

# Challenging Structural Racism in Medicine: Intro to Key Concepts of Critical Race Theory

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# Disclosures

No conflicts of interest or relationships to disclose

# Acknowledgment

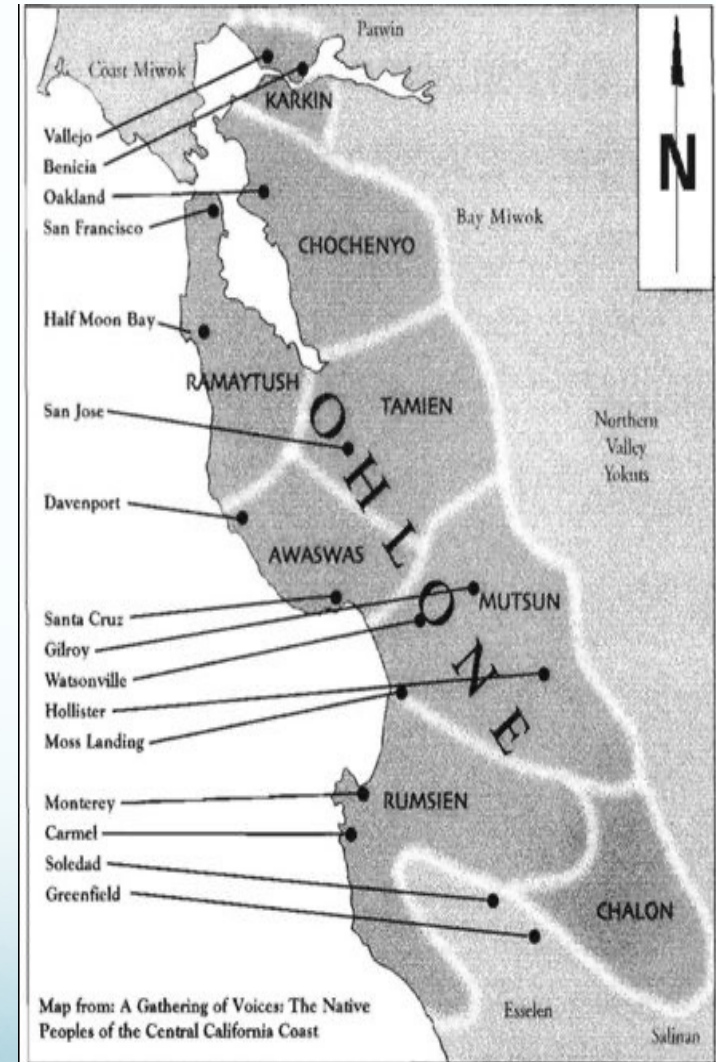
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# Land Acknowledgement

- Oakland, CA
  - Chochenyo Ohlone Land



Art/photo credit: Cece Carpio & Indal Rubin



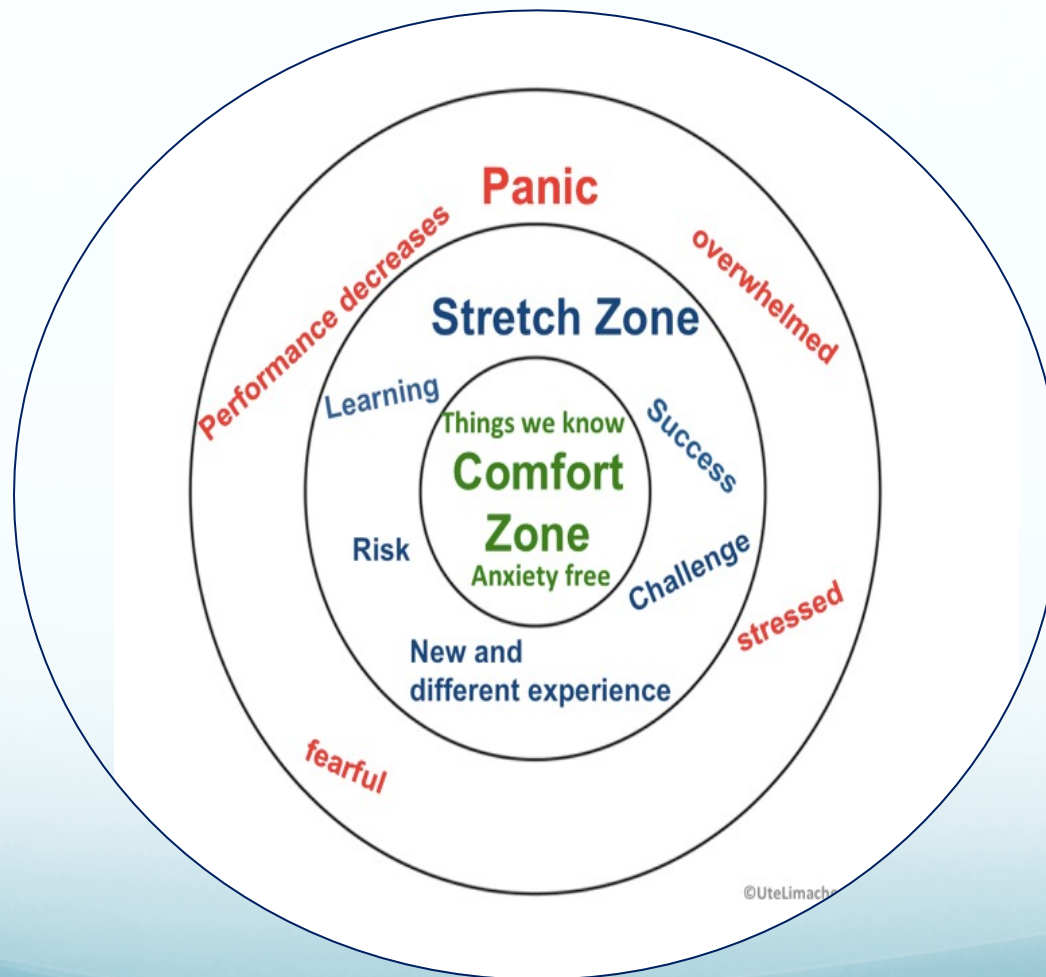
# Learning Objectives

- Describe historical examples of structural racism in history, science, and medicine and how they have impacted health.
- Describe the historical context of racism within HIV care and service provision.
- Discuss key concepts of cultural humility, anti-racism and Critical Race Theory frameworks as guiding concepts in our work towards antiracist clinical care.
- Review strategies for health providers to advocate for and utilize these frameworks and navigate barriers to implementation

# Reflection Questions

- What were you taught about race and racism during your training?
- How do you think about a patient's race in your clinical practice?  
How do you think it will impact your clinical decision making?
- Do you think in the HIV health and medical landscape that we do a good enough job of discussing race and the impact of racism?

