California Public Health/Prevention Medical Leadership Forum

30th Meeting; 4th using Video (Zoom, Courtesy of Loma Linda University)

Tuesday, March 9, 2021, 8:00-9:30 am PT

MINUTES *(Draft, 5/24/21)*

"Handouts" (this agenda, last meeting's minutes, and spreadsheet on California medical schools and prevention) were attached to the email notice. Presenters used Zoom Screen Share for slides.

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1. **Zoom attendance by Institution: Early attendees introduced themselves, supplemented by a roll call by institution.**

   17 total participants were documented: 13 regular members, 2 guests, and the 2 presenters. Brief introductions were offered by early participants, supplemented by a roll call. Additional participants joined later and some left early. Agenda items for which there was nobody to report are omitted below. Listed here by represented entity is a complete list of attendees:
   CAPM: Mark Horton (Chair), Ron Hattis, Don Lyman, Sumedh Mankar
   DHCS: Karen Mark
   CMA: Yvonne Choong
   UCSF SOM: George Rutherford
   Stanford SOM: Eleanor Levin
   CHSU, Osteopathic SOM: Sara Goldgraben
   Western U. Osteopathic SOM: Maryam Othman
   USC Keck SOM: Howard Hu
   UCI SOM: Ariana Nelson
   UCSD SOM: Margaret Ryan
   UCSD SPH: Linda Hill
   Guests: Susan Bradshaw, Cynthia Mahoney
   Presenters: Keith Norris, Jean Davis-Hatcher

2. **Minutes of December 8, 2020 Meeting** (previously shared with speakers; handout)

   One correction had been submitted in advance. There were no additional corrections, Determined by Chair to be approved, as usual without a formal motion.

3. **Reports from Any Members Who Will Be Leaving the Call Early**

   No early reporting was requested.

4. **Today's Special Topic: Factors Causing Health Disparities –**

   a. Keith Norris, nephrologist, UCLA Geffen SOM: Health Outcomes and Systemic Racism
   Systemic Racism/Sexism and Other Inequities of Past and Present, a Public Health Problem Requiring Medical Student and Physician Education

The UCLA SOM has added two curricular Assistant Deans to address Structural Racism. Their role is to go through the curriculum and presentations to find structural racism in the form of embedded policies, beliefs, narratives, etc. that may perpetuate myths and inequities.

Historical aspects: Dr. Norris oral presentation and slides made the following statements. Slavery lasted for 248 years starting about 1619, followed by 100 years of state-sanctioned segregation, share-cropping, and terrorism. The "Southern Strategy" for another 56 years, up to the present time, was to get around civil rights legislation of 1865 and 1964, by creating worse outcomes for blacks, e.g., collecting taxes but not giving benefits, inequities in the social determinants of health, etc. It is derived from an ideology of white supremacy and superiority as central in the founding of America.

Race can be defined as a social interpretation of how one looks in a "race"-conscious society, how society sees you and thinks of you. It has been expanded to marginalize other people based on ethnicity, culture, or language. Race is indirectly, not directly, related to ancestry. Racism can be defined as a system of structuring opportunity and assigning value based on the social interpretation of how one looks, or how society treats people based on the label of race. Rather than labeling individuals as racists, we should focus on actions and on whether they support a racist narrative or stereotypes.

Structural racism is the totality of ways in which societies promote racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, earnings, benefits, media, health care, criminal justice, etc. These also happen to be among the social determinants of health. These patterns and practices reinforce discriminatory beliefs, values, and distribution of resources. The Civil Rights Act of 1964 did not end racism, but it made strides toward the right to vote, empowered US district courts to give injunctive relief against discriminations in public accommodations, authorized the Attorney General to institute lawsuits to assure access to public accommodations and public education, extended the Commission on Civil Rights and authorized it to prevent discrimination in federally assisted programs, and established a Commission on Equal Employment Opportunity. However, an average black school district gets at least $1400 per student less than a low-income white district. The criminal justice system gives unequal treatment, and black applicants for employment and housing have fewer opportunities. Home appraisals may be higher if the appraiser thinks the home is owned by a white family.

In the case of COVID, there has been an increased risk of exposure, high chronic disease burden, and lack of access to quality care. One study showed physicians to be more biased than lawyers or PhDs. There are also sexist effects on health outcomes. A patient with heart disease treated by a provider of the same gender has a better chance of survival.

