Sarah Alger: Welcome to Proto, a podcast that explores the frontiers of medicine. I'm Sarah Alger.

Dr. Joseph Beta...: And I'm Dr. Joseph Betancourt. Right now, our nation is reeling from two consecutive tragedies. One is a pandemic that we were not prepared for. The other is the aftermath of George Floyd's death, which has triggered rage and frustration at the deep seated racial inequality in our country.

Sarah Alger: Are these two entirely distinct events or do they overlap? Those protesting for Black lives have had to reckon with the risks of coming together during a pandemic and the danger it poses to their own health. And the pandemic itself has begun to show fault lines along race and ethnicity, the result of years of structural bias in healthcare.

Dr. Joseph Beta...: The nation is having a difficult discussion about race and class and medicine needs to be a part of that. We'll explore in what we've learned about inequality in healthcare, how it plays into the COVID-19 pandemic and what we could do to bring enduring change.

Sarah Alger: A tale of two pandemics. Coming up on this episode of the Proto Podcast, brought to you by Massachusetts General Hospital. It may be true that a virus does not discriminate, but we know that viral epidemics have disproportionately hurt minority groups for as long as that kind of data has been collected. Native Americans died from the 1918 flu pandemic at four times the rate of other groups. During the H1N1 pandemic in 2009, Latinos in California were twice as likely as Whites to become ill and die. And the prevalence of HIV among African-Americans today is seven times higher than it is among Whites.

The reasons for this are complicated, rooted in enduring racism and its effects on economic opportunities, housing and healthcare. So it should come as no surprise that this disturbing trend has continued in the COVID-19 pandemic. In Chicago, to take one example, African-Americans make up 29% of the population, but account for 70% of COVID-19 related deaths. How can we make our society and healthcare more fair? And how can we quickly apply those lessons to a pandemic that has already killed 100,000 people? I'm speaking with Dr. Joseph Betancourt, a physician who in 2019 was named vice president and chief equity and inclusion officer at Massachusetts General Hospital. He has been on the front lines of the COVID-19 pandemic, trying to identify where underserved populations are at risk and where possible, trying to make their care more fair. Dr. Betancourt, welcome.

Dr. Joseph Beta...: Thank you so much, Sarah.

Sarah Alger: At the beginning of the pandemic, what are some of the ways that underserved communities, especially the Latino and Black communities, were particularly vulnerable to COVID-19?

Dr. Joseph Beta...: That's a great question. Coming into the pandemic, we clearly understood that and history has been our guide, that vulnerable populations always suffer disproportionally from disasters. And we anticipated that this pandemic was going to be no different, particularly because the information we got about COVID-19 was that it had a disproportionate burden as it relates to poor health outcomes among those with chronic conditions. And we know that minority populations entered this pandemic at a disadvantage with a greater burden of heart disease, diabetes, asthma, and other chronic conditions. So I think they entered with a disproportionate burden of disease, which put them at risk for poor outcomes, limited access to healthcare, certainly, and living in environments that we would consider difficult from the standpoint of social determines.

Sarah Alger: And so how have you seen that play out in the Boston area?

Dr. Joseph Beta...: It played out, unfortunately exactly as we predicted and I wish we could have been better at predicting it, to be honest with you. And then you think about what our recommendations were to prevent the spread of COVID. These populations were the canary in the coal mine. They were at risk right from the start. Why? Well, certainly we talked about socially isolating ourselves. These communities, primarily working class people, couldn't do that. They were essential workers. They had to take the bus and the train. So they couldn't drive their car on their own and park and kind of isolate themselves, even as they traveled. So, that increased the risk, traveling shoulder to shoulder in public transportation.

Certainly, they couldn't get groceries delivered and couldn't work remotely. So all those factors, the social conditions for, that made the spread of COVID-19, I think exponential, really disproportionately impacted these communities in very significant ways. And these are exactly where we saw hotspots across the state and certainly across the country.

Sarah Alger: Are there any ways that we traditionally deliver healthcare that are just a bad fit for the needs of these groups?

