was episode 7 that we had Dorothy Roberts on. So she had an incredible conversation with us, and I think the theme around narrative has also been a big part of our conversations. And this kind of segues into your work, Carine. A lot of our series, we focused on how to improve care delivery for specific minoritized or marginalized populations. We talked about those who are incarcerated and those who are experiencing homelessness. And in the wake of so many multilayered structural inequities, a lot of clinicians - many of us may be in the room - feel overwhelmed and unable to really find a good place to start. And, Carine, the place that you decided to start was in what we do every single day, which is talking to patients. And so maybe you can share a little bit about the literature and your research and the background that motivated your work and how patient-clinician communication actually directly influences health disparities.

CD 12:11

Thanks so much, Utibe. And again, I offer my thanks for the invitation. I'm excited to have this opportunity to connect with you all here live and the audience listening as well. And so I think for me, as a palliative care clinician, so much of what I do and focus on and the skills that I have are around communication. That's our specialty. I don't have the ability to wield a scope or do a procedure or anything, but I'm trained at talking with people. And that's really what, as you said, it comes down to. Sometimes we can feel really overwhelmed with so much going on left and right with patients, but you can always center yourself in some ways by coming back to the bedside or coming back to the office with the person that you're with, and it's just kind of you and them or whoever is accompanying them. And so as I embarked on this, this research kind of looked backward. First, we wanted to improve serious illness care. And to do that, you have to improve serious illness communication. In order to have good communication, you need to have patients who are willing to kind of speak up and engage with you. And their willingness to speak up and engage with you really depends on how much they've been listened to and heard in the past. Because if they've had prior experiences of not being listened to or being shut down, they're not going to feel comfortable putting themselves out there and opening up with you, and so you're not going to be able to engage in the important conversations that are really important for everyone, no matter at what stage of health or illness, but especially important for those with serious illness.

CD 13:45

And so that's why a lot of our research really focused on kind of, "Let's look back to experiences in the past around patient-clinician communication." And there is some literature and systematic reviews to show us and tell us that there are known inequities in patient-clinician communication, particularly for, as you mentioned, historically marginalized populations. And we know that has clinical outcomes. Not only does it have kind of immediate outcomes in terms of patient satisfaction, trust building in the moment, but we know it also has downstream health outcomes because if they have clearer communication, they're going to be better equipped and have more informed knowledge about what you're hoping for them to-- how you're hoping for them to kind of engage in their care. And you find if they're more willing to

trust you, they're more willing to kind of follow through and engage in their care kind of moving forward in a way that results in better health outcomes.

UE 14:40 Awesome. Thank you for sharing that, Carine. And thank you all for giving us kind of the intro to your work. And maybe we'll dive a little bit deeper in this next set of questions. So I'll start with you, Yannis. So for those who got to attend your presentation, you shared a little bit about how-- and you gave us a teaser earlier about how Black race was actually associated with higher odds of security emergency responses. And we've seen some of this in other data. I wonder if you can give us a little bit more specificity around your research findings, share a little bit about what factors you think are driving these differences, and then what interventions can we do to address them. So three-pronged question. No big deal. But--

YV 15:22 Yeah, absolutely.

UE 15:23 --you got this.

YV 15:23 Easy questions. Yeah, so I think the first part is obviously easier to answer. So what we wanted to look at is what happens in the inpatient non-psychiatric setting. So before our work, there had been two papers, one out of Yale and one out of MGH, that talked about the ED setting, and both of them had found that Black patients had a higher likelihood of being physically restrained in the emergency department than White patients. The ED is a little bit of a special setting because many emergency departments have security on standby all the time. The security guards are already there. And so it's a little bit of a different decision-making process. And oftentimes, the security guard might hear something and might decide to just go to a room. So it isn't as clear of a decision that, "Oh, we need to call security." There was also some literature in the psychiatric setting, which, again, very different setting; people are there for very different sets of diseases. But nobody had looked at the non-psychiatric inpatient setting. And so we said, "Well, in the inpatient setting, it's a little different. You need to make an active decision to pick up the phone and request security to come to the bedside." And so we wanted to study that decision moment. And then we also wanted to study the next decision moment, which is after security shows up, and usually, a respondent clinician, like a resident or a PA, shows up. What is then the next step that happens? And does race and racism play a role in that second decision moment?

