

The Fifth Annual Symposium  
on the Social Determinants of Health

# Race, Racism, and Baltimore's Future: A Focus on Structural and Institutional Racism



## Panel 2: Racism and Health

**#SDH2016**



Engaging communities, Improving health



## Introduction

After the death of Freddie Gray on April 12, 2015, and the protests and demonstrations that shook the city soon after, Baltimore became a symbol of racial strife and inequity and gained the media attention of not just the United States but the entire world. This was not news for the people of Baltimore or for many of the organizations that work tirelessly toward positive change in this city. To many, the death of Freddie Gray did not come as a surprise. To them, inequitable treatment of young, black men was nothing new; and it certainly was nothing that they had not heard, witnessed, or personally experienced. With the whole world watching, this tragedy brought determination; a determination that his death was not in vain, that the spotlight would not go away, and that together, through galvanized momentum, something would be done.

On April 25, 2016, over 700 people came together to attend the 5th annual Social Determinants of Health Symposium on **Race, Racism, and Baltimore's Future: A Focus on Structural and Institutional Racism**. The symposium was hosted by the Johns Hopkins Urban Health Institute and the Office of Provost. Attendees were a diverse group from the Baltimore area and beyond. Twenty-one invited speakers ranging from research and legal experts to leaders from non-profit community organizations spent the day in an intense discussion of race and racism in Baltimore. They participated in four panels, sharing poignant anecdotes about their personal experiences and presenting their research, all offering suggestions for ways forward.

This year, for the first time, the symposium also facilitated small breakout sessions in an effort to turn discussion into action, as tangible goals are necessary for making progress in Baltimore.

Speakers participated in four panels sharing expertise on:

1. overcoming structural racism,
2. how racism affects health,
3. how racism, racial segregation, and the education system are connected, and
4. racism and policing.

The goals of this symposium were to:

1. reiterate how salient structural racism is in the lives of people in Baltimore City,
2. acknowledge structural racism as a critical public health concern, and
3. critically assess the changes that we can make to reduce structural racism in our personal lives and in the institutions where we work.

Freddie Gray's death and the events that followed brought determination to the event—a determination that his death was not in vain, that the spotlight would not go away, and that together, through galvanized momentum, positive change would be made.

*This report summarizes key lessons learned and challenges as discussed by the symposium speakers. Additionally, successful Baltimore City organizations are highlighted throughout.*

## Panel 2: Racism and Health

### Disparities in health are a symptom of structural racism

**Keynote Speaker:** **David R. Williams**, PhD, MPH, Professor, Harvard T.H. Chan School of Public Health

**Discussants:** **Thomas A. LaVeist**, PhD, Chair, Department of Health Policy and Management, George Washington University Milken Institute School of Public Health

**Cory Bradley**, MSW, MPH, Doctoral Student, Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health

**Moderator:** **Maria E. Trent**, MD, MPH, Associate Professor, Johns Hopkins University (School of Medicine, Nursing, Bloomberg School of Public Health)

## Historical Context for Racism and Health

While many would like to believe that medicine and health care are free from bias and discrimination, the evidence does not support that perspective. As Byrd and Clayton explain, "Racism in medicine and health care has paralleled racism in society. The nation's health delivery system has been distorted by race and class problems from its beginnings."<sup>10</sup> Baltimore's health care legacy – while one of great advances in medicine – has been paralleled by racially segregated health care delivery.

Understanding the history of racism in medicine is important since many who lived through that era are alive today and the stories are passed from one generation to the next.

### late 19<sup>th</sup> and early 20<sup>th</sup> century

The late 19<sup>th</sup> and early 20<sup>th</sup> century American medical journals and textbooks were laced with "pseudoscientific racist principles, derogatory racial character references, and pronouncements of impending black racial extinction."<sup>10</sup>

### 1893

In 1893, Johns Hopkins Universities opened with racially segregated classes, hospital, and medical staff even while its charter avowed non-discriminatory health care delivery.<sup>10</sup>

### 1932

In 1932, the Tuskegee Institute in Alabama conducted the "Study of Syphilis in the Untreated Male," where even after a good treatment for syphilis was discovered, white physicians withheld treatment to examine how it affected black bodies.<sup>11</sup> Many men died or passed on the disease. This experiment continued for more than 40 years.<sup>10</sup>

"How is it possible that health care providers in the United States – well trained, highly educated, health professionals – wake up every morning wanting to do the best for their patients and still produce a negative pattern of outcomes?"

