Welcome to Conversations about Care, a podcast for pediatric clinical providers.

Dr. Hassink Hi. This is Sandy Hassink and I'm the medical director for the Institute for Health Childhood Weight at the American Academy of Pediatrics. Today I'm particularly excited to share a conversation with Dr. Joe Wright.

Dr. Wright is the Chief Health Equity Officer for the University of Maryland, a current member of the board of directors for the Academy of Pediatrics and is the chair of the boards committee on equity.

Recently, the Academy published a statement on eliminating race-based medicine which Dr. Wright was part of, and he shares some highlights from that new policy statement as well as how we as pediatricians can continue to elevate such topics within our practice, to help move the needle towards equity in health care for all children. Stay tuned to hear our conversation.

Joe, welcome. We're very delighted to have you with us here today and I wanted to ask you, you've done so much work on equity and you were a lead author on the policy. How did you come to this particular work?

Dr. Wright Well, thank you, Sandy, and thank you for having me on the podcast today.

Well, let me just start with the -- I think, the obvious, as a card carrying member of the American Academy of Pediatrics equity has certainly been part of the DNA of our organization for some time. What has evolved though over the course of the last few years is a concerted effort to actually execute on our promise to deliver and develop equitable systems of care for our kids. So from the standpoint of the professional work that I've been doing as a -- both a board member and actually chair of the board committee on equity, this is where I find myself professionally.

But I also want to stress that it's important for all of us to see ourselves in this work. And certainly from the standpoint of my own lived experience, this has been important to me and it certainly impacted my career as well as my life as a -- as a husband and father, and certainly, this is close to home personally. So the ability to bring all that together at this point is something that finds us where we're having this conversation today.

Dr. Hassink That's Joe. And for our audience, we're going to talk about the policy briefly, but then really hone in on the intersectionality of the policy and our work in obesity, and maybe some of the commonalities that we all face in addressing obesity in terms of weight bias and stigma and race.

And so Joe, I'd like to just have you start with giving us a primer of our new policy.

Dr. Wright Certainly. And what I'm going to do -- I will describe what we mean when we -- when we say race-based medicine and the elimination of race-based medicine. But I'll also share an example that I -- I think all of our members need to be aware of that -- that makes it clear what -- what we're doing here.

So there has been a long history in medicine and in our country of using race as a biologic proxy. And what I mean by that, race is a social construct and race has been used to -- to separate and define populations and -- and in medicine it's been used as a biologic proxy that has been incorporated into practice guidelines that drive care. So this is an inappropriate use of race as a biologic proxy and so it -- when we talk about the elimination of race-based medicine we're talking about the dismantling the inappropriate use of race of a dichotomizing or determinative variable in driving clinical care.

The example that is probably top of mind for most pediatricians and that has been the poster child, for lack of a better term, to highlight this is the clinical practice guideline around management of urinary tract infections in young children. This is a clinical practice guideline that was published in 2011, it was actually reaffirmed in 2016, and had recently come under scrutiny because the -- the clinical practice guideline has, as a decision making point, as part of the actual clinical algorithm whether a child presenting is black or white. And if that child is Black, investigators made a determination that there was a lower risk for urinary tract infection and thereby that child did not need a catharized urine, just to simplify the -- the actual impact on tear.

Well, it turns out that there is no evidence or no explanation for the risk differential that the office determined to use in incorporating race as a variable in that decision making. And I'm happy to report that because of the work -- the recent work around eliminating this kind of variable in not only this algorithm but others, the authors have gone back to the drawing board and recently published, just in June in fact, an updated UTI calculator which is eliminated the use of race as a determinative variable, and replaced it with two clinical variables, that being history of fever or fever of greater than 48 hours or prior UTI.

And so this is exactly what we're striving for, to -- to really do the work of incorporating meaningful clinical variables as opposed to lobbing in race when we don't necessarily understand what the difference -- epidemiologic difference may be. So I'm -- I really credit these authors, these investigators, for going back to their original science and building in meaningful variables that -- that we, as practitioners, can use. And in fact the calculator -- they report that the calculator performs as well -- as well without the race variable and with the addition of the two clinical variables, as I mentioned, as was reported in the original calculator.