YV 16:53 So for the first decision moment, we looked at, basically, everyone who got admitted to the Brigham in about a year and a half period. And this was all pre-pandemic because we thought pandemic changed a lot about where patients went because of where the negative pressure rooms were and blah, blah, blah. So we only looked pre-pandemic. And if you were admitted to the Brigham, and you were White, during that period, you had about a 1.5% chance of having security called on you, so a little more than 1 in 100, right? If you were Black, and you were admitted to the Brigham at the same period, you had a 2.8% chance of having security called on you, so essentially, double. And that's a very, very big difference. And I think none of us expected to find no difference, but I don't know that we expected to find a double difference. So then you say, "Okay. Are there other confounders that could be part of this process?" For example, we know that male patients are much more likely to have security called on them. Could it be that our Black patients were male to a higher percentage than our White patients? So we built a model, and we included a few other variables. So we included age, sex, ethnicity. And we looked at ICD-10 Codes, and so we were able to include binary variables for whether a patient had a mental

health diagnosis associated with that admission and whether a patient had a substance use diagnosis associated with that admission. Interestingly, there was some controversy, actually, within our team as to whether we should do that because some of our coauthors, like Karthik Sivashanker, said, "Well, it is entirely possible that we are more likely to assign a substance use diagnosis to a Black patient than a White patient even if both might be having the same process. And so by including that variable in your model, you might be overcontrolling it. That might be inappropriate." So we ended up deciding to do it because that was how the rest of the published literature was done, and so we wanted it to be consistent for comparison's sake.

YV 18:50

Anyway, when you include all those other variables in the model, the difference drops from double to more like 30% difference but still statistically significant, and so it's still very much a big deal. For the second decision moment, after what happens after security shows up, we did not find a statistically significant difference between Black and White. So then the second part of the question is why is there a difference in the first moment, and why is there no difference in the second moment? For the, "Why is there a difference in the first moment?" I think that the leading hypothesis is racism. I think the leading hypothesis is that staff at the hospital are more likely to perceive a Black patient as threatening and, therefore, feel like they need to call security. And I really cannot think of many more explanations than kind of racism and conditioning by media and the society we live in, the United States of America, that has kind of indoctrinated many of us with those ideas. Could there be other mechanisms at play? For sure. Could it be that language in the medical record influences whether someone decides to call security? If a patient has been described as aggressive in the medical record, maybe that makes a provider more likely to feel like they need security. We didn't study that so maybe. And then you could think about other unmeasured covariates.

YV 20:11

Why is there no difference in the second step? So we found that after security shows up, it was the same likelihood for a Black patient or a White patient that they would end up physically restrained. And why is that? It could be that having three people make a decision together. So a security officer, MD, and a RN kind of making a decision together kind of lowers the impact of racism and implicit bias because now, you have three people making a decision together, as opposed to one person making a decision alone. That's a possibility. I can't really prove it. The other thing that's interesting is that the security workforce at the Brigham is quite diverse, and they have a lot of Black officers, and so is it possible that the race of the provider has something to do with the dynamics of the interaction? We didn't study whether the race of the provider mattered because we didn't really have that data in a reliable format, and we also didn't want to focus so much on the provider and the provider experience because, at the end of the day, this paper is about the patient experience.

EO 21:13

I have a question. So what about the possibility that the Black patients, who are having security called on them, are not as aggressive as the White patients? Meaning when White patients have security called on them, they actually need security to show up, but there possibly could be Black patients who that's not the case, and so there could still be that disparity there.