*David R. Williams*

## late 1930s-40s

In the late 1930s and 40s, birth control was tested in the black community before it was known to be safe.<sup>12</sup> The 20th century was also a time when black women underwent forced sterilization.<sup>12</sup>

## 1951

In 1951, Henrietta Lacks, a black woman, died of cervical cancer even after receiving treatments that were the standard of care at that time. Physicians successfully cultivated her cancer cells and the result was used for the last 65 years as a major culture medium used in medicine. The family was only informed years later.<sup>13</sup>



Photo of Henrietta Lacks

## mid-1960

In the mid-1960s, Johns Hopkins University integrated patient care wards.<sup>10</sup>

## 1964

In the 1964 Civil Rights Act, there were several movements that created significant positive changes for African Americans in health care including hospital desegregation, the passage of Medicare and Medicaid, the Voting Rights Bill, and the health center movement.<sup>10</sup> Federal funding for health services allowed African Americans, many for the first time, access to medical care.<sup>10</sup>

## 1980s

It wasn't until the 1980s that the proportion of black physician graduates rose above 2%.<sup>10</sup>

## Current Status in United States, Maryland, and Baltimore City

### Racial Disparities in Mortality and Morbidities in Maryland and Baltimore City

Today, substantial racial differences persist in both mortality and morbidity based on race in Baltimore City. As can be seen in figure 3, with the exception of a marginally higher rate of adult asthma for white residents of Baltimore City, every single health indicator, including diabetes, obesity, high blood pressure, childhood asthma, smoking, and poor mental health days is higher for African Americans than for white residents in this city. Of greatest concern is the substantial disparity between childhood asthma rates at 38.16% (black) and 11.36% (white), more than a three-fold difference.

Infant mortality, which is often used as an indicator for population health, has substantial inequities by race in Baltimore City. In Maryland, African American average annual infant mortality rates in 2012 were substantially higher at 12.2 deaths per 1,000 live births, than whites (4.5 deaths per 1,000 live births), American Indians (5 deaths per 1,000 live births), Asians (3.6 deaths per 1,000 live births), and Hispanics (3.8 deaths per 1,000 live births). Disparities were greatest for black male babies residing in Baltimore City. In fact, African American male infant mortality rates\* for Baltimore City

were 3.21 times higher than their white counterparts; and African American female infant mortality rates were 2.82 times higher than for white female infants.<sup>15</sup> While these disparities are great, it is notable that there has been a 24% reduction in African American infant mortality overall for the state of Maryland between 2001 and 2012, declining from 13.6 to 10.3 deaths per 1,000 live births in the 11 year period.<sup>16</sup>

### Minority Medical Professionals Underrepresented in Maryland and Baltimore City

- The following graph helps us understand the marked differences in graduation rates from U.S. medical schools for physicians by race. Number for Asian physicians has risen substantially since the 1980's however the rates for Hispanic or Latino, black, and American Indian's have stagnated.<sup>17</sup>

In addition, these disparities continue within the state of Maryland and within Baltimore City:

- Despite African Americans representing 29.2%, and Hispanics or Latinos representing 9.0% of Maryland's total population, they only account for 9.4%, and 1.9%, respectively of Maryland's total physician count (excluding residents and fellows). This is in stark contrast to Asian physicians, who only represent 6.0% of the total Maryland population, yet account for 10.5% of Maryland's total physician count.<sup>17</sup>