# Fixed mindset → Growth mindset



# Public Health Critical Race Framework: Key Concepts from CRT

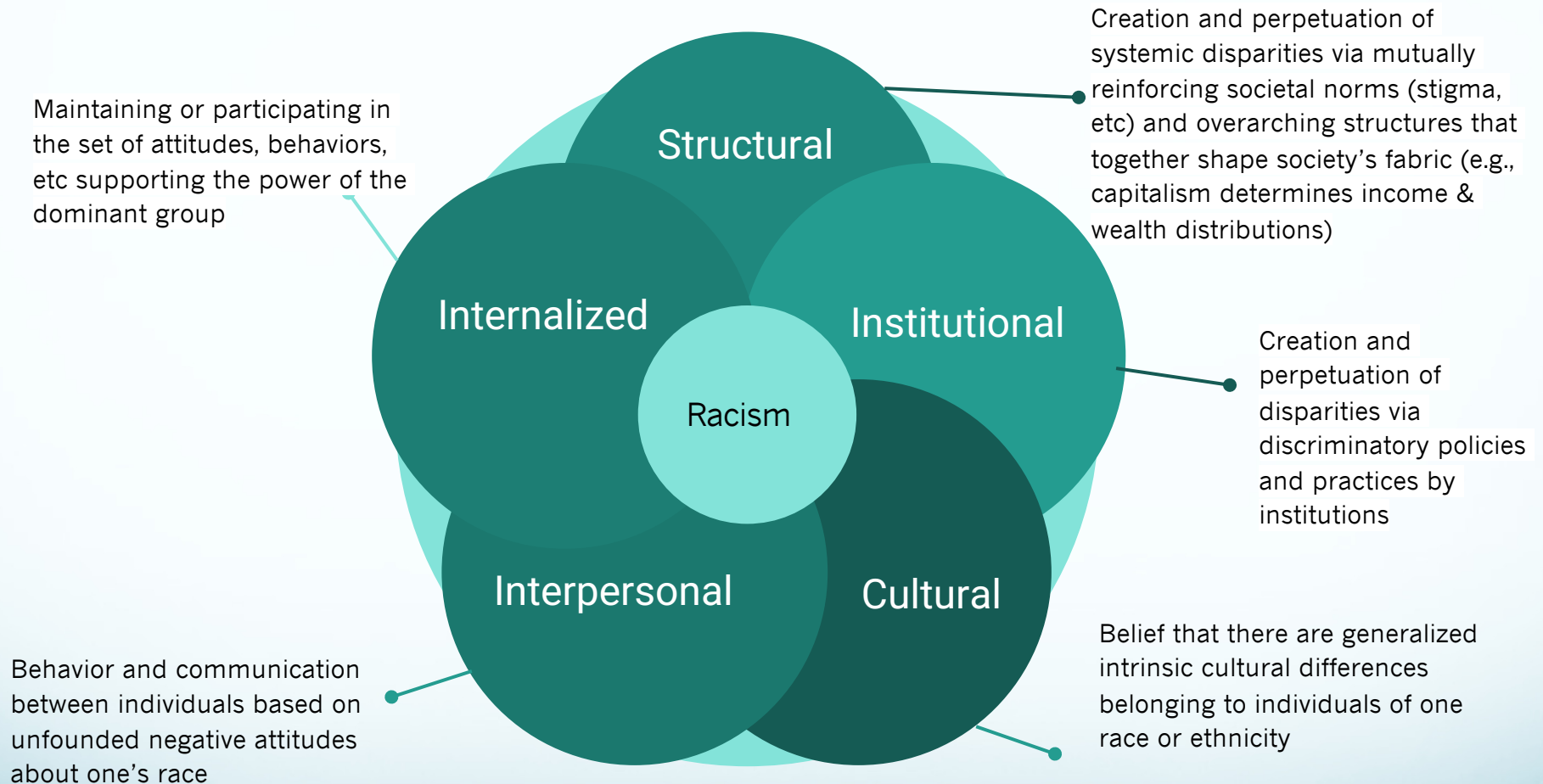
- **Ordinariness:** The nature of racism in post-civil rights society: that is, integral and normal rather than aberrational
- **Social construction of race:** The endowment of a group or concept with a delineation, name, or reality based on historical, contextual, political, or other social considerations
- **Centering in the margins:** Making the perspectives of socially marginalized groups, rather than those of people belonging to dominant race or culture, the central axis around which discourse on a topic revolves
- **Challenging Ahistoricism:** Contextualizes the role that racism has in shaping institutions and policies.
- **Race consciousness:** Explicit acknowledgment of the workings of race and racism in social contexts or in one's personal life (contrary to color-blindness)
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- **Praxis:** Iterative process by which the knowledge gained from theory, research, personal experiences, and practice inform one another



# Key Definitions: Racism

- A **system** of structuring opportunity and assigning value based on the social interpretation of how one looks ("race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.

# Types of Racism



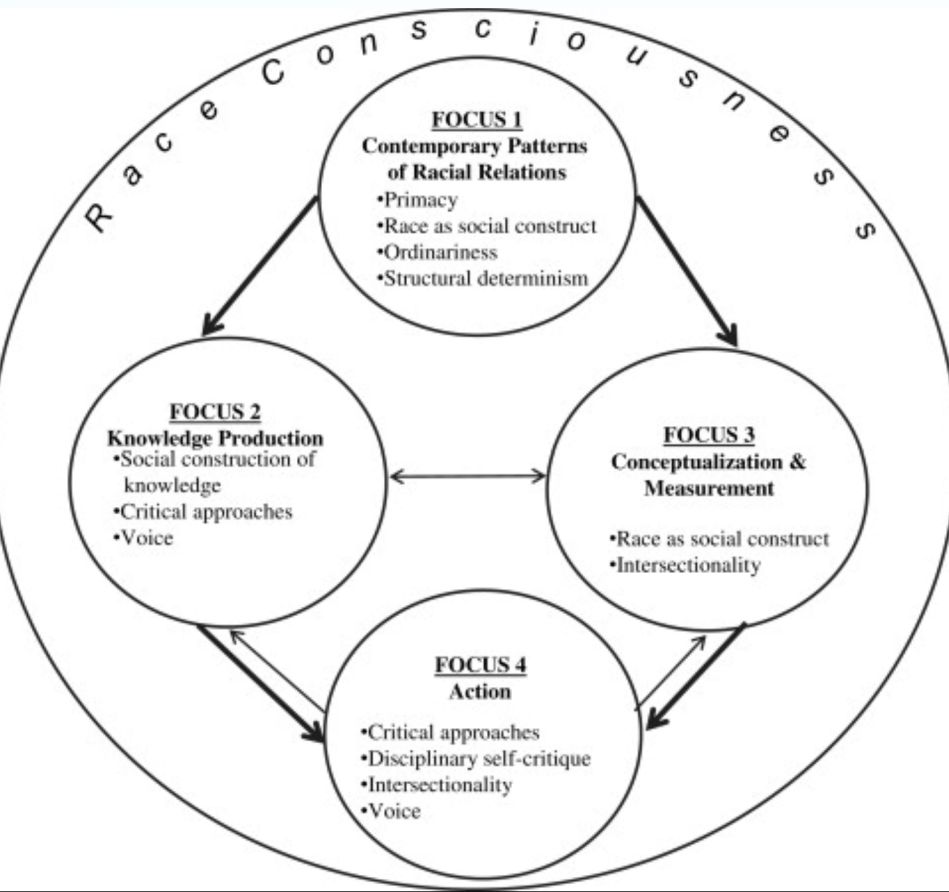
<sup>1</sup> Jones CP. Confronting institutionalized racism. Phylon 2002

Definitions adapted from many scholars including Bailey Z et al (2017)

# Race & Structural Racism

- **Structural Racism Definition:** 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.
- White Supremacy
- Understanding **Racism**, NOT Race, as a risk factor when examining health disparities

# Critical Race Theory (CRT) and CRT Public Health Praxis



- CRT: A transdisciplinary, race-equity methodology that originated in legal studies and is grounded in social justice.
- CRT offers the field of public health a new paradigm for investigating the root causes of health disparities.

(Ford CL, Airhihenbuwa CO. The public health critical race methodology: Praxis for antiracism research, *Social Science & Medicine*, Volume 71, Issue 8, 2010)

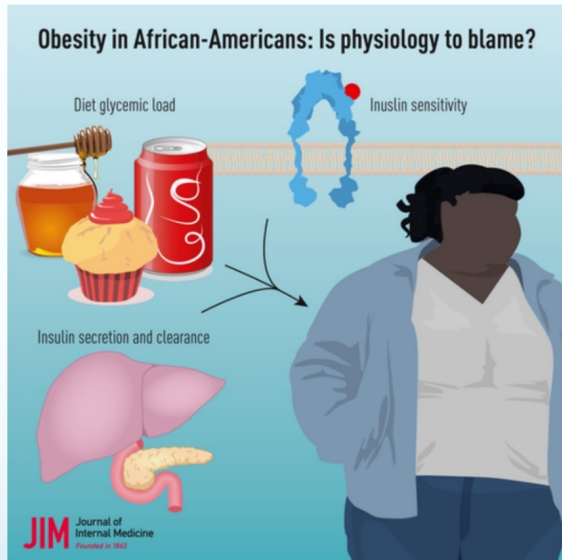


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# Structural Racism in Medicine

Pathologizing Race



Journal of Internal Medicine, May 2020

False Beliefs re: Racial Differences

## Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

Kelly M. Hoffman<sup>a,1</sup>, Sophie Trawalter<sup>a</sup>, Jordan R. Axt<sup>a</sup>, and M. Norman Oliver<sup>b,c</sup>

<sup>a</sup>Department of Psychology, University of Virginia, Charlottesville, VA 22904; <sup>b</sup>Department of Family Medicine, University of Virginia, Charlottesville, VA 22908; and <sup>c</sup>Department of Public Health Sciences, University of Virginia, Charlottesville, VA 22908

Edited by Susan T. Fiske, Princeton University, Princeton, NJ, and approved March 1, 2016 (received for review August 18, 2015)

Black Americans are systematically undertreated for pain relative to white Americans. We examine whether this racial bias is related to false beliefs about biological differences between blacks and whites (e.g., "black people's skin is thicker than white people's skin"). Study 1 documented these beliefs among white laypersons and revealed that participants who more strongly endorsed false beliefs about biological differences reported lower pain ratings for a black (vs. white) target. Study 2 extended these findings to the medical context and found that half of a sample of white medical students and residents endorsed these beliefs. Moreover, participants who endorsed these beliefs rated the black (vs. white) patient's pain as lower and made less accurate treatment recommendations. Participants who did not endorse these beliefs rated the black (vs. white) patient's pain as higher, but showed no bias in treatment recommendations. These findings suggest that individuals with at least some medical training hold and may use false beliefs about biological differences between blacks and whites to inform medical judgments, which may contribute to racial disparities in pain assessment and treatment.