YV 21:42

Yeah, I think that's an excellent point. And I think that even though there was no statistical significance, directionally, just in terms of numbers, Black patients were less likely to end up physically restrained after security had been called on them than White patients. And I don't want to make too much out of that finding because it wasn't statistically significant, but that's where my mind went is maybe a lot of those

calls were unnecessary, and so when the security officer showed up, it was very clear that they weren't necessary, and then they didn't do anything. And then your last question is what do we do for it? And I think that's the hard one. So there's a couple of people at the Brigham Emergency Department doing super cool work. So Dana Im and Farah Dadabhoy are doing super cool work, and they're doing simulation-based training on how to deal with the agitated patient, specifically with a racial equity mindset. And so they have hired Black actors to play standardized patients, and then they go through a sim of the patient getting agitated. And then at the end, they debrief. They have the actor kind of join in the conversation and kind of discuss their experience and how it felt for them. And I think that's super interesting. And I think there's very much power in simulation-based training to kind of allow people to see how they act under pressure and then be able to discuss it and reflect on it and say, "Okay. Did I make a different decision because I was treating a Black patient or a Black-standardized patient? And would I have acted differently if I was treating a White-standardized patient?" And so I think that's a really powerful intervention, and maybe you can talk to them at some point about their work.

CD 23:28 Yeah, I think just to highlight on that, that's one of the projects that the institution, Mass General Brigham, has made an institutional effort of called United Against Racism and selected 19 projects across departments and divisions. And it was really exciting that the emergency department clearly identified this, granted, in a different location than what you studied precisely, but is really undergoing a lot of efforts, including things like the simulation, to really try to get at this problem from an active-quality-improvement effort.

EO 23:59 And I have something. It's not related to this, but I-- well, I guess it is related, but I cannot remember the sport. But I think there was a study that was done looking at referees and how they called on players based on race. And the study involved sort of providing them that information for them to see, "Okay. This player did this, but you behaved this way. And this other player did this, and you responded this way."

YV 24:24 [crosstalk].

EO 24:24 And they were able to see that after that sort of intervention, there was much more-- the way in which the referees made their calls was less racially biased. So I think that there's support for them.

YV 24:40 Yeah, I think there is power in knowing, and I'm hoping that--

CD 24:45 Getting feedback on your own behavior.

YV 24:48 Right. Right. And I'm hoping that we'll find a way, and that's what we're working on, to share everything that we've done with residents and attendings and nurses in a way that isn't about blaming anyone and isn't about calling out anyone but really about saying like, "Okay. This is how we behave. This is what we're doing. Let's just be honest about it and then move forward from it towards a solution."

SK 25:14 This has been such an amazing conversation already. I think I really appreciate y'all's analysis of what's obviously a very complex issue. And then something I thought of, as you were talking about potential interventions, was also Dr. Prothrow-Stith's words this morning from the plenary talk about kind of being solution-oriented and thinking about these potential interventions as well. And I really appreciate that that's obviously being well-thought-of as well. Switching gears again to, Ebi, a little, as someone who works in the field of research into race-based shortcuts or decision

support tools, what do you think are interventions that are needed at both the educational and systems levels to ensure the next generation of clinicians thinks twice before using them or engaging in them?

EO 26:12 Okay. So hold me accountable because my memory is short. And so there was a part that I didn't answer before, which was what I'm actually doing, so I'm going to try to do that and then just hold me accountable for what I actually say.

SK 26:24 Of course.

EO 26:25 So as you mentioned, I'm studying how clinicians think about and use race in care, and part of that work was a systematic review essentially evaluating how physicians think about race and why they engage in race-based care. And as part of that work, I saw that there was this language about racist culture that there are biological difference between racial groups, but there's also cultural differences, and their values are held by racialized communities that contribute to their poor health outcomes, essentially. And so that was the motivation for the study that I presented today, where I essentially looked at beliefs regarding the etiology of racial differences in health outcomes and the use of race in clinical care. And so there are three questions, and each one identified a different etiology. So there was a question about genetics: to what extent do racial differences in genetics explain racial differences in health outcomes? There's a question about differences in culture, values about health, essentially, diet and exercise, and whether cultural differences between racial groups explained differences in health outcomes, and then also a question about social conditions, which was about the environment, socioeconomic status, and these sort of things.