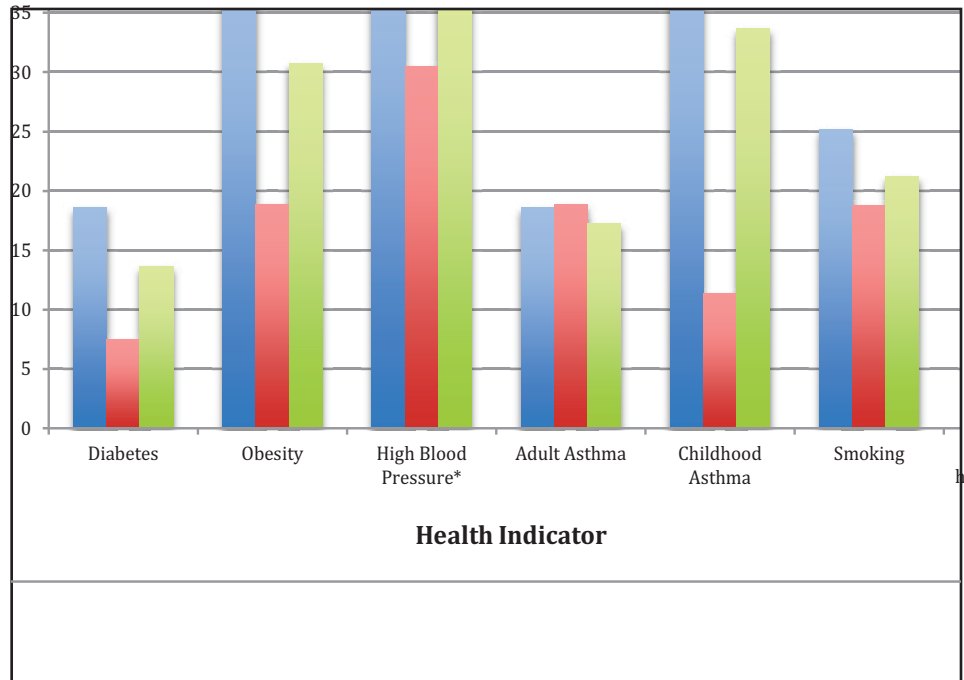


Figure 3. Source: Baltimore City Health Disparities Report Card, 2013.<sup>14</sup>  
\*Note - Blood pressure estimates are for 2011.

