"WHAT IS MEDICAL ANTHROPOLOGY?"

SEASON 4, EPISODE 3- STUDY GUIDE

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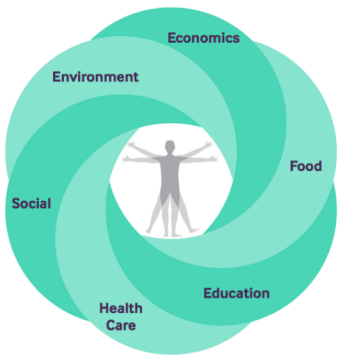
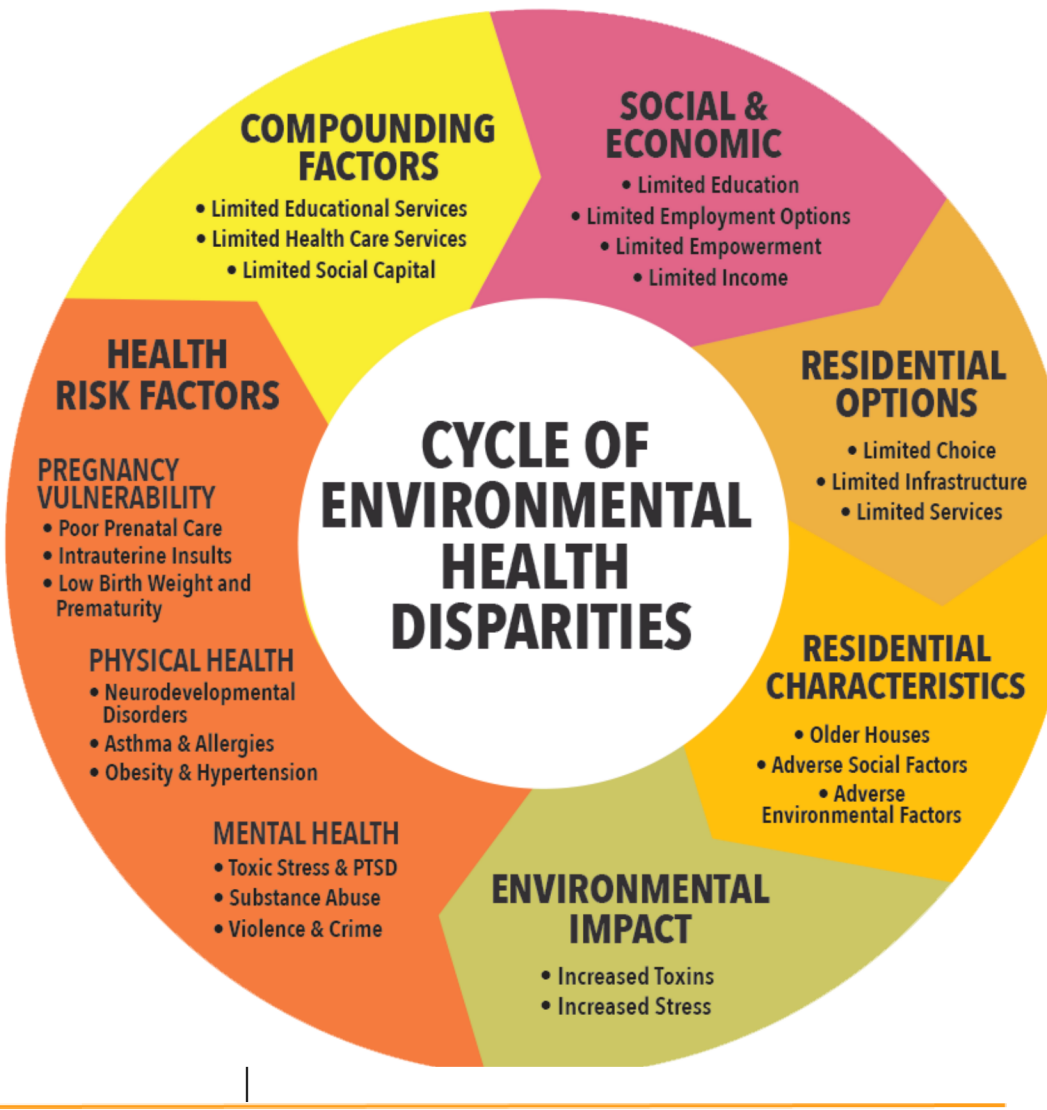
GLOBAL BIOCULTURES
ANTHROPOLOGICAL PERSPECTIVES ON PUBLIC HEALTH

Health Care should be....

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

Social Determinants of Health





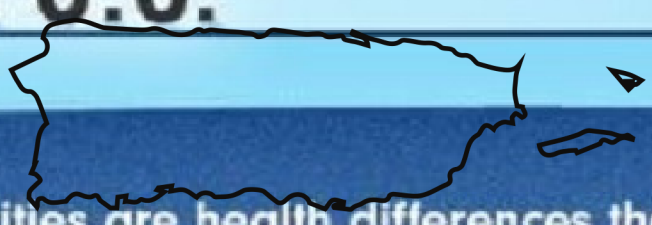
Health Disparities:

"…**preventable** differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations"[1]

Health Equity:

"When **every person has the opportunity to 'attain his or her full health potential'** and no one is 'disadvantaged from achieving this potential because of social position or other socially determined circumstances"[2]

HEALTH DISPARITIES IN THE U.S.