Dr. Joseph Beta...: Absolutely. I think this pandemic really unearthed these and it gave us a chance, quite frankly, in a short amount of time, to try to fix as much as we could. And we hope these lessons we learned can be deployed in the longterm and more so, we hope we've plugged some of these gaps. But they begin with, I think, first communication. In a pandemic of this nature, communicating frequently as information changes, but doing that in a language that people understand, doing that with a trusted messenger is really, really critical. And you can't over-communicate. I think that's something that we don't do well as a healthcare system and certainly, even as a public health system, it tends to be more an afterthought. Hey, can we translate that activity? Can we think about getting a Spanish speaker to do this? And I think the key lesson is here. How do we think about communicating and democratizing communication to communities in these ways, right from the start.

Sarah Alger: As this first wave subsides, are there other techniques or lessons we can file away for potential future outbreaks?

Dr. Joseph Beta...: Yeah, absolutely. I think we're considering this kind of next bit of work in three phases, kind of this what we call peri-COVID phase, which is one of the things we still need to do right now to make sure that the fires in these communities are really out. Then the reopening, what do we need to do to get people back safely? And then third is lessons learned. And I think from the lessons learned standpoint, a lot of the clinical innovations that I mentioned, those are things that we want to sustain. But I think from a surveillance standpoint, we know that number one, this virus hasn't gone away. And number two, these communities are still at risk because all those factors that I mentioned haven't changed for them. Right? And they've probably gotten worse. Food insecurity is worse. People are out of work.

And so there's housing insecurity, issues of domestic violence where people can't isolate now that they've been kind of together in these spaces, are all worse. So these social determinants are all worse. And so I think it's critical to be able to understand that we need to continue to address those, but provide real surveillance to make sure that we don't develop brush fires in these places where we've been successful enough in helping put out these fires. And so as we go forward, it's creating surveillance, acting quickly, moving fast. Ultimately, these communities were the canary in the coal mine. These individuals were told, "You don't have to wear a mask," when they were taking the train and the bus. And common sense told them that they probably should be wearing a mask. So we've created some mistrust there that we need to really address and rebuild. As we think about the next surge, communication's going to be key.

Sarah Alger: So when you say people weren't wearing masks for a long time, what was that a result of? Was it information through social media or health authorities or others?

Dr. Joseph Beta...: So let me be clear about this. Early in the pandemic, health authorities, the CDC across the country were saying that people, no one should be wearing masks and the masks weren't needed. At that time, myself and my colleagues were going down and doing educational sessions for individuals who work in materials management, environmental services, nutrition and food services. These individuals primarily are minorities or they're individuals with limited English proficiency. And they live in a lot of the hotspot communities that were ravaged by COVID, that we've talked about earlier.

And at that time, when we would share information about infection control strategies early in the pandemic, and we were communicating to them that the going guidelines and recommendations were, wash your hands, cover your cough, clean surfaces. We were telling them how it was spread very easily through cough or sneeze and droplet. Their question early on was, "If you're telling me it's spread so easily, I'm on a train and a bus that's incredibly crowded. Shouldn't I be wearing a mask?" And ultimately, a few weeks later as the pandemic really picked up and the surge hit, our national guidelines changed. And the guidelines became that everybody should be wearing a mask, indoor and out.

And so those communities are left feeling like, wow, when we were really at risk, the going recommendations were to not wear a mask. Now that we've been ravaged, now that those lessons have been learned, everybody else is wearing a mask. So, these are the types of lessons, I think, that make us understand how mistrust is created. And I think that's an important lesson for the future, especially as information changes and people's conditions are different. So this mass lesson, I think, has been one that's been really, really important for us.

Sarah Alger: Thank you so much. Coming up, the death of George Floyd unleashed a flood of emotion about inequality in this country. What lessons should medicine be taking from that?

Dr. Joseph Beta...: Next on the Proto Podcast, brought to you by Massachusetts General Hospital.

Sarah Alger: On May 25th, George Floyd was killed by police officers during an arrest in Minneapolis. The protests sparked by that senseless and violent act have taken place every day since, and are ongoing at the time of this podcast recording. Their target is the structural bias that African-Americans face from law enforcement and the criminal justice system. But to what degree is this kind of structural bias also present in healthcare? And what can we do about it? Proto editor, Jason Anthony, discussed this with Dr. Dayna Bowen Matthew.