So long winded answer, but this is -- and let me be clear. I used a pediatric example, but these examples are throughout medicine. Many, many examples. Perhaps one -- one other I'll mention briefly that also has got a lot of attention, very high profile, is the risk classification for chronic kidney disease. And the fact that for decades there has been a risk adjustment based on race in calculating the -- something called the Glomerular Filtration Rate, the estimated GFR, and we're familiar with that from -- from medical school and training, but guess what, all of that training, all of that -- for all of us included -- a race corrective factor that found black patients with chronic kidney disease presenting later and  -- and in most cases, in more advanced stages of disease than white patients based on this erroneous -- this erroneous, unsubstantiated calculus that was used to justify, and I won't get to the technical details, but it was based on a belief that black patients had a different skeletal mass than white patients. And that explains the difference in creatinine and thereby when you -- when you compare the calculation of the EGFR, Black patients did not need to be referred for instance to advance kidney care, or in the worst case scenario, to transplantation at the same level of disease as white patients.

So that, again, I gave two examples; one pediatric, one, obviously, we have children with chronic hidden disease as well. So Sandie, that's the technical application of race-based medicine, two examples, and we have a heavy lift ahead of us to unwind what has historically been imbedded in the practice of medicine for a long time.

Dr. Hassink So Joe, thank you. I really appreciate your explanation. And I often think about race as we do our work in obesity because many, many, many studies, maybe all previous studies, have looked at the prevalence of obesity by race, which is a demographic variable. But if we stop there, it really represents a barrier to our understanding of the underlying context and risks of that particular child and family. And so -- true, there are vulnerable groups that have higher rates of obesity, but allowing yourself to, sort of, attribute that two ways, prevents you -- prevents me, as a clinician, from really understanding what about that child and family, what about that environment that they're living in, and the stressors to which they have been exposed is contributing to obesity. So it's not exactly what you said, but it does bear real thinking about. How we're thinking about race as applied in what we're discussing today in understanding race in the context of the data on obesity.

So do you have any thoughts on helping us do that? To me I look at race and I think, yes, true, but not helpful. Helpful is understanding that child is -- might have food insecurity or might not be able to get physical activity or might have been a child born of a mom who had gestational diabetes. Do you know what I -- do you see where I’m going with this?

Dr. Wright Yeah. Yeah. And something you said that is very important for us to understand -- we cannot ignore race. Let me be clear.

Dr. Hassink Right.

Dr. Wright When we talk about dismantling or eliminating race-based medicine we're talking specifically about the use of race as a biologic proxy. What you're describing is -- highlights the point that we can't ignore the impact of race on lived experience, in many cases differential lived experience for our patients. And in fact, we must continue demographically to track what race may represent, or race assignment may represent in terms of the experiences of -- of families who maybe suffer with obese or overweight children or that characteristic in their family. Because, in fact, we know -- we know that there are many attributable consequences that result from bias and discrimination, they may be based on race, they may be based on being overweight and that does impact outcomes.

So what you described is a perfect example of how we need to be aware, and particularly from the standpoint of the intersectional contribution of either stress or -- or negative experiences on children and their families, based on race, based on other attributes, so we have to be cognizant. And the term that I'm -- that we're introducing, Sandy, is that we have to be conscious of what race means. We -- we cannot base our approaches on race as an independent factor, but we do have to be conscious of what race means in terms of what our families are experiencing. Historically, can't ignore the contributions of race with regard to its impact on access and other factors.

So it is very important to make clear, and I'm glad you -- you put it in that -- in that context. We can't -- this isn't inappropriate characterization for two pediatricians to -- or for this pediatrician to say, but we -- when it comes to race we can't throw the baby out with the bath water. We're not -- we absolutely must continue to be conscious of the impact of race on our -- the lived experience of our families.

Dr. Hassink So Joe, now you're making me think of two things. One is race as sort of a barrier to further understanding and the other is racism itself as a stressor similar to what we have talked about with weight bias and stigma that is an actual physiologic trigger to hypothalamic pituitary activation and chronic stress which you can draw a straight line from that to the propensity for obesity at -- in a person and a child who has undergone any number of chronic stressors. I think it's important as we're thinking this through to think about that as well. That racism -- the effect of the toxic effect of racism is a physiological one as well as a psychological one and all the other effects it has. How -- how are you thinking about that?