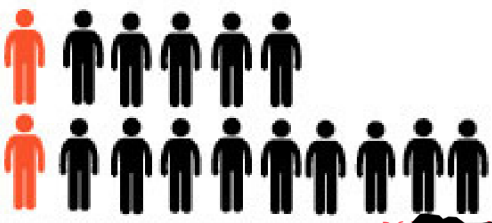
Health disparities are health differences that negatively affect specific population groups. These are groups who have experienced obstacles to quality health care due to discrimination or exclusion based on ethnicity, socioeconomic status or other factors. As the U.S. becomes more diverse, health care disparities are becoming increasingly problematic, affecting quality care for large numbers of people and hindering health care equity.

Health disparities are differences in rates of disease across racial, ethnic, income, and other social groups. They are a result of obstacles to health including systemic racism, poverty, and lack of access to healthy food, stable housing, employment, and healthcare.

DIABETES

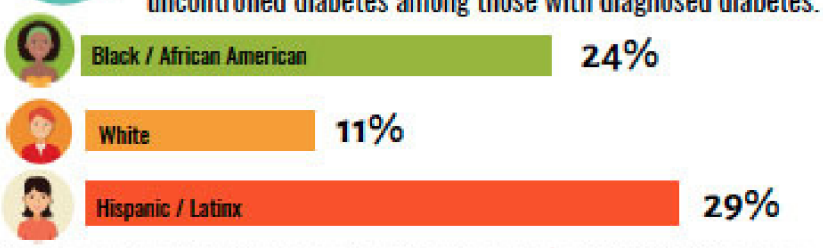
Prevalence In Adults

1 in 6 Black/African American adults have diabetes compared to 1 in 10 White adults



Uncontrolled Diabetes

3X Hispanic/Latinx have three times the rate of uncontrolled diabetes (A1C >9%) than Whites. Below shows percent of uncontrolled diabetes among those with diagnosed diabetes.



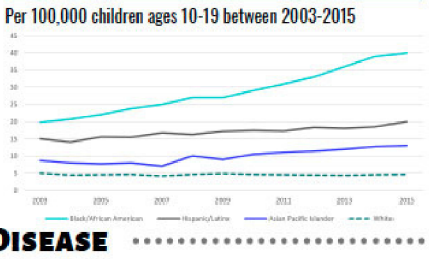
EL APAGON- BAD BUNNY

What about children?

Type 2 diabetes among children ages 10-19 has risen dramatically for Black/African American children compared to all other groups.

Type 2 Diabetes Incidence Among Children

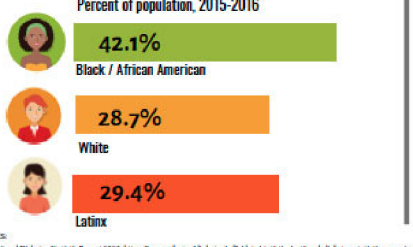
Per 100,000 children ages 10-19 between 2003-2015



HEART DISEASE

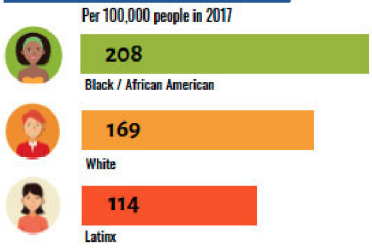
High Blood Pressure

Percent of population, 2015-2016

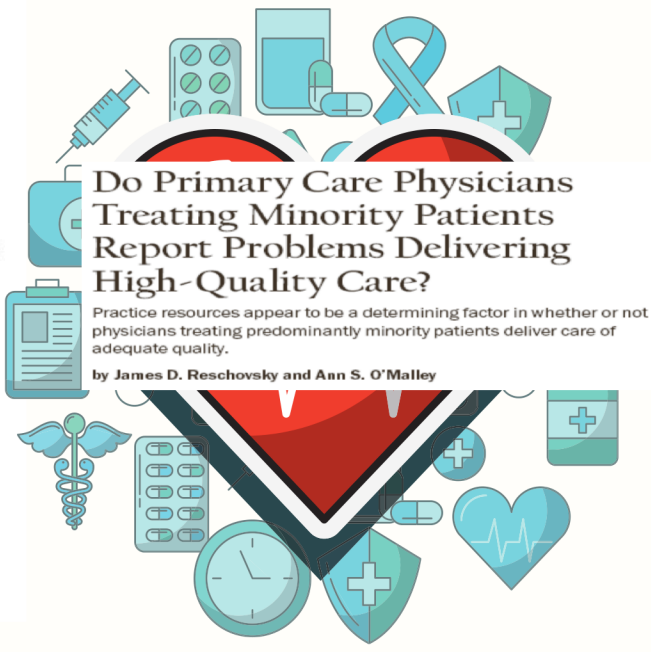


Death From Heart Disease

Per 100,000 people in 2017



SOURCES:
CDC National Diabetes Statistic Report 2020: https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf
Healthy People 2020 Disparity Data, 10yo-20y6: https://www.healthypeople.gov/2020/data/disparities/detail/Chart/4123/all/206
CDC Heart Disease Spotlight 20.g: https://www.cdc.gov/nchs/nvss/deaths.htm



Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care?