Dr. Matthew is a professor of public health sciences at the University of Virginia school of law. And as of July, will become the Dean of George Washington University law school in Washington, DC. Her contributions to healthcare policy have been considerable, including work with the Brookings Institution, the Robert Wood Johnson Foundation and the Congressional Black Caucus Foundation. She's also the author of Just Medicine, A Cure for Racial Inequality in American Health Care.

Dr. Joseph Beta...: Dr. Matthew, welcome. The world has been shocked and mobilized by the death of George Floyd and others over the past few weeks. But you've said that there were actually 84,000 people who die every year from racial bias, if we look at the healthcare system. What do you mean by that?

Dr. Dayna Bowen...: What I meant by that number, it's an estimate that actually is empirically supported by Tom LaVeist's work and David Williams' work, so many others' work that suggests that because of racial bias within the healthcare system itself, we have unnecessary, preventable and avoidable deaths. These are excess deaths due to illness that could be prevented if people had equal access to healthcare and equal quality healthcare for the various diseases and maladies that they experienced, but do not because of their race or ethnicity.

Dr. Joseph Beta...: There's a lot to say about bias within the structures of healthcare and you outlined these in your book, Just Medicine. But for our listeners, I wonder if you can walk us through what we mean by bias in the clinical encounter itself, in the meeting between the practitioner and the patient.

Dr. Dayna Bowen...: So bias can manifest in a couple of ways. One, we have seen that the prejudgment and the stereotypes that providers of all sorts, not just physicians, but nurses and dentists and PAs, and even the staff at a healthcare provider, because we live in a world where the messages that we get about people's race are so completely biased in their own right. They're negative and they're limited, and our segregated society doesn't permit contact across racial lines. We are divided physically from one another. So we use those stereotypes, those messages that we get from our music, from our newspaper, from our television, from our political discourse, we use them as heuristics for how we will interact with people and how other people will interact with us.

So at the very sort of basic level, at an individual level, I may walk into a physician's clinic and I, as an African-American woman, will send signals that call up these heuristics, these stereotypes. And I'm not dealt with as an individual, and the studies show that the interaction between me and the provider, whether it's a nurse or physician in my example, will be different than it would be if I was a white person. Or if I was a white male, in particular.

It may compromise the communication between us. I may be asked fewer questions. I may be credited less fully with my account. Examples in my own research include Black women not being believed for the level of pain that they have or not being engaged in conversations in which they weren't, in which the physician was verbally dominant. And didn't give them an opportunity to give full information for their background, and that could compromise the care.

Dr. Joseph Beta...: And in fact, your book is filled with chapter after chapter of these frankly horrifying studies on how racial bias has been shown to play a measurable role in diagnosis, in treatments, in follow-up, in trust of what patients say to physicians and what physicians will ask their patients. And one of the main takeaways of Just Medicine, it appears to me, is a quote from one of your talks. We should be looking for and thinking of interventions that are directly intended to treat the disease of racism. So what can practitioners do to counter that disease of racism in the healthcare system and in society at large? What does that look like?

Dr. Dayna Bowen...: I so appreciate that question, Jason. That is what I am hoping the change in healthcare will be as a result of our awakening to structural racism in America. The change in healthcare has to be that we see racism as a fundamental cause of poor health outcomes. That is, racism actually is a risk factor for poor health outcomes. And as a result, the responsibility to address the structural racism upstream that is affecting the social determinants of health does not lay solely with politicians or sociologists or housing experts. But it is a part of a public health and a comprehensive healthcare solution to the health problems that have produced the underlying comorbidities, for example, that made Blacks and Browns predisposed to disproportionate death from the COVID pandemic.