These disparities in pain treatment could reflect an overprescription of medications for white patients, underprescription of medications for black patients, or, more likely, both. Indeed, there is evidence that overprescription is an issue, but there is also clear evidence that the underprescription of pain medications for black patients is a real, documented phenomenon (1, 4). For example, a study examining pain management among patients with metastatic or recurrent cancer found that only 35% of racial minority patients received the appropriate prescriptions—as established by the World Health Organization guidelines—compared with 50% of nonminority patients (4).

Broadly speaking, there are two potential ways by which racial disparities in pain management could arise. The first possibility is that physicians recognize black patients' pain, but do not to treat it, perhaps due to concerns about noncompliance or access to health care (7, 8). The second possibility is that physicians do not recognize black patients' pain in the first place, and thus cannot treat it. In fact, recent work suggests that racial bias in pain treatment may stem, in part, from racial bias in perceptions of others' pain. This research has shown that people assume a priori that blacks feel less pain than do whites (11–17). In a study by

racial bias | pain perception | health care disparities | pain treatment

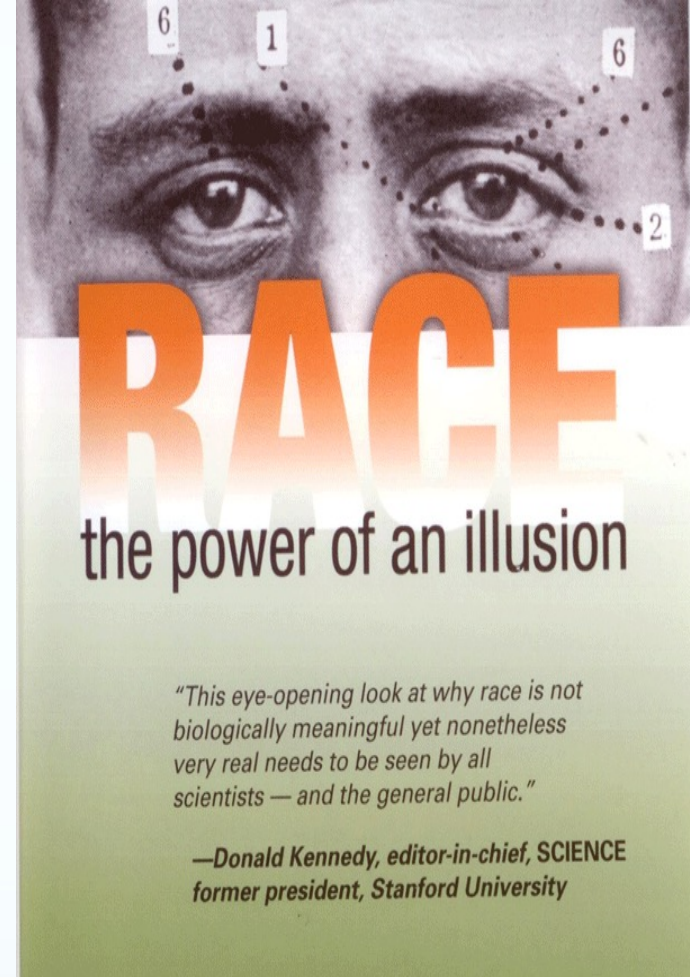


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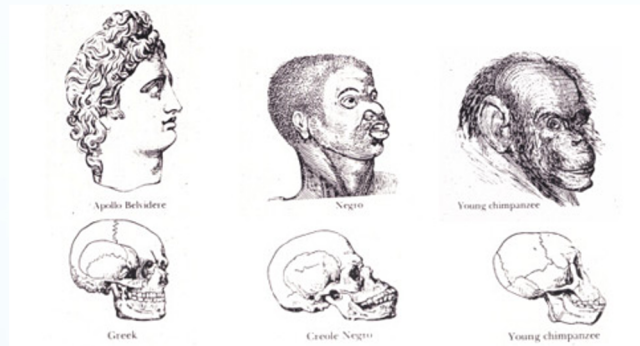
# Race is a social construct with no biological basis

- Race is not equivalent to genetics nor ancestry
- Racism has been codified in medicine, used to justify beliefs of racial inferiority/superiority

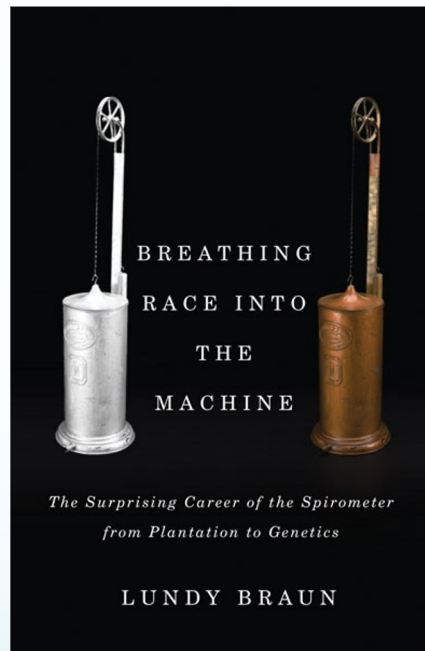




# Racism Has Been Historically Codified in Science and Medicine



People	Cranial capacity (in <sup>3</sup> )
Modern Caucasians	87
Native Americans	86
Mongolians	85
Malays	85
Ancient Caucasians	84
Africans	83



*The conceptualization of race as biology is rooted in colonization*

# Race-Based Medicine: Examples

	How race is used	Rationale for race-based management	Potential harm	Race-conscious approach
eGFR <sup>6</sup>	eGFR for Black patients is multiplied by 1.16–1.21 the eGFR for White patients, depending on the equation used	Black patients are presumed to have higher muscle mass and creatinine generation rate than patients of other races	Black patients might experience delayed dialysis and transplant referral <sup>8,9</sup>	Use eGFR equations that do not adjust for race (eg, CKD-EPI Cystatin C) <sup>10</sup>
BMI risk for diabetes <sup>7</sup>	Asian patients considered at risk for diabetes at BMI $\geq 23$ vs 25 for patients of other races	Asian patients are presumed to develop more visceral than peripheral adiposity than patients of other races at similar BMI levels, increasing risk for insulin resistance <sup>7</sup>	Asian patients screened for diabetes despite absence of other risk factors might experience increased stigma and distrust of medical providers <sup>11</sup>	Screen patients with lower BMIs on the basis of indications of increased body fat (eg, body roundness, <sup>12</sup> body fat percentage), not based on race
FRAX <sup>13</sup>	Probability of fracture is adjusted according to geography or minority status, or both	Different geographical and ethnic minority populations are presumed to have varied relative risks for fracture on the basis of epidemiological data	Some populations, including Black women, might be less likely to be screened for osteoporosis than other populations <sup>14</sup>	Screen patients for osteoporosis on the basis of clinical risk criteria, rather than race; counteract existing biases that place Black patients at risk because of racial essentialist beliefs about variation in bone density <sup>15</sup>
PFT <sup>16</sup>	Reference values for pulmonary function are adjusted for race and ethnicity	Racial and ethnic minority groups are presumed to have varied lung function on the basis of epidemiological data	Black patients might experience increased difficulty obtaining disability support for pulmonary disease <sup>17</sup>	Use unadjusted measures of lung function for all patients; counteract existing biases that harm Black patients because of racial essentialist beliefs about variation in lung capacity <sup>18</sup>
JNC 8 Hypertension Guidelines <sup>19</sup>	Treatment algorithm provides alternate pathways for Black and non-Black patients	ACE-inhibitor use associated with higher risk of stroke and poorer control of blood pressure in Black patients than in patients of other races	Black patients might be less likely to achieve hypertension control and require multiple antihypertensive agents <sup>20</sup>	Consider all antihypertensive options for blood pressure control in Black patients; adjust as needed to achieve goals and manage adverse effects

## MEDICINE AND SOCIETY

Debra Malina, Ph.D., Editor

### Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms

Darshali A. Vyas, M.D., Leo G. Eisenstein, M.D., and David S. Jones, M.D., Ph.D.