EO 27:56 And the reason I tried to ask those last two more social questions in that way is because I was trying to tease out this idea of racial groups who are being responsible for their poor health outcomes through their own actions, behaviors, and values, and the society that we've constructed that contributes to those poor health outcomes. What I found is that belief in genetic differences, explaining racial differences in health outcomes, was associated with race-based practice. And I should mention that each one of these questions, etiology questions, were scored on a five-point Likert scale, and the outcome measure was the RACE scale. Racial Attributes in Clinical Evaluation was developed by Bonham and Sellers, and it's been used in other studies, several questions about, "Do I think about my patient's race when I select medications? Oh, I think about chronic disease management," and things of that nature. And so genetics was very strongly associated. So a one-point increase in score in genetics resulted in a three-and-a-half-point increase in RACE. When looking at cultural differences, a one-point increase in that score was associated with a 1.5 increase in RACE. And social differences questions was not associated with race-based practice.

EO 29:24 Now, what does that mean, and why does that matter? We, as clinicians, have a lot of say in the questions that we decide to evaluate and the way in which we evaluate those problems. African-Americans, for example, have the highest rates of hypertension in the US. And we can say, "Well, what is it about African-Americans? And let's go looking into genetic differences. And what can explain these high rates?" And we'll get funding for that, right? And meanwhile, African-Americans are a very marginalized group in the United States, are living in a society where over-policing, discrimination and financing, segregation and housing, etc., and yet our eye is turned on genetic differences between Black and White people that could explain high rates of hypertension? And then I started looking into this question some more. So where

	are people hypertensive? And what I saw-- I feel like I'm going on a tangent if that's all right. So what I saw is that--
YV 30:30	You're doing great.
EO 30:32	--"Wait, there are high rates of hypertension in Eastern Europe. Okay. In the study that was done and published in Atlanta in, I think, 2010, they looked at all these different countries and highest rates of hypertension in men in Eastern Europe. Okay. So where are the studies about Eastern Europeans versus Western Europeans? Who gets to ask these questions? And how do we frame them?" And I think our beliefs about race-- our beliefs about race is biological leads us to ask questions in a certain way.
YV 31:06	Did you measure age of the physicians that you were working with? And did it matter?
EO 31:12	That's a great question. It did not matter, but this is why I think it didn't matter, because I did another study where age was relevant, and there are other studies on this issue. I mentioned Bonham and Sellers, Cunningham, they've done studies evaluating beliefs about race is biological and engagement in race-based practice, and their study was on internal medicine physicians around 2010. But anyway, in these other studies, age has shown up. In what I did, age did not show up as being important. But then in reality, it's not age that creates the beliefs that you have, really, right? So age is associated with beliefs about race, and our ideas and understandings about race changes over time. But it's not age itself. So then when I control for those beliefs, then age, I think, becomes irrelevant.
YV 32:04	I guess I was wondering whether being trained in the last few years, where I think some but not all medical schools and residencies have been more thoughtful about how they talk about race and racism in medicine, might have shaped people's beliefs, but maybe it's too early to tell.
EO 32:28	No, I definitely think they have. So the scores we got on the RACE scale were much lower than scores in prior years, so I think that that's the case. I think that there's been a lot of education post-George Floyd, etc., and also our society is evolving in how we think about race. Our society is becoming more multiracial. One, I think the study was done-- Pew Research Center looked into this, and I think their 2016 data said that one in six newlyweds is interracial union. So as our sighting becomes more multiracial, we're going to start to ask, "Oh, Black and non-Black eGFR--" It's going to start to become confusing. And so I think part of that is our society is also changing. And the second part is, as I said before, the age is related to that change that I mentioned, the evolution of how we think about race. Age is going to be related to that, too, and age is also going to be related to where they fall in training. So it's really hard to separate those two. It's really hard to find much older physicians who just finished residency, right, and young people who've been practicing for 20 years. So yeah, it's one and the same.
UE 33:49	Awesome. Loving this back and forth. And again, I think we're feeling inspired, y'all, by you guys' work. So I'll transition to you, Carine. I had a chance to listen to your lovely Hamolsky talk today, where you specifically focused on how past trust building or trust eroding, which I think attributes to some of the conversations that Yannis and Ebi are having, really influences what and how patients choose to communicate with clinicians. So maybe you can share a little bit about your research, your actual findings, for those of us who weren't able to make it to your session; so many great sessions here, and tell us a little bit about how we can, in our own practice, start to address some of these trust-eroding experiences.