102, 103,000 people in the United States have died. 23% of them are African-American. We represent 13% of the population. The explanation that we are predisposed because of the prevalence of comorbidities like heart disease and diabetes is a structural problem that is ascribed to racism, not simply bad diet. So what would it look like? It would look like healthcare providers becoming active in the structures like poor and substandard housing, substandard access to education, disproportionate, low wage representation for Black and Brown people. These are health, as well as social issues. And we must dismantle the silos that artificially separate those social determinants of health from biological determinants of health.

We have to teach medical school differently. We have to compel providers to engage differently, and we have to break down the silos that allow one of those problems not to touch and talk to the others of those problems. Therefore, all of these are public health issues that healthcare providers should be involved in equalizing, should be involved in dismantling racial discrimination and racism. And that's the change I would like to see as a result of this moment. There is so much to do and so much structural inequality for all of us to pay attention to. The message I would like to leave with healthcare providers is one of hope, that if you will begin to enlarge your view of your role, if you will begin to enlarge your view of what affects patient outcomes and align yourself as providers with the upstream needs, with dismantling the disproportionality of access to the social determinants of health.

If you will speak out against the discrimination that makes it impossible for your patients to take your advice, that is, to go out and get exercise or to eat better. If you will begin to address those as structural issues and not leave those for simply the lawyers, who are trying to work for legal change, then together, our voices will be heard. Together, we can make structural change. If nothing else has been made clear through this pandemic, it is that we are interconnected and our lives and our health all depend on dismantling inequality and racism together.

Dr. Joseph Beta...: Dr. Matthew, thank you so much for your time today.

Dr. Dayna Bowen...: You're welcome. Thank you for asking me.

Sarah Alger: I'm here with Dr. Joseph Betancourt, chief equity and inclusion officer here at Massachusetts General Hospital. I'd like to ask you for your perspective on the protests around the death of George Floyd. This was a wake up call for so many of us about this systemic mistreatment of the Black community. Has the healthcare system played a part in this double standard in delivering different or worse care?

Dr. Joseph Beta...: I spent a lot of time, most of my entire career studying racial ethnic disparities in healthcare. And certainly, I think what we understand, without a doubt, is that the issues of our nation's history. People talk about the term structural racism. I think it's important to understand that many of the issues we face today are a result of a long and winding set of deliberate policies and actions that ultimately limit the advancement and wellbeing, particularly of communities of color. And African-Americans and the Black population in particular.

What we've seen around the demonstrations related to George Floyd, I think ultimately our manifestation of just incident after incident, after incident. And this potential energy, really, that was pent up with two incidents that really weren't covered, or didn't make headlines as much, around Breonna Taylor and Ahmaud Arbery. Three in a row of these, I think really on top of the pandemic, disproportionately impacting communities of color. People being at home, it really led to kind of a scream, that's enough. And in healthcare, we are not immune to this. We have seen for probably over 100 years, but even more recently in the last 30 years, a robust set of evidence in some of our top journals that clearly indicate that if two people present to the emergency room, any emergency room today, with chest pain, there is a great likelihood that the individual who is Black or African-American or Latino or a minority may receive a lower quality care than their white counterparts.

They may not get referred for cardiac catheterization, angioplasty, bypass surgery, cardiology specialist care. And that's just one of probably hundreds of examples of what we call racial and ethnic disparities in healthcare and the quality of care that patients receive. And while we've tried to say it's due to multiple factors, which it is, including mistrust and difficulties with communication, and certainly issues related to stereotype. Again, bias and assumptions about patients that shaped clinical decision making. We also need to understand that there's a lot of hidden structural racism in our healthcare system that kind of sets the pace, sets the tone, sets the standard for these issues happening. And for us, allowing them to continue to happen and not being more bold and courageous and eliminating it.

Sarah Alger: So as we've watched the protests occurring across the country, what kinds of discussions have those sparked among your colleagues?

Dr. Joseph Beta...: There's no doubt that I believe we're at a tipping point. I think this incident in particular, coming on the heels of the pandemic, impacting communities of color, coming on the heels of Brionna Taylor, coming on the heels of Ahmaud Arbery, has just really led to this incredible sense from everyone of how these injustices can no longer be tolerated. And people are standing up in ways that I think I certainly haven't seen in my lifetime. I think there's incredible potential here to drive in some real significant changes.