Physicians still lack consensus on the meaning of race. When the *Journal* took up the topic in 2003 with a debate about the role of race in medicine, one side argued that racial and ethnic categories reflected underlying population genetics and could be clinically useful.<sup>1</sup> Others held that any small benefit was outweighed by potential harms that arose from the long, rotten history of 1 two sides, t concluded t “fraught wi abuses and race-based r unwise to at when we h architecture

diagnostic algorithms and practice guidelines that adjust or “correct” their outputs on the basis of a patient’s race or ethnicity. Physicians use these algorithms to individualize risk assessment and guide clinical decisions. By embedding race into the basic data and decisions of health care, these algorithms propagate race-based medicine. Many of these race-adjusted algorithms guide decisions



### Toward the Abolition of Biological Race in Medicine

Transforming Clinical Education, Research, and Practice

Noor Chadha, Bernadette Lim, Madeline Kane, and Brenly Rowland



# Advocacy to Abolish Race-Based Medicine

INSTITUTE FOR HEALING AND JUSTICE  
FALL TEACH-OUT SERIES

*centering student activism & interdisciplinary collaboration*

## REMOVING RACE FROM eGFR

RSVP AT  
[INSTITUTEFORHEALINGANDJUSTICE.ORG/EGFR](https://INSTITUTEFORHEALINGANDJUSTICE.ORG/EGFR)

TUESDAY, AUGUST 18  
4:30-6:30 PM PST | 7:30-9:30 PM EST

learn about institution-specific activism from trainees and faculty at  
uc san francisco, university of washington, brown, vanderbilt, & ama

resource-share and organize for local action in facilitated small groups

zoom link sent upon rsvp

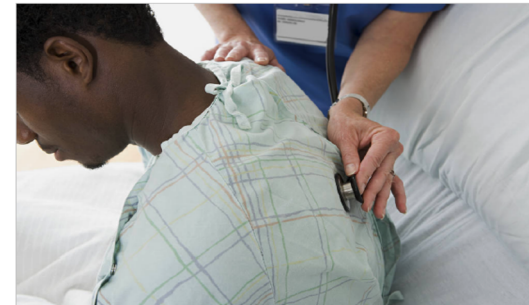


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IN MEDICINE

THE HUB



Doctors should educate themselves toward ending manifestations of race-based medicine. (Courtesy photo)

### Abolish race-based medicine in kidney disease and beyond

COMMUNITY CONTRIBUTOR / Nov. 27, 2019 1:30 a.m. / OPINION

Racism in health care made headlines last month when it was revealed that a prominent algorithm, used widely in hospitals across the U.S. to manage and allocate health care, has been systematically relegating black patients to decreased access and poorer quality of care. While some scientists are shocked that an algorithm that set out to be “color blind” has led to racial inequity, blatant examples of race-based medicine leading to unequal treatment are commonplace.

### Working Groups:

- eGFR
- Spirometry
- ASCVD
- Sexual & Reproductive Health



**Table 1. Misrepresentation of Race in Preclinical Curricula.**

Domain	Description	Representative Examples
Semantics	Using imprecise and nonbiologic labels that inaccurately conflate race and ancestry	Widespread use of “Caucasian,” “Black,” “African American,” and “Asian” as labels to denote biologic differences between patients Describing a Nigerian patient as “African American” in a clinical vignette
Prevalence without context	Presenting racial/ethnic differences in disease burden without contextualization	Teaching students that “Black” patients have higher rates of asthma than “White” patients, without reference to the effects on asthma prevalence of residential segregation and unequal access to high-quality housing and health care <sup>16</sup> Teaching students that “Black” patients have higher rates of hospital readmission, without any discussion of the underlying causes of these disparities
Race-based diagnostic bias	Presentation of links between racial groups and particular diseases	Priming students to view sickle cell disease as affecting only Black people, rather than as common in populations at risk for malaria <sup>17,18</sup>
Pathologizing race	The tendency to link minorities with increased disease burden	In a slide showing the incidence of 13 types of brain tumors in Black patients and White patients, using the title “Incidence rates are higher among Blacks than among Whites,” even though 10 of the tumors occurred more frequently in White patients
Race-based clinical guidelines	Teaching of guidelines that endorse the use of racial categories in the diagnosis and treatment of diseases	Teaching students to use different first-line antihypertensive drugs in Black patients than in White patients, without any exposure to literature that questions these practices and misleading interpretations of information <sup>19-21</sup>



# Stigmatization, Racialization and Criminalization in Medicine

**Assaultive and belligerent?**



**Cooperation often begins with HALDOL<sup>®</sup> (haloperidol) a first choice for starting therapy**

**Acts promptly to control aggressive, assaultive behavior**

Several studies have reported the rapid effectiveness of HALDOL (haloperidol) in controlling disruptive and dangerously unstable behavior. "Even the number of violent assaults committed by a group of criminal patients 'resistant to emotional lysis of phenothiazines' was reduced substantially during treatment with HALDOL. Symptoms control can be achieved rapidly, frequently within a few hours when the intramuscular form is used for initial control of severely agitated psychotic states."

**Usually leaves patients relatively alert and responsive**

Although some instances of drowsiness have been observed, marked sedation with HALDOL (haloperidol) is rare. In a report on a study with criminal psychotics, the investigators state, "The patients remained alert and more amenable to psychotherapeutic intervention." Another investigator reports that HALDOL "normalizes behavior and produces a sensitivity to the practitioners that allows more effective use of the social milieu and the therapeutic community."

**Reduces risk of serious adverse reactions**

HALDOL (haloperidol), a butyrophenone, avoids or minimizes many of the problems associated with the phenothiazines. Hypotension is rare and acute orthostatic hypotension has not been reported. There is also less likelihood of adverse reactions such as liver damage, ocular changes, serious hematologic reactions and skin rashes. The most frequent side effects of HALDOL (haloperidol) — extrapyramidal symptoms — are usually dose-related and readily controlled.

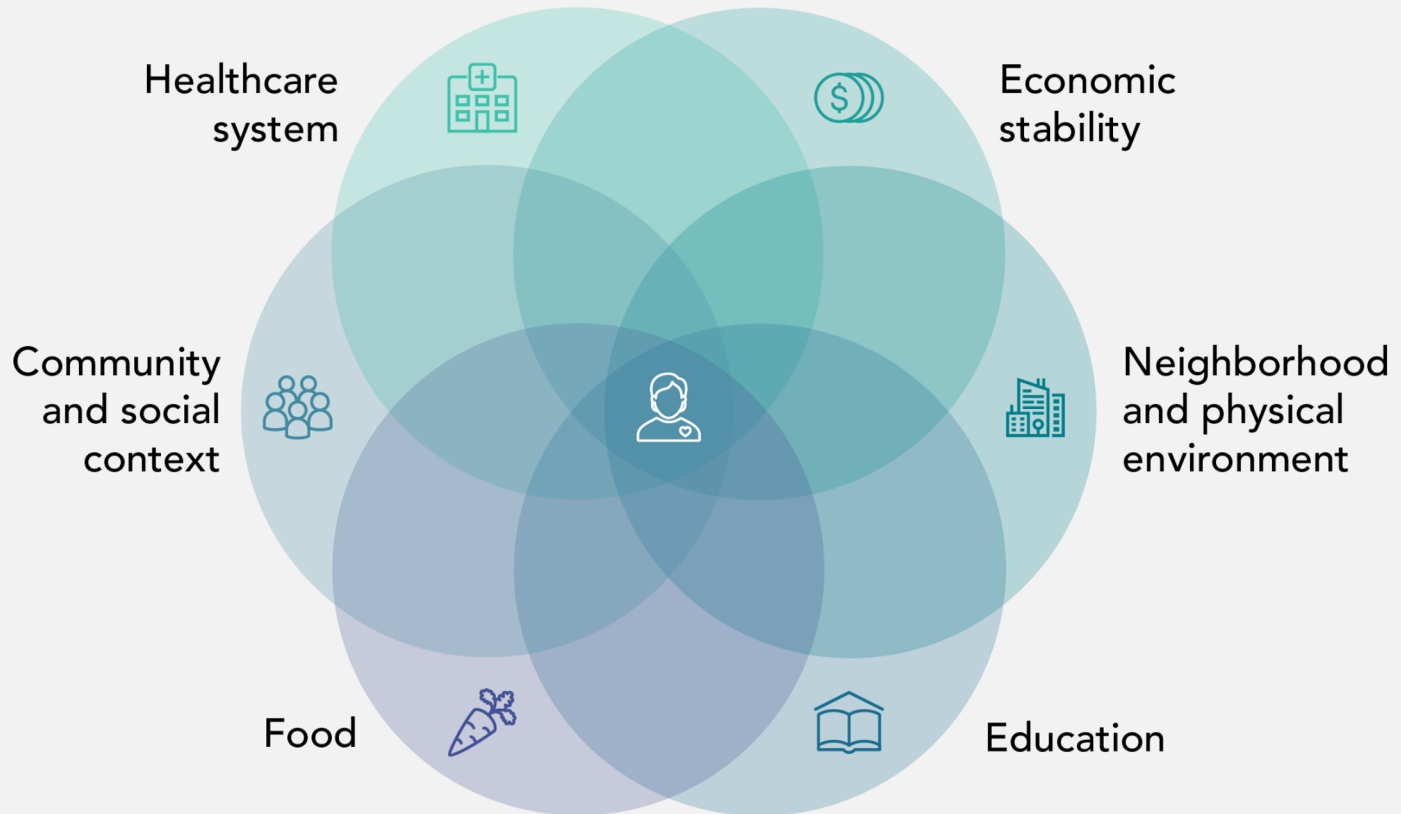
Wolfe, S., Darling, W.F., De Niro, Ann. 10:10 (Jan 1971), 3; Wex, F.L., and Chen, C.H., Psychopharmacol. 19:166 (1971); Chouinard, J.A., and Lalonde, S., Paper presented at the 10th Annual Symposium, General Hospital, N.Y., Nov. 15-20, 1971; Wexler, S.W., Clin. Neuro. 10:110 (1971); A. Bennett, L.S.G., Clin. Neuro. 11:110 (1972).