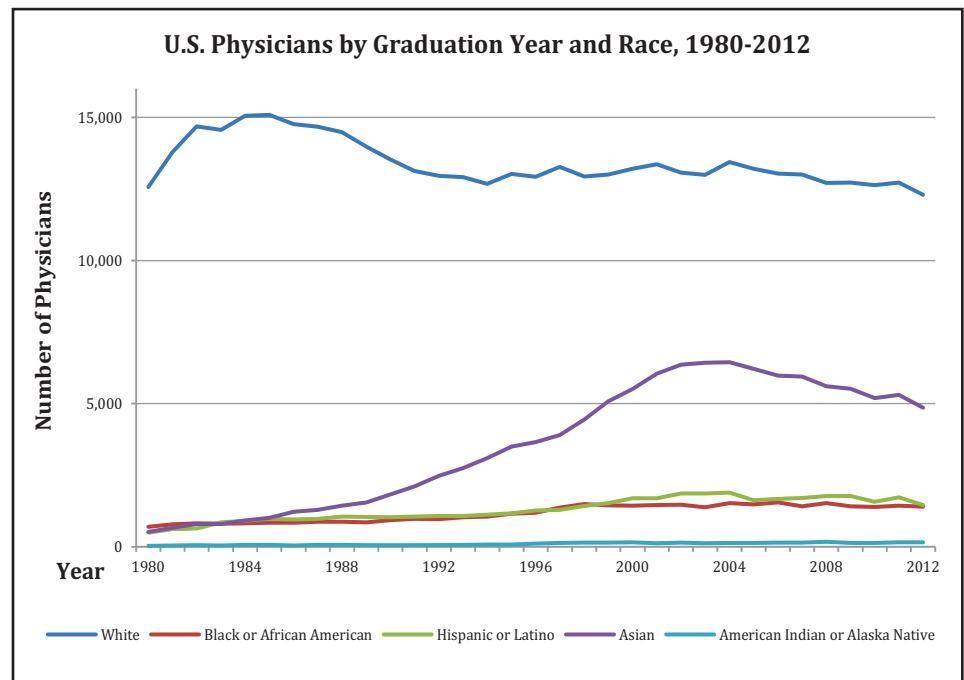


Figure 4. Source: Association of American Medical Colleges (2014).<sup>14</sup> Chart generated by Alicia Vooris using data from the AAMC Data Warehouse: Minority Physician Database, AMA Masterfile, and other AAMC data sources, as of 1/22/2014

\* Infant Mortality (<1 year), denominator - total live births

- According to the American Association of Medical Colleges and their 2013 Minority Physician Database,<sup>17</sup> in Baltimore City there are a total of 2,480 physicians (again, excluding residents and fellows). Of these physicians, there were 434 (17.5%) Asian doctors, 346 (14.0%) black doctors, 84 (.03%) Hispanic or Latino doctors, 1,612 (65%) white doctors, and 4 (.002%) American Indian or Alaskan Native doctors in Baltimore City. However, according to the U.S. Census Bureau's 2010-2015 estimates, the population is 62.9% black, 28.3% white, 4.8% Hispanic or Latino, 2.8% Asian, and .4% American Indian. Given both the numbers of the demographics of Maryland, and the physician count by both state and Baltimore City specifically, it is apparent that there is severe underrepresentation of Hispanic and Latino physicians to care for Hispanic and Latino patients. This is a particularly salient problem with a predicted increase in the Latino population in the city.<sup>14</sup>

Thomas LaVeist noted in a paper published in 2014<sup>18</sup> that there are six public health benefits to increasing diversity in the health workforce:

1. Improved overall quality of care through higher levels of patient satisfaction and trust
2. Enhanced level of cultural competency in patient-provider relationships
3. Expanded minority patients' access to and utilization of health services
4. Increased access to care for geographically underserved minority and white communities, as minority physicians are more likely to locate to underserved communities
5. Improved breadth and scope of medical research with a broader range of racial/ethnic perspectives
6. Larger societal benefits including having more minority providers running their own practices

### Racial Bias from Medical Professionals

A recent systematic review by Hall and colleagues<sup>19</sup> has found that a majority of health care providers appear to have implicit bias in terms of positive attitudes towards whites and negative attitudes towards people of color. Public and professional awareness is key to reducing these disparities, and this systematic review can be used as an educational tool. It is the most recent, comprehensive meta-analysis on racism and health to date.

**“Racism never acts alone, in the reek of its havoc. It thrives in collaboration and collusion with a host of other oppressions, acting simultaneously to impact health.”**

*Cory Bradley*



One of 20 love walls around Baltimore, Maryland, part of the Baltimore Love Project. This is in southwest Baltimore near Hollins Street Market.

## Lessons Learned

- **Racism never acts alone in its effects on health.**

In fact, there are multiple pathways in which racism and racist systems affect health, including increased stress associated with racism (discrimination, physical/chemical exposures, historical trauma, internalized racism, etc.), fewer opportunities because of societal and individual level racism (educational, employment, income, etc.), and reduced access to societal resources because of institutional racism (medical care, housing, neighborhood/community).<sup>20</sup> In order to address the elements of racism in the health care system that perpetuates health disparities, David Williams spoke of increasing accountability and reducing discretion, as well as working on key leverage points.

- **Racism affects our behaviors and physiological responses.**

Although 'race' is a socially constructed idea, an individual's racial classification has profound impacts on their health. Racism and racist systems affect a person's behavioral patterns (health practices, everyday resistance), their psychological responses (internalized racism, racial identity, self-esteem), and their physiological responses (central nervous system, endocrine, metabolic, immune, and cardiovascular).<sup>20</sup>

- **Racism itself is a determinant of health.**

These racial and ethnic disparities in health exist even when insurance status, income, age, and severity of conditions are comparable.<sup>21</sup> Speakers discussed how racism can affect both mental and physical health, and for people of color it can create internalized racism where they believe and act upon the negative stereotypes that are perpetuated about them.