So the conversations we're having, they're anger, frustration, sadness, exhaustion. They kind of run the gamut of emotions and they run the gamut of emotions depending on who you are. Because Black people are just, they're like this isn't anything new, but we've had enough. White people, who have seen this, say, "Boy, I've literally watched somebody's life ended in front of my eyes." Coming off the heels of us and healthcare, doing everything we can to save every life. And ultimately, this idea of I can't breathe. I mean, that's exactly what happened with COVID and we fought tooth and nails, the healthcare community, to help people breathe. And to watch somebody deliberately do that, I think has really activated the nation and the world, I'd say, to a call for justice and change.

Sarah Alger: Is there any concern that the protests might play into a next wave of COVID-19 infections? And if so, is there any way to get ahead of that?

Dr. Joseph Beta...: It's a really interesting question. I think it's a question that's being asked and it's a concern that's being raised. And it's fascinating because I find this kind of a full circle, right? These communities of color came into this with disadvantages based on issues of structural racism, classes, and some of the other things I mentioned. They were disproportionately impacted. And now, here we are, and they're protesting the same disadvantage. And many are saying, "Well, you're putting yourself at risk." It's a challenging question because many are saying, "You know what? I mean, we get killed by police. COVID, it's the last of my concerns right now. I want justice." And so do we believe that a lot of people in a small space, even with mass, increases the risk of transmission of COVID-19? Certainly, it increases the risk. There's no doubt.

Is there a way to protest, such that we could mitigate that risk? Yes. Everybody can wear a mask. Everybody could make sure they're not touching each other. Everybody could try to social distance. Is that really difficult and in some ways unrealistic to expect? It is, and this is what we're left with. I guess I just really would hate for the narrative to be that the rekindling of the COVID-19 pandemic was coming as a result of people behaving irresponsibly. When in fact, the most irresponsible act in the last week was the murder of George Floyd, which has really spurred this incredible amount of activism. And I think that's what we really need to be concerned about.

Sarah Alger: So given what you've seen in the course of your career and what you've seen even in the past couple months, are you hopeful or pessimistic about the decade ahead?

Dr. Joseph Beta...: I'm really hopeful about the next two weeks. I believe we have an opportunity in the next two weeks, as our nation is expressing a collective kind of sense of outrage and a scream for justice. I think we have an opportunity to really be bold and courageous about a lot of things related to racism, both outside the walls of MGH and inside the walls, quite frankly. On the outside, I think we are, and we'll be fighting for racial justice in ways that might've taken five to 10 years to accomplish now, at a fever pitch. And I think we will be able to get a lot of things done, given this tipping point.

On the inside of MGH, we have incredibly caring, committed people who just rally to the care of vulnerable communities, who are disproportionately impacted by COVID in our beds, on our ventilators. Incredible efforts that I was a witness, as a caregiver myself on the inpatient floors. But we still have inequality inside our walls that we need to better understand and root out. And so in the next two weeks, we wanted to be big, we want to be courageous. We want to kind of rip the band-aid completely off and say, "Now is the time to look under every rock, under every crevice. Look around every corner for where any kind of a whisper of structural systemic racism is playing any role in inequality, and the care of the people going through our doors. And root it out, develop a plan to address it."

And this is the excitement that we feel. We're tired, we're frustrated, we're sad, we're angry, but we're not defeated. And we're looking at this as an opportunity to really make sustainable change. But kind of like COVID, every second counts and we're moving fast to build some sustainable changes into our society and certainly into our healthcare system.

Sarah Alger: Dr. Betancourt, thank you so much.

Dr. Joseph Beta...: Thank you so much for having me and for this great conversation.

Sarah Alger: And listeners, thank you for tuning in to the Proto Podcast.

Dr. Joseph Beta...: Today's podcast was produced by Emily Silver, Bradley Klein and Jason Anthony.

Sarah Alger: Thanks also to our technical directors, Adam Keller and Chelsea Andies. Subscribe to the Proto Podcast on iTunes and Stitcher and follow us on Facebook, Twitter, and Instagram. Stay safe and see you next time. (silence)