For information relating to Indications, Contraindications, Warnings, Precautions and Adverse Reactions, please turn next page.

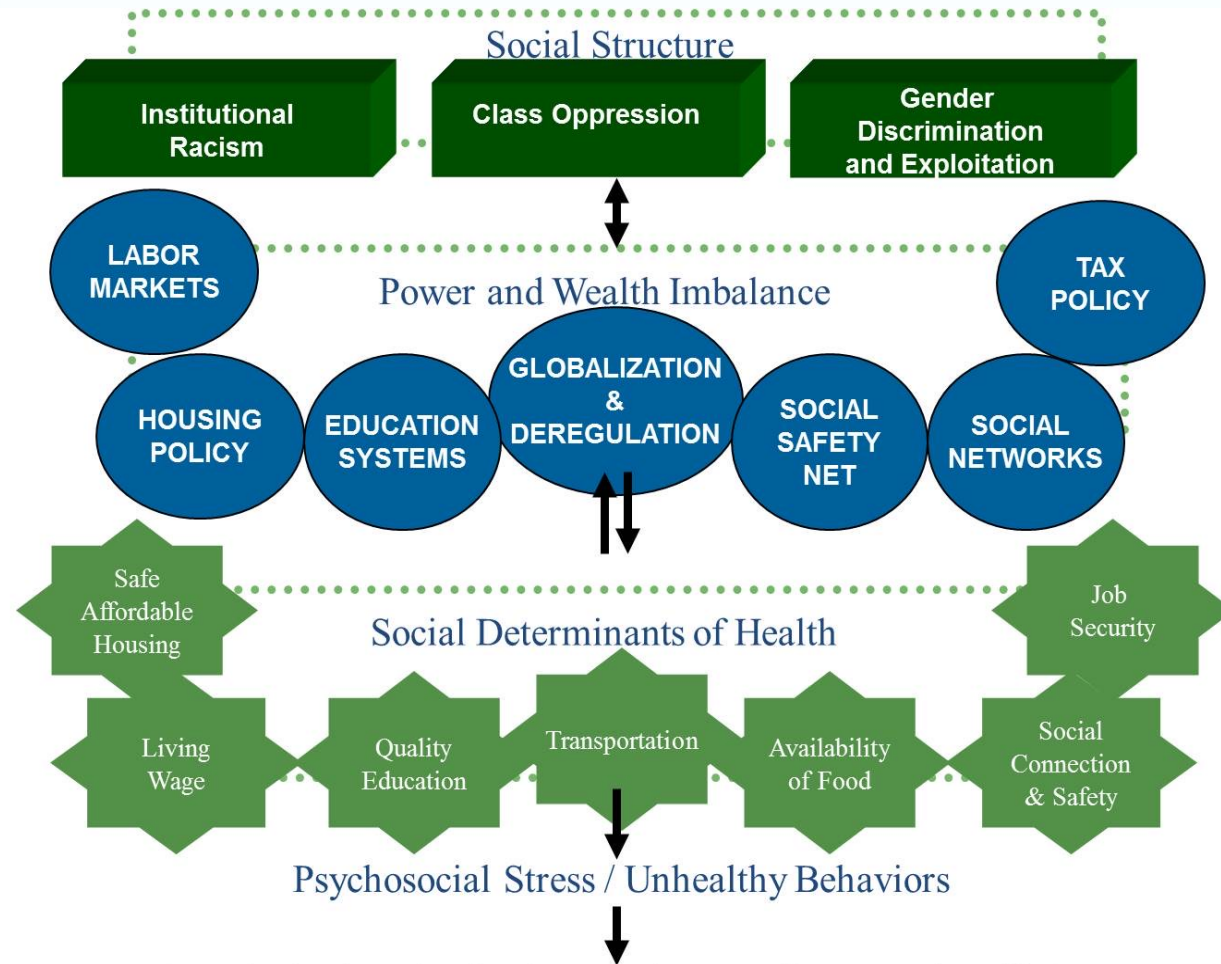
© 1974 Ciba-Geigy, Inc.

1974 Haldol advertisement, *Archives of General Psychiatry*

# SOCIAL DETERMINANTS OF HEALTH



# Understanding Health Inequities & Structural Oppression



Disparity in the Distribution of Disease, Illness, and Wellbeing

Adapted from R. Hofrichter, *Tackling Health Inequities Through Public Health Practice*.

# COVID-19 Outbreaks: Congregate settings

Coronavirus cases at San Quentin soar to 190;  
'they're calling man down every 20 or 30 minutes'

Jason Fagone and Megan Cassidy

June 20, 2020 | Updated: June 20, 2020 5:13 p.m.



[Coronavirus](#) [Local](#) [Food](#) [Election](#) [Sporting Green](#) [Biz+Tech](#) [Culture Desk](#) [Datebook](#) [US & World](#)



Ninety-one prisoners have now tested positive for the virus at San Quentin State Prison — a figure that has increased more than fivefold in the past 11 days.

Photo: Paul Chinn / The Chronicle

## Navajo Nation Has Most Coronavirus Infections Per Capita In U.S., Beating New York, New Jersey



Alexandra Sternlicht Forbes Staff

Business

I cover breaking news

Updated May 19, 2020, 04:04pm EDT

**TOPLINE** Navajo Nation, which extends through Arizona, New Mexico and Utah and is home to over 173,000 Native Americans who operate under their own tribal governance, has surpassed New York and New Jersey with most infections per capita.





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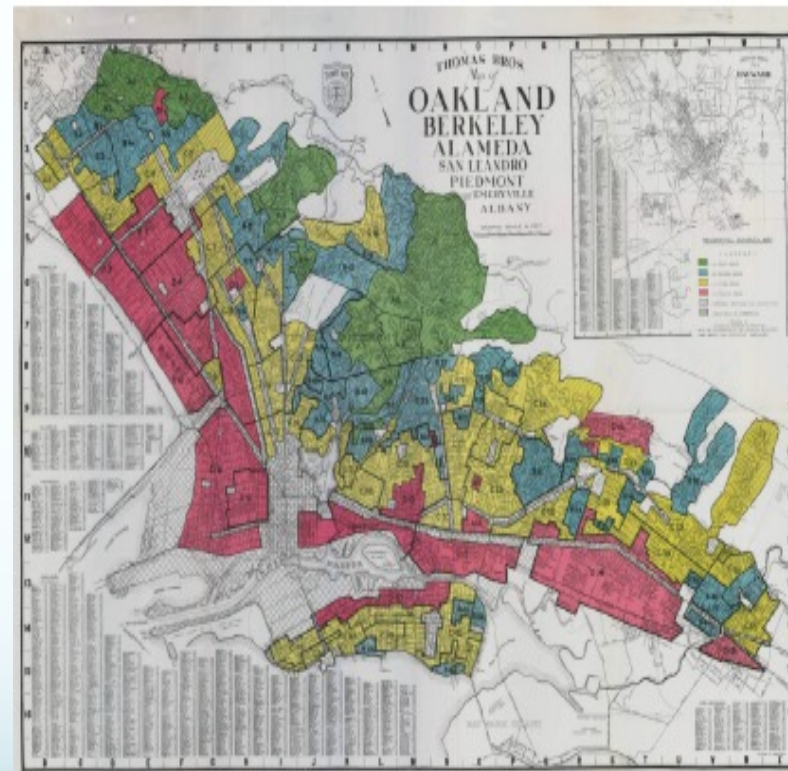
# Challenging Ahistoricism & Contemporary Racial Mechanisms: Historical Relics of Redlining