Practice resources appear to be a determining factor in whether or not physicians treating predominantly minority patients deliver care of adequate quality.

by James D. Reschovsky and Ann S. O'Malley

EMORY INTERNAL MEDICINE RESIDENCY: RACISM & BIAS IN MEDICINE

Race and Pain Assessment

How do false beliefs about biological differences between Black and White people affect pain assessment and treatment?

Study Design

92 **White, US-born laypersons**

222 **White, US-born medical students and residents**

1. Rated the **truth of 11 false biological differences** between Black people and White people
   - "Blacks' nerve endings are less sensitive than Whites'"
   - "Blacks' skin is thicker than Whites'"
   - "Blacks have stronger immune systems than Whites"
   - "Black people's blood coagulates more quickly than Whites'"
2. Rated the **amount of pain** a Black or White target would feel in different scenarios
3. Rated **accuracy of pain treatment recommendations** for each scenario

Results

	Laypersons (n=92)	Medical Trainees (n=222)	
	Participants who endorsed ≥1 false belief: 73%	Participants who endorsed ≥1 false belief: 50%	
Participants endorsing **MORE** false beliefs	Black < White: rated **Black** targets as feeling **less pain**	Black < White: rated **Black** targets as feeling **less pain**	Black < White: gave **less accurate** treatments for **Black** targets
Participants endorsing **FEWER** false beliefs	Black = White: **did not differ** in pain assessment	Black > White: rated **Black** targets as feeling **more pain**	Black = White: **did not differ** in treatment accuracy

CONCLUSION

- **False beliefs about biological differences** between Black people and White people are associated with **racial disparities in pain assessment and treatment recommendations.**
- Greater **racial bias in pain ratings** were associated with greater **racial bias in accuracy of treatment recommendations.**

Reference: Hoffman et al. *Proc Natl Acad Sci USA.* Apr 2016
doi: 10.1073/pnas.1516047113

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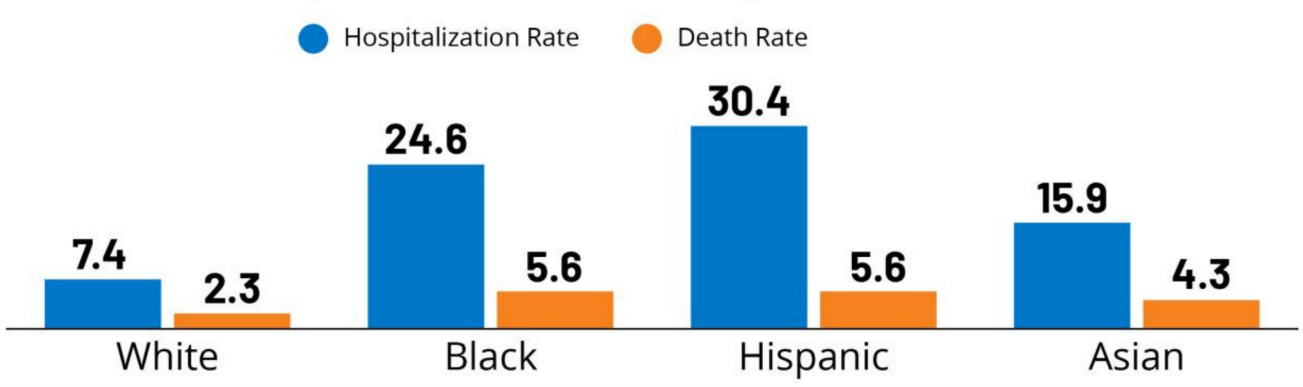
Table 1. Misrepresentation of Race in Preclinical Curricula.

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[16] 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[17,18]
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[19-21]

COVID-19 Hospitalization and Death Rates among Active Epic Patients by Race/Ethnicity

Rate per 10,000, as of July 2020



	White	Black	Hispanic	Asian
Total Active Patients (millions)	34.1	7.0	5.1	1.4

NOTE: Rates for Black, Hispanic, and Asian patients are statistically significantly different from White patients at the p<0.05 level.
Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic.
Data for other racial groups not shown due to insufficient data.
SOURCE: Epic and KFF analysis of Epic Health Record System COVID-19 related data as of July 2020.

KFF EPIC HEALTH RESEARCH NETWORK

HEALTH DISPARITIES: DIFFERENCES IN THE:

- INCIDENCE,
- PREVALENCE,
- MORTALITY, AND
- BURDEN
- OF DISEASES AND OTHER ADVERSE HEALTH CONDITIONS THAT EXIST AMONG SPECIFIC POPULATION GROUPS IN THE UNITED STATES (NIH DEFINITION)