Dr. Wright Yes. And again, you're highlighting another important point for our members. It is racism, not race. Let me say that again. Racism, not race. And we have to think about the impact of discrimination and bias on not only the lived experiences of families but as you mentioned, on the actual disruption on psychological pathways that you referenced.

And not only that, we're also learning, and this was a science that was not around at least when I was coming through training, the epigenetics, the impact, the historical or intergenerational transmission of the stress that you referred to, not only can impact the individual directly, but may have downstream intergenerational impacts on families. And we see this, obviously, we're learning that the chronic stress in particular can actually impact at the level of DNA, at the cellular level, and be transmitted from generation to generation. A newer science, obviously, that certainly I am learning more and more about, but to your point, it highlights the fact that we must be cognizant not just of the -- the psychologic impacts of being exposed to bias, discrimination on a daily basis, but also the long term impacts that historically mediated racism for instance can have on future generations.

Dr. Hassink So you're making me really think about all our thinking about race, bias, and stigma and how that similarly impacts families and mothers and babies in terms of stress. And the (indiscernible 0:17:03) commonalities between and people experiencing weight bias and stigma as well as racism. It's just additives. Now you have, you know, a cluster of factors that are just increasing the stress. As well as inhibiting many times access to care and triggering tremendous biases that people may not even recognize they have in terms both of weight bias and stigma and racism.

So one of the things we've been asking pediatricians to do in the -- in terms of weight bias and stigma is trying to be reflective in themselves and understand that there is an implicit cultural bias about obesity. And even take some of the implicit biases tests to just understand where they're coming from. Not in a blame scenario but just understanding that we all are products of our culture and bring some of these things into our interactions with patients and we need to understand that. Doe that resonate with how you're thinking about helping people with understanding racism and the impact of racism?

Dr. Wright Yes. Sandy, you're hitting all the -- you're hitting all the points that we need to be making in terms of socializing this content with our members. Yes. We all have biases. We all have implicit biases that are a function of our own lived experiences. What I'm encouraged about, however, is that some of the more recent explorations into how implicit biases may manifests in terms of -- of how we treat our patients in clinical care may actually be amenable to change. And, you know, one of the challenges that I will often get is that, well, implicit bias, isn't that unconscious? You know, what can I do about that? Well, in fact, some of the work that's been done by some members of the -- of our organization have begun to look at the awareness of what one's own implicit biases are through mechanisms like you said, like the implicit association test and others. And what we're finding is when clinicians are made aware of their own biases, in particularly when those biases result in differential outcomes, some of the more high profile work has been done around pain management and recent publications have demonstrated very clearly that implicit bias certainly plays a part in the use of pain relief for kids who have appendicitis, long bone fractures. Many studies have been done in adults but more recently in kids that has been shown. And -- and so what has encouraging is that by showing people what their biases are in a very codified way. And then also leaking it, and this is the next frontier if you will, of work we need to do. Linking the outcomes of implicitly held biases to deleterious outcomes. No one is going to be able to argue that, again I'll use the pain example, not reliving -- adequately relieving pain in a child with appendicitis is the correct thing to do.

So awareness around implicit bias at least is -- is seemingly a pathway for change, for people to be aware, to bring that from the unconscious to a conscious level of practice. So people are thinking about it, and this is work that is yet to be done, but again, you make the point that the first step is for all of us to admit that we -- we hold biases and some of them may be implicit and that need to be explored. And so yes, you're absolutely right that the first step is for our members to just acknowledge that we all hold biases and that's -- that is just part of being human beings in our society.

Dr. Hassink You know, Joe, and I'm -- I'm thinking now one of the things that's important in -- in addressing, or helping, patients and families with obesity is we have medication, we have surgery, but the core here is helping them achieve a healthier lifestyle. And one of the things I'm really thinking about as we're talking about is these biases, both weight and race, can lead to judgments and judgments lead to, I think, not being nearly as effective as helping your patients change their lifestyle. So we're trying to really get to a judgment free zone, that place of understanding and -- in thinking about weight bias and stigma and racism.

One of the toxic effects is it can lead to making judgments about patients in an arena where we can't afford to make judgments. We have to really work toward achieving understanding and partnering with the patients.