CD 34:31

Yeah, no, absolutely. Thanks for that. And so my research was done in partnership with an organization called the Massachusetts Coalition for Serious Illness Care. But as I mentioned before, they've done research in the past, and really, what they wanted to do with this phase of research that I partnered with them on was, first and foremost, take a more equity-centered approach to designing the right questions. And like I said, we always think about, "How do we improve communication moving forward?" and that starts by looking back. And so we conducted a mixed-methods research strategy that really, first, started with the community, working and talking with people from community-based organizations, like East Boston Neighborhood Health Center for us, and really working on refining and designing questions that we're trying to get at the concepts that we were getting at. So we were wanting to ask about people's health experiences in ways that actually felt authentic and resonated to what people shared have happened to them before. And so with that information, we kind of designed our study instruments. And so the next piece was a large national survey that reached over 1,850 individuals nationally, and this is all commerce, all adults, not just those with serious illness, and really asked about delving into these healthcare experiences. And then our final phase was actually a newer strategy, or kind of it's a strategy used more commonly in market research. And so we designed these online community forums and imagine an active discussion board, where people are getting prompts and responding, and the moderator has an opportunity to follow up and ask probing questions in a way that over a couple of ways at the forum, we were able to engage with 580 individuals, which is a really outstanding number for qualitative research, and getting at delving into some of these experiences.

CD 36:19

So as you highlighted, one of my favorite findings from the qualitative research, when we began asking about experiences, was, first of all, many experiences were universal, and we grouped them all together and kind of came up with this framework of people, as they engage in the healthcare system, are constantly engaging in this dynamic process of either trust-building or trust-eroding experiences. And every single touchpoint, from walking in, getting your vitals taken, checking your medication list, as well as, of course, minutes in with the clinician, was an opportunity to either have a trust-building or a trust-eroding experience. And that is one of the things-- or one of the things that we want people to kind of take away from it is that it's just as important-- the minutes that you have in with the clinician, you need to make sure that all the people that you work with care just as deeply and also feel a sense of ownership around creating a positive patient experience kind of all the way through. And so then what we found-- so that was kind of a helpful framework to be thinking about, "How do we evaluate these experiences?" And then through the quantitative data that we had asked about the frequency of these things happening in different populations, we broke down and started looking at that by race and ethnicity. And you will likely not be surprised to hear that our Black and Hispanic survey respondents were less likely to have had these positive trust-building experiences and more likely to have had the negative trust-eroding experiences. And we reflected on that data, and in some ways, we're like, "Duh, that's not surprising. That's kind of what we see," and yet suddenly, it was a lot more powerful to have nearly 2,000 people informing us that this really is the case nationally.

UE 38:08

Yeah, that's really powerful. And thank you for sharing that, Carine, and for everyone for sharing your amazing work. Again, our podcasts are usually focused on one specific topic, whether it's the trustworthiness episode we had back in episode 6 with Kimberly Manning and Giselle Corbie-Smith, but it's so cool to kind of have this thread

cut across everyone's work around how race, discrimination, racism, bias, whatever it is, trustworthiness or lack thereof kind of influence our patients' health and their lives. And really appreciate you all sharing with us.