THE CALIFORNIA REPORT

## Asthma Rates Higher in California's Historically Redlined Communities, New Study Finds

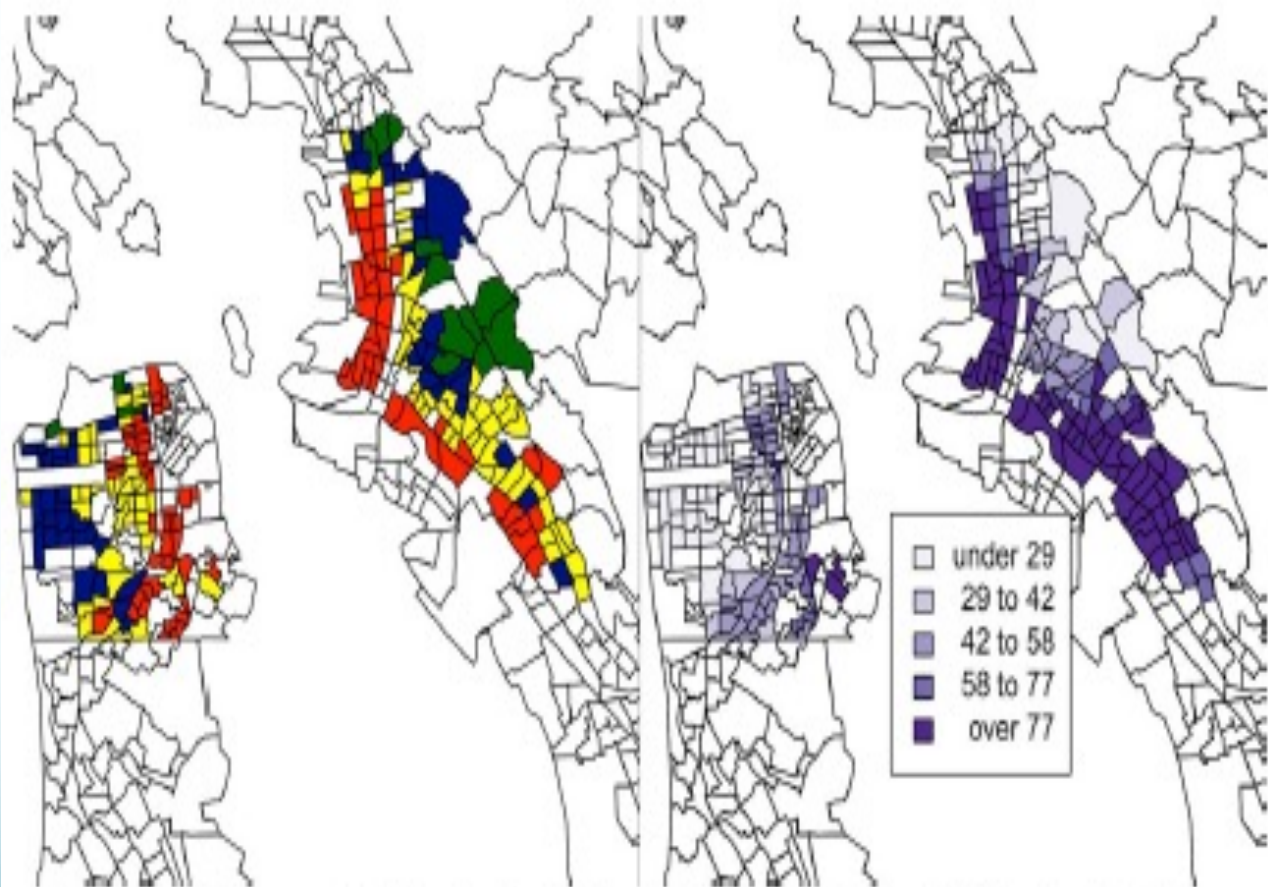


By [Laura Kilvans](#), [Matthew Green](#) May 23, 2019



Home Owners' Loan Corp. (HOLC) ratings of Oakland, Berkeley and Alameda neighborhoods, with green indicating "best," blue indicating "still desirable," yellow indicating "definitely declining" and red indicating "hazardous." (Courtesy of the [University of](#)

# Challenging Ahistoricism & Contemporary Racial Mechanisms: Historical Relics of Redlining

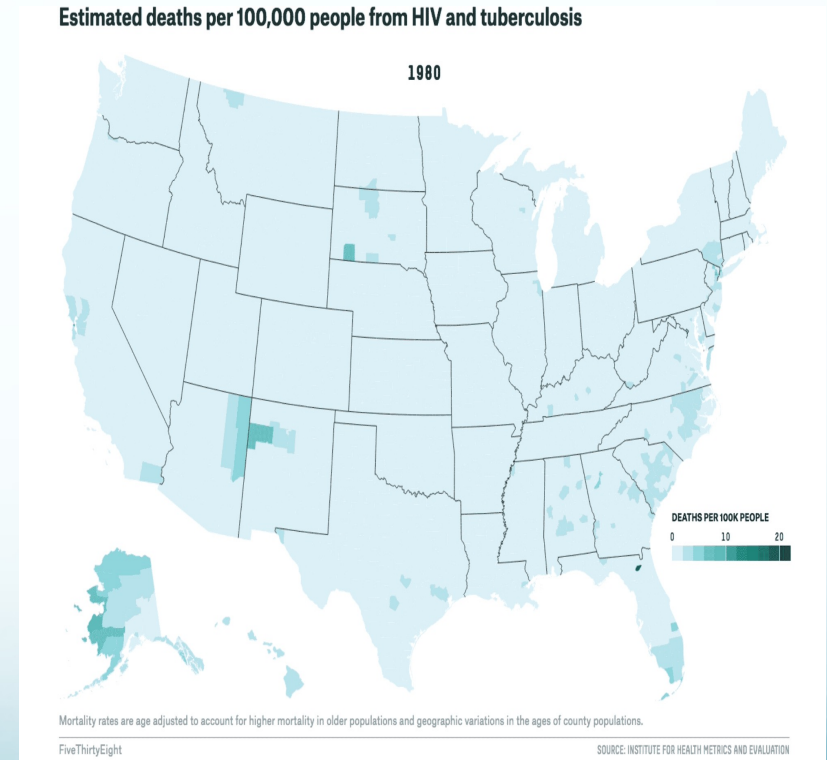
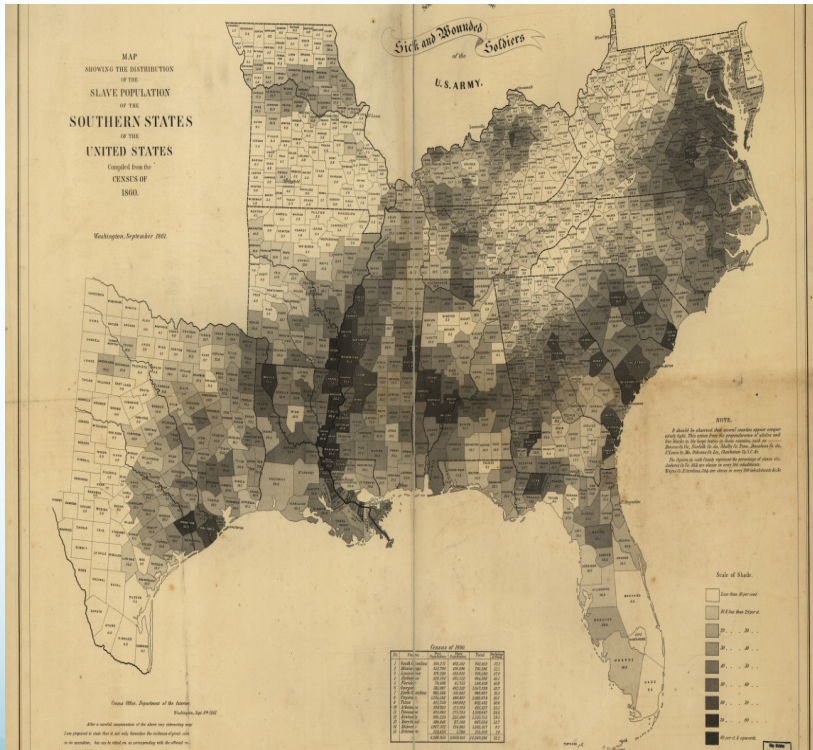


The map on the left shows census tracts in the cities of San Francisco and Oakland categorized according to their Home Owners' Loan Corp. rating, with green indicating 'best,' blue indicating 'still desirable,' yellow indicating 'definitely declining,' and red indicating 'hazardous.' The map on the right shows the rate of asthma-related emergency room visits per 10,000 residents for those same census tracts. (Anthony Nardone/UC Berkeley)

# Health Inequity Roots: HIV landscape

1860 Census % Enslaved

Modern-day HIV & TB deaths



Source: [fivethirtyeight.com/features/mortality-black-belt](https://fivethirtyeight.com/features/mortality-black-belt)



# Addressing Health Inequities with Social Justice, CRT lens

THE CONVERSATION

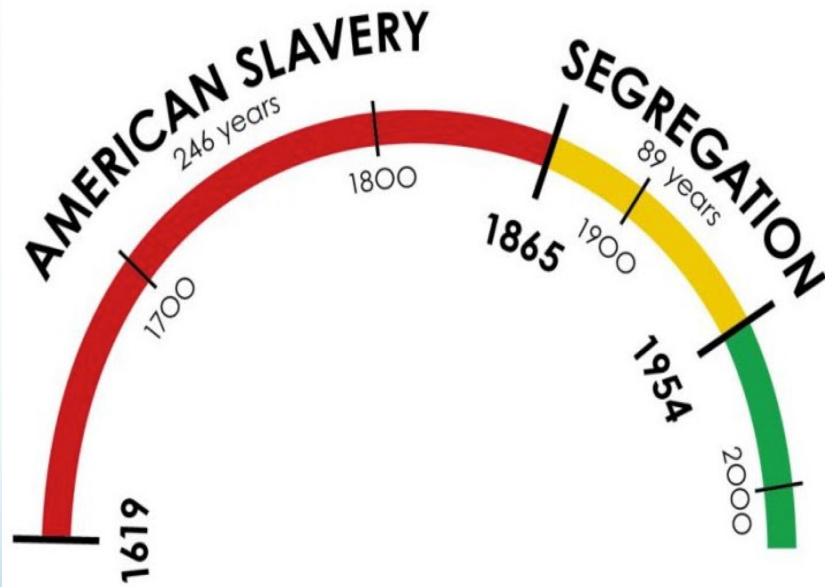
Academic rigor, journalistic flair

## Doctors can't treat COVID-19 effectively without recognizing the social justice aspects of health

June 3, 2020 8.14am EDT



Emergency medical technicians bring a patient into Wyckoff Hospital in the Borough of Brooklyn on April 6, 2020 in New York. Bryna R. Smith/AFP via Getty Images.