In the struggle for equity, an analogy was offered of ladders, some with more steps to climb up from a "hole," and other ladders being broken. One limitation of diversity is if more people have access to ladders, but they are broken. Justice is needed for true equity. The ladders need to start

from an equal level and to be working. But some people complain of reverse racism when extra advantages are given to disadvantaged groups, and they want extra advantages too. The equity and anti-racism mindset recognizes the needs to address inequities in policing, education, wealth, overcoming judge bias, case law, campaign financing, etc.

We should not deny bias, or be afraid of it, but everyone can work to minimize it. Structural racism should not be a scary term, however everyone can help to dismantle it. Today's providers did not create these conditions and do not take responsibility for them, but should devote attention to mitigating them.

b. Jean Davis-Hatcher, Assoc. Prof., Drew University:
Community Distrust of the Medical System, Nutrition, and Other Factors Affecting Health Outcomes

Distrust of the medical care system in the African American community has been sparked by a number of episodes, including:

- The well-known Tuskegee syphilis study in which black men were followed through the course of the disease without being informed of their infections or offered treatment
- A past practice of American medical schools of obtaining mostly black bodies for dissection, some allegedly by theft
- Failure to give the family of Henrietta Lacks a share of proceeds earned from the HeLa cell line
- Past forced sterilizations as part of a "eugenics" program, with California accounting for 80% of these by 1921; and a renewal of forced sterilizations of immigrant women in an ICE detention facility as recently as 2020
- Contemporary bias among health care providers and systems

Social determinants of health reflect social factors and physical conditions of the environment in which people are born, live, work, play, and age. These impact a wide range of health, functioning, and quality of outcome. Four major components in communities of color are dietary intake, environment, activity, and psychology.

It is estimated that over 24 million Americans live in over 6500 food desert communities, some urban and some rural, and they tend to be disproportionately populated by communities of color. Rural food deserts (a high proportion of which are in the Midwest) are defined as counties where access to fresh fruits and vegetables and supermarkets with high quality whole foods requires at least a 10 mile drive; urban deserts are neighborhoods at least one mile for such access. As low-income people move into urban neighborhoods, high-income people tend to move out, and grocery stores may move or not open in anticipation of lower income. Prices for healthful foods also tend to be high. These areas are full of liquor stores, selling large volumes of both alcohol and tobacco products, and fast food restaurants abound. Diets tend to be deficient in fruits and vegetables and high in sugars and fats, placing the population at high risk for chronic diseases, which begin to develop in childhood.

Discussion: Ron Hattis asked how we can develop a generation of medical students more aware of the above factors. Keith Norris said that introducing this to the curriculum is a priority, and should be considered "front and center" as a public health issue. Providers tend to have "blinders" on to all these conditions, but in recent years, there has been more attention to how the social determinants of health affect individual patients' ability to respond to medical recommendations. Many patients are doing the best they can given their conditions, and providers need to approach them with empathy. Medical institutions like universities also need to invest in improving health-influencing conditions in communities at risk. Jean Davis-Hatcher added that some health recommendations are not feasible or are dangerous in patients' communities. Communities are not monolithic, and practical plans should be developed with individual patients, meeting them "where they are."

Howard Hu said many scholars at USC are working on health disparities issues along racial and ethnic lines, but have found it difficult to influence the overall medical education culture. Within his department there are Associate Deans for Racial and Social Justice and Community Engagement, but the medical education committees sometimes do and sometimes do not take into account the factors we have been discussing. What seems to work best is when an enthusiastic faculty member (e.g., Jo Marie Reilly, who heads the MD/MPH program) involves medical students directly in the low-income neighborhoods surrounding the university. Directly seeing conditions is more effective than just learning abstract concepts. Dr. Reilly is the co-author of an article showing that over the past 15 years, there has been a 400% increase in medical students also obtaining MPH degrees. Ron Hattis suggested that Dr. Hu invite Dr. Reilly to attend this Forum.