CD 38:42 I mean, if I could just pop in for a second that it's so much about that because I think many of our questions asked about whether they trust clinicians to do what is right for them and things like that, and the answer to that question, whether you trust or don't trust, is not an individual patient factor that's modulating that. It's really about what has the clinician in front of you or what has the system or the clinic or the hospital done in the past to demonstrate that they are trustworthy because really, the onus is on us. It's our responsibility to consistently demonstrate trust-building, trustworthy behaviors to earn our patients' trust. And in the past, historically, our systems have not done that, and so it's not surprising that we see the findings that we see. And so the onus is really on us and to really think about systems-level change that can begin to change that in order for us to be better equipped to earn all of our patients' trust.

SK 39:45 The benefit of hosting a live episode at a medical conference like this is that we also get to have our guests take questions from the audience. So at this point, we're going to break from the questions that we have scripted and ask the audience members if they have any questions for any specific guest or all of our guests and come up and ask away.

UE 40:13 No pressure, y'all, but you will be on the greatest podcast in the country.

AM #1 40:20 This is a question for everybody. Does anybody know why or how the different standards for eGFR got developed by race? And the other question is a follow-on question is what do you do with the fact that maybe that's not a good idea? It could be a benefit or disadvantage being African-American and be considered to have a higher GFR than maybe you really do. So can anybody shed any light on this? Because I don't know why.

YV 40:53 Yeah, we--

CD 40:53 And--

YV 40:54 Oh, go ahead.

CD 40:54 No, I was just going to say it's definitely a movement around advocacy because I think it was actually medical students locally in several large cities who started kind of petitioning and advocating to their institutions, underscoring to them why this wasn't a clinically appropriate utilization of different approaches to calculate a GFR. And so several institutions, and hopefully, the list continues to grow, have changed that practice so that now, electronic medical records are only reporting a single one because unfortunately, many things are based on the GFR, including medication dosing that's completely unrelated to chronic kidney disease and things like that, and that, unfortunately, was often delaying eligibility to be listed for transplant or to undergo a kidney transplant workup and things like that. But to underscore, it can feel like a daunting problem. And large institutions are making moves so it's possible. And a lot of that originated with loud student voices, to be honest.

YV 41:57 Yeah, I guess two things I would quickly add. Some of my colleagues at the Brigham have done a ton of work on this, which I have not, but this differential calculation of eGFR is firmly rooted in racism. So essentially, there was this racist belief that got perpetuated in medical literature that Black men have more muscle mass, and therefore, their creatinine clearance is different. And the students and doctors that

track this through the medical literature were able to trace it back to eugenics papers, essentially, that are part of the racist body of literature that we still have built our foundation of medicine on and need to be always examining. And then the second thing I'll say is that these things are so ever-present. Yes, totally transplants but also recently with COVID and crisis standards of care and figuring out how to allocate limited amounts of medications, GFR was part of every single criterion for everything. And so we don't like to talk about rationing care, but sometimes when things are limited, we have to think about that. And how we calculate who is and isn't eligible plays a huge role even right now.

UE 43:12

Yeah, absolutely. And such great responses. And we also had an whole episode from episode 4 of our podcast on clinical-base calculators, specifically around eGFR, which is episode 4 of our podcast with Doctors Jenny Tsai and Nwamaka Eneanya, so definitely a great conversation there for folks who are still interested. All right. I see my brother in the back with a question.

AM #2 43:37

This is for Carine. I was really struck by what you had mentioned about how your findings really wanted you to sort of think upstream about what we could do to earn back the trust of our patients. And maybe this is also a question for the other two panelists, but I'm thinking a lot about, well, what can we do in medicine to organize within healthcare to maybe flip that and try to figure out how we can earn back that trust?