**Source:** Client Highlight: How White Supremacy Attempts to Make Slavery and Segregation, “Soooo Long Ago.”, Zerflin.com, April 6, 2016

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# From Cultural Competency to Cultural Humility

## **Cultural humility:**

- A personal lifelong commitment to self-evaluation and self-critique
- Recognition of power dynamics and imbalances, a desire to fix those power imbalances and to develop partnerships with people and groups who advocate for others
- Institutional accountability

(Tervalon & Murray-Garcia, 1998)

# Vaccine (In)Equity & “Medical Mistrust”

## CRT Concept: Centering in the Margins



Dr. Ala Stanford receiving her COVID-19 vaccine. Stanford's vaccination was televised in order to promote the safety and efficacy of the shot. Photo credit: Emma Lee, TIME Magazine

PREVENTION RESEARCH

## COVID-19 Related Medical Mistrust, Health Impacts, and Potential Vaccine Hesitancy Among Black Americans Living With HIV

Laura M. Bogart, PhD,<sup>a</sup> Bisola O. Ojikutu, MD, MPH,<sup>b,c,d</sup> Keshav Tyagi, MPH,<sup>e</sup> David J. Klein, MS,<sup>a</sup> Matt G. Muchler, PhD,<sup>e,f</sup> Lu Dong, PhD,<sup>a</sup> Sean J. Lawrence, BA,<sup>e</sup> Damone R. Thomas,<sup>e</sup> and Sarah Kellman, MS<sup>e</sup>

**Background:** Medical mistrust, a result of systemic racism, is prevalent among Black Americans and may play a role in COVID-19 inequities. In a convenience sample of HIV-positive Black Americans, we examined associations of COVID-19-related medical mistrust with COVID-19 vaccine and COVID-19 treatment hesitancy and negative impacts of COVID-19 on antiretroviral therapy (ART) adherence.

**Methods:** Participants were 101 HIV-positive Black Americans (age: M = 50.3 years; SD = 11.5; 86% cisgender men; 77% sexual minority) enrolled in a randomized controlled trial of a community-based ART adherence intervention in Los Angeles County, CA. From May to July 2020, participants completed telephone interviews on negative COVID-19 impacts, general COVID-19 mistrust (eg, about the government withholding information), COVID-19 vaccine and treatment hesitancy, and trust in COVID-19 information sources. Adherence was monitored electronically with the Medication Event Monitoring System.

**Results:** Nearly all participants (97%) endorsed at least one general COVID-19 mistrust belief, and more than half endorsed at least one COVID-19 vaccine or treatment hesitancy belief. Social service and health care providers were the most trusted sources. Greater COVID-19 mistrust was related to greater vaccine and treatment hesitancy [b (SE) = 0.85 (0.14),  $P < 0.0001$  and b (SE) = 0.88 (0.14),  $P < 0.0001$ , respectively]. Participants experiencing more negative

COVID-19 impacts showed lower ART adherence, assessed among a subset of 49 participants [b (SE) =  $-5.19$  (2.08),  $P = 0.02$ ].

**Discussion:** To prevent widening health inequities, health care providers should engage with communities to tailor strategies to overcome mistrust and deliver evidence-based information, to encourage COVID-19 vaccine and treatment uptake.

**Key Words:** adherence, Black/African American, COVID-19, HIV/AIDS

(*J Acquir Immune Defic Syndr* 2021;86:200–207)

### INTRODUCTION

Nationally, Black Americans are more likely to be diagnosed, to be hospitalized, and to die from COVID-19.<sup>1–5</sup> The death rate from COVID-19 has been reported to be 2–3 times higher among Black versus White individuals.<sup>4,6</sup> Black individuals comprise 13.4% of the US population, yet account for more than 24% of COVID-19 deaths.<sup>4,7</sup> Inequities affecting Black Americans are believed to stem from systemic racism, which has led to higher levels of social risk factors such as unstable housing and homelessness, poverty, and lower-wage, higher-risk employment, which in turn are associated with a greater prevalence of underlying health conditions, such as hypertension, diabetes, and obesity (which are risk factors for severe COVID-19 disease and death).<sup>8–10</sup>

Medical mistrust, defined as “distrust of health care providers, the health care system, medical treatments, and the government as a steward of public health,”<sup>11,12</sup> is a response to current and historical systemic racism in health care and society as a whole and may play a role in COVID-19 inequities. Medical mistrust is particularly prevalent among Black Americans, compared with other races/ethnicities.<sup>13,14</sup> The 2016 National Survey on HIV in the Black Community found that 18% of Black individuals agreed that the government usually tells the truth about major health issues.<sup>15</sup> Medical mistrust has been associated with suboptimal health behaviors among Black individuals with HIV and other conditions, such as medication nonadherence and low health care engagement, as well as poor self-reported health, lower quality of life, and decreased uptake of screening and preventative behaviors<sup>16–21</sup> and vaccines.<sup>22</sup> Medical mistrust

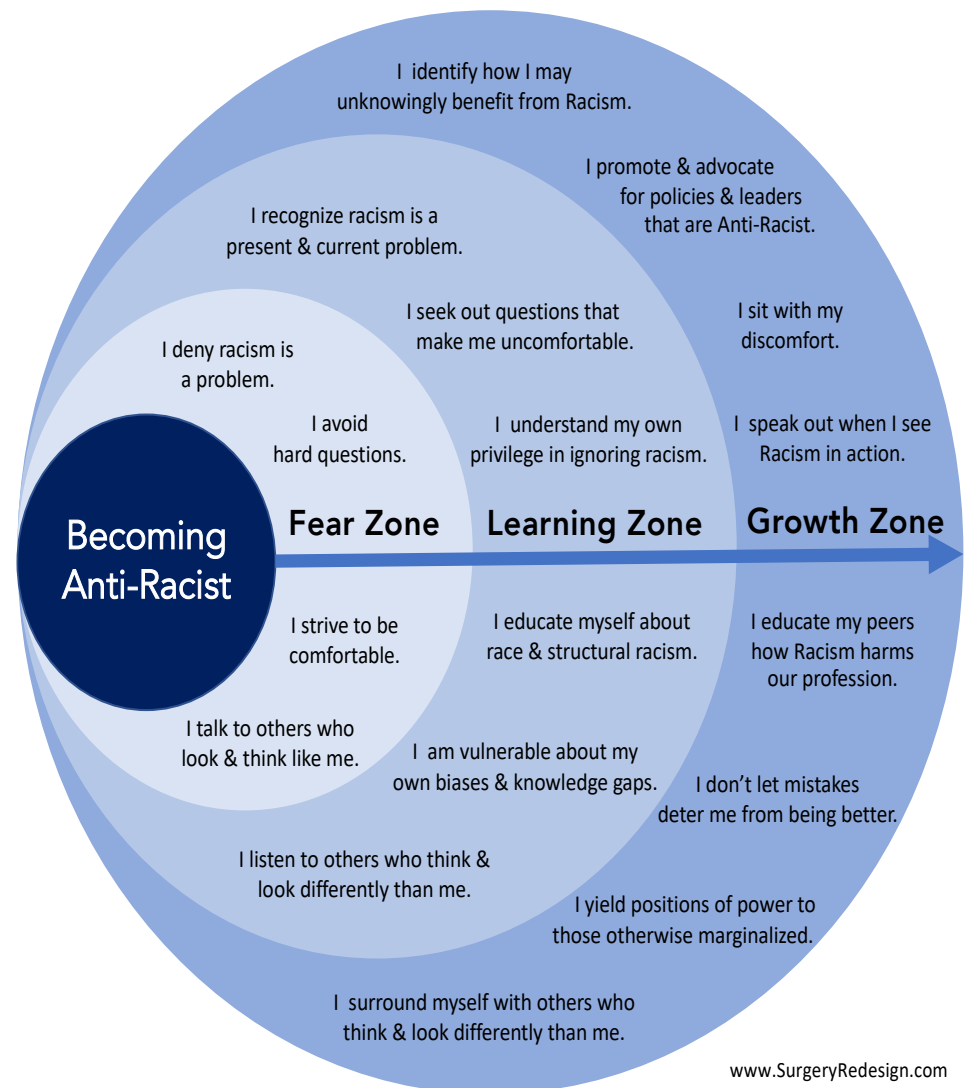
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# Anti-Racism Framework

Anti-racism: The conscious decision to make frequent, consistent, equitable choice daily. These choices require ongoing self-awareness and self-reflection as we move through life.