- **Place matters – disparities in health among minority groups are intimately connected to residential segregation.**

Moreover, speakers discussed how the institutionalized isolation and marginalization of racial populations has adversely affected health and life chances in multiple ways. It determines whether it is easy or difficult to be healthy in your neighborhood. As Dr. Williams explained, "Where you live in the United States determines where you go to school, and the quality of the education you receive. It determines your access to employment opportunities. It determines the quality of your neighborhood and your housing conditions and how much lead exposure you have." In addition to impacting physical health, it is also about wellbeing. Living in an unsafe, unhealthy, run-down neighborhood decreases your quality of life.

- **Embrace, rather than avoid intersectionality.**

When understanding the health consequences of racism, we need to embrace, rather than avoid, intersectionality. That is to say, individuals have a myriad of identities that makes them who they are, including their sexual orientation, their gender, their socioeconomic status (SES), their disability status, and their race. In understanding their health and making positive changes to improve it, we must highlight how these identities are intertwined.

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**"There is a particular indifference in the United States for particular groups of people. Most Americans are compassionate and caring, but we need to overcome this peculiar indifference and have the political will."**

*David R. Williams*

## Challenges

- **Health care providers are part of the problem.**

They are part of the problem, as bias, stereotyping, prejudice, and clinical uncertainty negatively affect health outcomes of patients of color. Speakers discussed how this was not necessarily overt, or blatantly discriminatory acts against patients, but that racism affects the choices that physicians and health care providers make in the care of their patients. We must work hard to provide our medical professionals with adequate training on implicit racial bias and cultural competency to combat this problem.

- **One of the most dangerous forms of racism is indifference.**

Racism often occurs without malicious intent<sup>22</sup>; and thus, providers need to understand and acknowledge their often hidden biases. Speakers noted the challenges of addressing hidden bias since first there is the need to make them visible to the individual and then develop a strategy to address them.

- **We need political will to dismantle how structural racism affects health.**

To make changes in the health care and social systems that lead to persistently poorer health outcomes of some groups, we need a political will since health care access alone will not in itself alter the statistics.

## Components to Address

When addressing poor mental and physical health outcomes that are related to racism, there are multiple systems that need to be addressed. Ultimately, all of the following components need to be improved to reduce inequities in health:

- **Health care system**  
including insurance, funding, majority white health care provider system, and access
- **Health care providers**  
including unconscious bias, attitudes, and racism
- **The patient**  
including mistrust, health behaviors, health literacy, and fear
- **The community**  
including transportation to hospitals and collective efficacy

## Examples of Successful Baltimore Organizations

- **B'more for Healthy Babies** is a program of the Baltimore City Health Department and the Family League of Baltimore City. They work towards improving health outcomes for women, children, and their families through public health initiatives including safe sleep, teen pregnancy prevention, family planning, health literacy, and housing. [www.healthybabiesbaltimore.com](http://www.healthybabiesbaltimore.com)

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“Racial differences in socioeconomic status are not acts of God, they are not random events. They didn’t just happen or come out of thin air. They reflect the successful implementation of social policies, and residential segregation is doing exactly what it was intended to do and it is a structural component of racism that we will not see progress on, unless we find ways to dismantle its negative effects.” *David R. Williams*

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## Who we are

Established in 2000, the UHI serves as an interface between Johns Hopkins University and the Baltimore community in which it resides. Together with its university and community partners, the UHI explores ways that the research, teaching, and clinical expertise of the University can be better harnessed for the benefit of the residents of Baltimore.

## Our Mission

To serve as a catalyst that brings together the resources of Johns Hopkins Institutions with the City of Baltimore, to improve the community's health and well-being, and in so doing serve as a model of community-university collaboration regionally and nationally.

We would like to acknowledge the contributions from the Community-University Coordinating Council and community planning meeting participants in helping to shape the symposium.

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