CD 44:03

Yeah, well, thanks so much for that question, Carlos. It is a very big problem, and like with all big problems, it can feel too daunting to calculate-- or to figure out. And that can sometimes make us feel paralyzed because you don't know where to start; the problem feels too big. And so in situations like that, I always like to say kind of start small. So that was the foundation of like, "Let's look back. Let's go back to the bedside." But I think in part, you kind of start small with your own clinic setting. Whether it's an outpatient clinic, whether it's your medical team in the hospital, kind of start small with making everybody on the healthcare team feel valued and important and make sure that they feel invested in creating a positive patient experience for each and every one of our patients. So I think you kind of start there. But in some regards, you need a bigger systems-level change to make systems kind of prioritize that aspect of the patient experience. And maybe it's that we need to borrow training from more customer-experience type settings that are outside of healthcare in order to make people, like I said, along every step of the chain, feel invested, or maybe it's that we need more patient-driven kind of outcomes are suddenly now new quality metrics. And I think part of that is under development of how do we really include and incorporate the patient's voice and perspective and make that matter to systems or make that matter and link that to clinicians? And sometimes people speak in dollars and cents. How do you make sure that creating that positive experience, that exhibiting those trustworthy behaviors to help promote positive experiences for patients get rewarded and get perpetuated all along the chain?

EO 46:02

And I have something I want to say about that. I think in addition to the great things that you mentioned and looking really further upstream, that there needs to be a much greater emphasis of trying to recruit providers from communities where this lack of faith and trust exists, and I think that that's going to be a very fundamental part of changing people's abilities to trust the healthcare system. I think that for people who hold underrepresented identities, being in that environment is a very othering experience, and I don't see how we can change how patients feel in terms of

their safety without also aggressively trying to recruit people. And I'm not just saying by race. There is a serious problem of physicians coming from a different class than the American population, too. And so I think that's very important.

CD 47:09

And just to further that, I think it's so important what you said, Ebi, in terms of changing who is caring for patients and making sure that we better reflect the diversity of the populations that we care for. And we know that it takes a very long time to work through the medical pipeline. And programs that are actually investing in the recruitment and fostering and supporting of URM clinicians will take decades to take effect, and we can't possibly wait that long. And so somehow we need to all take ownership of embracing respectful, empathic listening and cultural humility and caring for the diverse patients that we have now. And we all need to be a part of that solution now and not expect it to be fully on the shoulders of URM physicians and clinicians of the future.

EO 48:03

Yes, so I definitely agree, but what I'm also saying is that the presence of those physicians changes the space. So it's not necessarily that they are going to do that work of getting the trust from minority patients, but rather, that their presence there changes the nature of the space. And I wanted to also say that because there's a lot of energy about what the appropriate medical student looks like, what the appropriate metrics for evaluating a medical student should be, and this conversation about elevating, let's say, minority groups or people who are underrepresented minorities without the understanding that the purpose of all of this is to create a healthcare system that serves the American people. And so we have to start with that and work backwards. And so that's why I'm saying so it's not just getting people interested in biology. Actually, it's right now who stays and who doesn't continue on this path, when they get to residency, who is getting the mediation, who's getting a lot more of those negative eyes on them instead of the support to succeed because we cannot say, "Oh, we need doctors of color," and at the same time, make the path so challenging for those who are already on that path. And so that's why I say that.

SK 49:38

As a quick plug again to one of our previous episodes, we talk about reimagining a learning environment in medical education in episode 9 of our podcast. With that, I think both of you spoke very elegantly about the issue. I think in terms of audience questions, we can take one more question and then get ready to wrap up.

AM#3 50:04

Thank you. My name is Anna. I'm from the University of Cincinnati. First, I will quickly say the GFR, you can actually look up the equation for the CKD-EPI 2021 if you search that. I think it's on the National Kidney Foundation. And so that was the workaround we were using for a while is by little active rebellion or activism was just to do that and calculate it on my own. But for some hope, Mark Twain once said that at the end of the world, he wanted to be in Cincinnati because it would come 20 years later, and I can say that multiple institutions in Cincinnati have now moved to the new equation and have gotten rid of race-based GFR, so there is hope due to the amazing activism that you talked about. My question is directed to you. I'm a geriatrician, and I think to some of the false beliefs and stereotypes that we keep hearing, I think one that's still having a huge impact is that Black families don't accept hospice as much. And it drives me crazy and just thinking about, "Okay. What are all the layers of that? That's such a simplistic statement." And with good communication and time and patience and everything else, I've not seen that to be the truth. So how are you approaching that with both your learners, with your staff? Because I think it's one of those self-fulfilling prophecies: if we go into the room, and we think a family is not going to accept

hospice, of course, we're not going to communicate the same way. So what are some ways to build trust around that as well?