(Source: Talking About Race, National Museum of African American History & Culture)

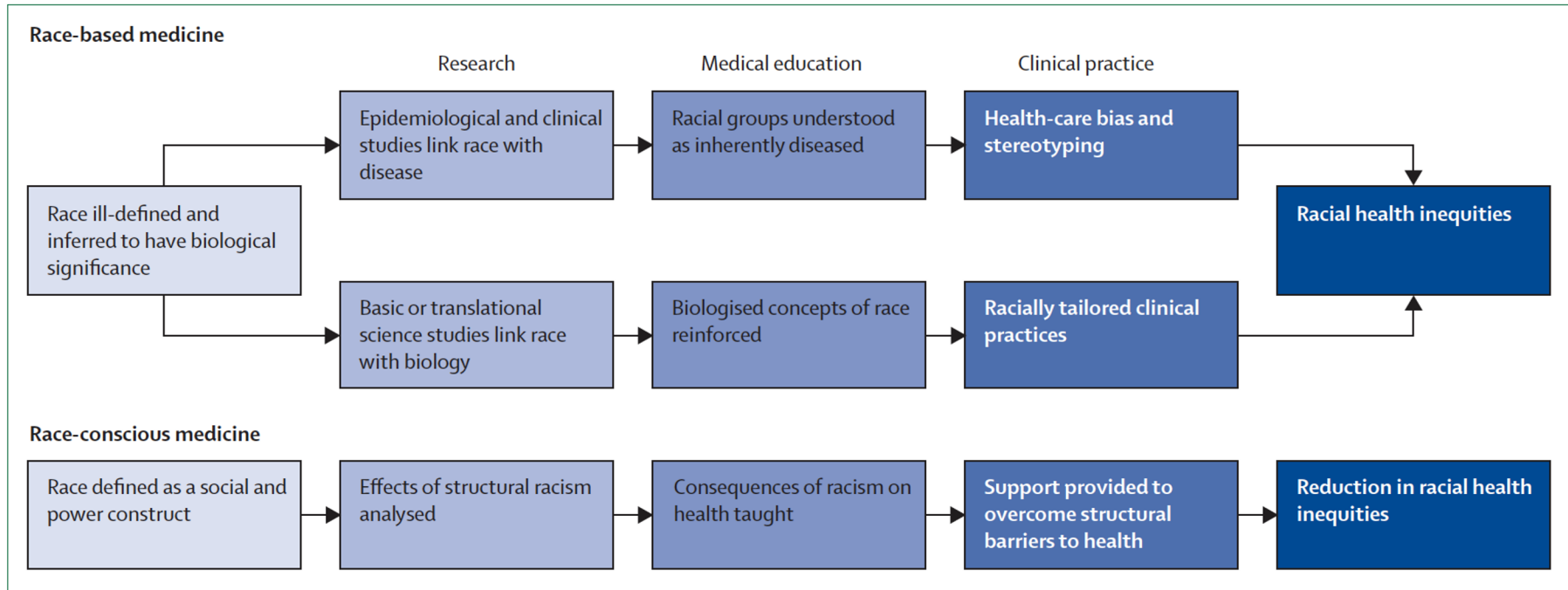


# CRT Key Concept: Race Consciousness vs. Color-Blindness

Term	Definition	The usual approach	CRT Approach
<b>Race Consciousness</b>	Deep awareness of one's racial position; awareness of racial stratification processes operating in colorblind contexts	Colorblindness-belief in the irrelevance of racism characterized by the tendency to attribute racial inequities to non-racial factors(e.g., SES)	A researcher clarifies her racial biases before beginning research within a diverse community

(Ford CL, Airhihenbuwa CO. The public health critical race methodology: Praxis for antiracism research, Social Science & Medicine, Volume 71, Issue 8, 2010)

# Structural Anti-Racism: Race-Conscious Medicine



**Figure: How race-based medicine leads to racial health inequities**

An alternative approach to race-conscious medicine; defined as medical practice and pedagogy that accounts for how structural racism determines illness and health.

Cerdeña JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: how anti-racist uprisings call us to act. *Lancet*. 2020;396(10257):1125-1128. doi:10.1016/S0140-6736(20)32076-6





**Are people of different races represented?**

Representation matters! Note who is represented and how in your case examples, images, and questions. Consider implicit and explicit representations of race and intersecting identities such as gender, class, etc.

yes

no

**When race is mentioned, is it relevant?**

Representation matters! Note who is represented and how in your case examples, images, and questions. Consider implicit and explicit representations of race and intersecting identities such as gender, class, etc.

yes

no

**Have you eliminated inadvertent stereotypes?**

Stereotypes reinforce associations that narrow clinical reasoning. Stereotypes can be conveyed through traits, abilities, roles, behaviors, and physical characteristics you've associated with race.

Your sensitivity to stereotypes will depend on your experience and blindspots.

yes

no

**Have you addressed health disparities?**

To disrupt racism, address the health disparities it causes. Identify barriers to progress, opportunities, and successes.

yes

no

**Do your materials disrupt oppression?**

Who benefits from or is burdened by your content, focus, and message? Consider learners, patients, families, communities, staff, and colleagues.

yes

no

**Congratulations! 🎉🎉🎉**

Now ask a colleague for a second opinion.

**Stop, Reflect, Correct.**

What biases are present in your choice of representation? Adjust representation or contextualize the lack of representation.

**Stop, Reflect, Correct.**

Why is race mentioned? If race is not clearly relevant, eliminate it. Distinguish race from biology, and use geographic ancestral origin to discuss genetic risk.

**Tip! 🌟🌟🌟**

When discussing a person's race, use "the patient identifies as [race]" or "they are of [origin] descent/ancestry" rather than "they are [race]?"

**Stop, Reflect, Correct.**

How does your portrayal sound if you swap races? How would a loved one feel if your portrayal described them? Create dignity-driven content.

**Stop, Reflect, Correct.**

Are there data on structural causes of health disparities related to your topic? If not, discuss why.

**Stop, Reflect, Correct.**

Do your materials promote equity or equality? Leverage your educational materials to uplift or unburden patients, learners, and communities facing disparity.

# Declaration of Racism as a Public Health Crisis



## Racism and Health



### Racism is a Serious Threat to the Public's Health

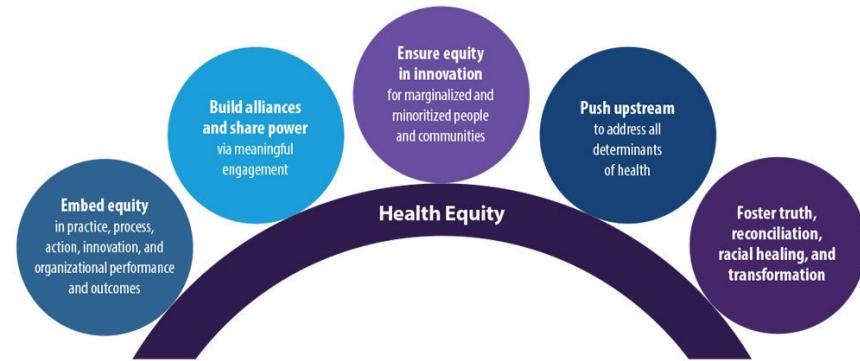
Racism is a **system** —consisting of structures, policies, practices, and norms—that assigns value and determines opportunity based on the way people look or the color of their skin. This results in conditions that unfairly advantage some and disadvantage others throughout society.

Racism—both **interpersonal and structural**—negatively affects the mental and physical health of millions of people, preventing them from attaining their highest level of health, and consequently, affecting the health of our nation.

A growing body of research shows that centuries of racism in this country has



## AMA Strategic Approaches to Advance Health Equity



# Reimagining a “New Normal”



Photo credit: UC Berkeley School of Public Health



Photo credit: UCSF School of Medicine



# Critical Reflection & Dialogue

- How did you feel in your body when hearing examples of structural racism in medicine?
- How have we accepted and participated in upholding racist narratives in the way we evaluate and interact with patients? In the way we approach community engagement? In the way we approach research?
- What commitments can we make to ourselves and to each other to address the harm caused historically and today in regards to racism in healthcare?
- How will we ensure we hold ourselves accountable to supporting antiracist, culturally-affirming care that centers in the margins?
- How will we push for systems change to disrupt systems of oppression in our academic and healthcare institutions?

# Thank you!

- Let's support each other and keep growing together!
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This workshop has been approved for **1 CEU** by the  
Washington Chapter,  
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Health Counselors.



Our Provider number is #1975-433.

Extra slides if  
time/questions