Don Lyman said he had observed similar food deserts in Mexico and Brazil, and asked if other countries have found strategies that work in medical education. Keith Norris agreed that similar problems are universal in human society. We should think in terms of ethnic groups, because there is only one race, the human one. Humans love each other within close circles, but as concentric circles get larger, at some point they draw a line and consider everyone else as "other," not hesitating to discriminate or even kill. The challenge is to dissipate the circles. Regarding access to health care, South Korea covers everyone, with either a single-payer system or a Medicaid-like safety net. Other countries have similar universal coverage systems and their main inequities are between urban and rural communities. There may be no society that has done an ideal job with respect to health equity.

George Rutherford said that UCSF has an elaborate system with a lot of faculty re-education and "forward education" for students. Equity issues are taken exceptionally seriously. He noted that such corrective initiatives may take 10 years or more to evaluate for effectiveness.

Ron Hattis noted the higher maternal mortality among African American women, even those of higher income, and suggested that pregnant African Americans should be considered as high risk pregnancies, but asked if this would be race-based discrimination. Jean Davis-Hatcher concurred with the proposal and replied that differential treatment would be equity and mitigation of racism and not discrimination,.

Mark Horton asked if we are looking at data that can detect systematic differences in how patients are being treated. Keith Norris agreed that outcome differences among subgroups need to be compared

and then analyzed. Mark also recommended with regard to structural racism, that inequitable policies be identified and that efforts be directed at reversing them. Ron Hattis mentioned that the Wisconsin Public Health Association has declared racism to be a public health crisis.

5. **Medical Schools and Prevention/Public Health - Need More Information to Fill In Spreadsheet Started 2017: Ron Hattis (**handout, Excel spreadsheet)

   Columns at far right have been added for social determinants of health and dealing with racial inequities. Please check your school's row; much incomplete information. No information has been received yet from newest schools. Ron Hattis asked for input to be emailed to him.

6. **COVID-19 Updates: Mark Horton and General Discussion**

   Mark recommended a recent NPR broadcast on "Fresh Air" by Terry Gross on the advantages of messenger RNA vaccine technology. NIH and CDC are both studying "Long COVID," also known as "long-hauler syndrome" and by other names. CDC has issued some guidelines on school reopenings.

   Ron Hattis noted that almost 3 million doses of COVID vaccines are currently being administered nationwide every day, but expressed concern that premature reopenings in many states and more hazardous new virus variants threaten to cause another surge in cases and resultant hospitalizations and mortality.

7. **Legislation**

   Cynthia Mahoney drew attention to SB 467, an "anti-fracking" bill that should be considered by entities concerned about climate change and environmental health. The bill has been expanded to phase out not only fracking but also other dangerous injection drilling techniques, and setbacks of wells from schools and residential areas. Mark Horton mentioned AB 526, which would allow dentists to administer COVID and influenza vaccines.

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8. **California Medical Association**

   Yvonne Choong was no longer connected. Don Lyman, a member of the CMA Council on Science and Public Health, noted that there is a large list of "consent calendar" bills that CMA will be supporting. Climate change is likely to be a main topic at the annual House of Delegates. That would require a "white paper" prepared in advance for review by the delegates.

9. **Updates from Schools of Medicine**

   California Health Sciences Univ. (CHSU, Clovis): Sara Goldgraben reported that the first medical school class was admitted in July 2020, and that the second class will start in July 2021. Social determinants of health are dealt with in the first semester. Nutrition training also begins in the first

year, with a combination of case presentations and remote instruction in actual cooking to learn how to make healthy meals, in hopes that in practice, physicians will instruct patients on how to do this. CHSU also has a pharmacy school.

UC Irvine: Ariana Nelson reported that initiatives to combat racism began 2 years ago, including an "anti-blackness" curriculum, and that there is a group on social determinants of health. As at CHSU, nutrition training includes cooking, and remote learning has been especially effective for this topic. Remote learning may be continued as a component of medical education even after the pandemic.

USC: Howard Hu reported that USC has COVID Pandemic Research Center within his department, and is about to launch a 3,000-person cohort study, in partnership with L.A. County Department of Public Health and with CDC funding. This study will follow a low-income population in Los Angeles County to determine how immunization, vaccine hesitancy, and poverty interact to impact the course of infections.

10. Next Virtual Meeting: June 8 or 15, 2021; Agenda Ideas

Ron Hattis invited Howard Hu to present research findings from the USC Department of Preventive Medicine (the state's largest such department), on both COVID and health equity, and to bring along any appropriate lead investigators. Dr. Hu agreed to do this.

Presented by Ronald Hattis, Secretary