CD 51:29

No, it's such a good question, and I think it's so important to reflect that, again, stepping back, we use race and ethnicity, but what does it mean? It's really just kind of identifying people based on this social construct that really only measures and reflects kind of how our society treats individuals. But reality, Blacks are not a monolith. Latinx people are not a monolith. They do not carry some core exact same set of values. And so I think where you have to start is always with curiosity and without any assumptions or shortcuts, which is really challenging because in medicine, what we've been taught is to come up with a clinical picture and what's the shortcut for what illness that means. That's how we learned to practice medicine. And we have to unlearn that in terms of looking at the patient in front of you and just asking curiously for them and/or their family what are their beliefs or what are they open to and force yourself to think that, "When I look at the clinical picture in front of me, is this a patient who might be appropriate for hospice? Is this a patient who might be appropriate for palliative care?" and in some ways, kind of use your same script of introduction because I think you constantly surprise yourself. You might have a preconception or misconception that maybe this Black patient or this Black family is going to be really resistant to the idea of kind of transitioning to more comfort-focused care and making the assumption that they always want more aggressive life-sustaining treatments, and yet when you actually engage in the serious illness conversation and share prognostic information that you have, people can only respond to the information that's presented to them. And so I think asking curiously about what are the things that are important to them, sharing the same medical prognostic information based on everything that you have about the clinical picture, and helping them integrate that into actually making the best decisions for themselves.

CD 53:26

And so one of the things that I get frustrated about sometimes is that when there's, let's say, for example, a critically ill patient who I get called for because, "We've had multiple goals of care conversations, and they just don't get it. And we need your help, and we need to get the DNR. We need to get the transition to comfort care." And they expect me to come in with magic and kind of get the right answer. And we really have to fight back and step back. There is no right answer from our perspective because our perspective kind of doesn't matter. And we should never walk into these meetings with an agenda of what we think the outcome should be. We should walk in with kind of humility and curiosity to explore and support the patient and family's perspective of what feels most right and kind of uplift that and hold that. And they may make different choices than we might make, but it's not our place to judge them for those decisions. Similarly, I feel like sometimes as clinicians, I walk into kind of a premeeting or a family meeting, and they're like, "Well, we need to engage in shared decision-making and present these two options." And in reality, the team is very clear on what the right answer is and what the wrong answer is, and then they get really distressed if the patient or family chooses what they perceive as the wrong answer. And I kind of try to pry people to think, "If you truly believe that there is a right and a wrong answer clinically, then why are we offering that decision? If there's really only one kind of clinically correct answer, then why even offer the cardiac catheterization if it's not actually right?" or whatever other interventional procedure. It's not right. It's creating a false sense of shared decision-making that isn't appropriate.

SK 55:17	This has been such a powerful conversation with so many amazing takeaways on three issues that are very different but are all rooted in structural and systemic racism. I remember listening to the live episode from last year and thinking [music], "There's something so special about this setting because we get to talk about topics that are obviously so important to all of us in front of other people who also consider these topics very important." So and with the audience questions coming in, I think that really was the icing on the cake. I wanted to take a second to thank our guests so, so much for joining us and sharing their wisdom with us and all of our listeners. I really hope all of you are able to keep doing the work that you're doing and continue on.
UE 56:11	Thank you, all. Really appreciate y'all. [applause]
YV 56:14	Thank you so much.
S4 56:15	Thank you for having us.
EO 56:16	Thank you.