So how would you help us, Joe, approach our patient here? Like do we talk about race? What do we do when we open the clinic door -- how do we approach this? I get this question a lot with weight bias and stigma. You know, we -- we address it with our patients, we acknowledge that kids may have been teased and bullied about their weight and often the kids don't even tell their parents this is happening and it's illuminating for all of us. How do we -- how do we help -- how do we do this work that we need to do around racism?

Dr. Wright Well again, you're hitting on a very important intervention that we -- we actually have the 0:23:20 to apply. So when we think about the rudiments of longitudinal care, bright futures for instance, racial socialization needs to be a part of that longitudinal relationship that we have with our patients and their families. So yes, we do need to talk about it, we do need to begin to -- children experience -- the research shows -- begin to experience bias in a very early age. And so we must incorporate, thereby we must have our -- our colleagues, all of us, be aware of the rudiments of -- of racial socialization in this country so that means that we all have to come up on our learning curve to be able to speak to -- knowledgeably -- with our families and our patients about what they are experiencing and to do so in an open ended fashion so that the -- the patients have an outlet for even understanding what they are experiencing. And -- and so I'm encouraged -- part of the -- one of the objectives, one of the goals, of our equity agenda at the Academy is to formally incorporate racial socialization into bright futures so that our -- our office based pediatricians in particular, have a guide, if you will, to assist in the relationship -- longitudinal relationship -- I keep emphasizing that because clearly this is a developmental process the way that kids and families experience bias, experience stigma, and being able to help requires all of us to come up to speed on what that means as well. So we're -- we're in the middle of a cycle of the revision of bright futures and so we are working towards formally incorporating what you're describing into Bright Futures on the go -- on the go forward.

Dr. Hassink Joe, I'm really happy to hear that because we're all looking for, you know, practical ways to help our patients. And we're -- we're winding up our podcast today, and is there anything that you would like to leave our members with as we close out this podcast?

Dr. Wright Well, Sandy, what this conversation today has had me realize is that we -- we have been discussing the impacts of bias and discrimination largely through a race ethnicity lens. And that's appropriate -- very appropriate particularly given the events of the last several years and the -- the focus on -- on anti-Black racism in particular. But -- but what we are -- we have to be very cognizant of is that children experience bias in many different ways. And that for -- and for many different reasons. And certainly that construct of intersectionality there may be discrimination coming at children from a variety of directions for a variety of reasons based on a variety of phenotypic attributes. And that's real life. And so when we think about how we -- how we engage our members, we have to do it through -- from a real life frame. And look, I have been a Black pediatricians all of my professional life and I have been a Black man all of my life, but there are many, many experiences that are a function of -- of other things that I do, other attributes, other unique components of my family, etc., that all weight into the experience that I have. And -- and I think that that's -- we have to have a healthy respect for difference, the importance of difference, the synergy of difference. We collectively add up to a whole that's greater than the individual sum of our parts and that's -- that's something I want to leave all of our members with, that there is real value in appreciating the -- the differences that all of us bring to the table including our patients.

So Sandi, again, I appreciate the opportunity to have this conversation today and it's certainly been enlightening for me as we thing very strategically about how we engage our members in -- in what can be difficult conversations.

So thank you.

Dr. Hassink Yes. So thank you, Joe, and I really look forward to your work and the further work of the Academy on this really important topic. So thank you very much.

Thank you for listening to my conversation today with Dr. Wright. As you heard, Joe has been doing equity and health equity work on behalf of children for a long time and there are several takeaways from this conversation. But the one I'd like to highlight is the importance of looking beyond prevalence of disease by race alone because stopping there creates a barrier to our understanding of what is the lived experience of our patients and the intersectionality between race, and in this case, obesity.

I also want to call your attention to resources that may be helpful: Eliminating Race-Based Medicine Policy Statement, Stigma Experience by Children in the Adolescence With Obesity, and the AAP Equity Agenda.

This information, resources, or opinions expressed during the Conversations About Care Podcasts series are solely those of the individuals and do not necessarily represent those of the American Academy of Pediatrics. The topics included in this podcast do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations taken into account individual circumstances may be appropriate. The primary purpose of this podcase is to explore common themes related to quality pediatric care from the perspective of clinicians. This podcast series does not constitute medical or other professional advice or services. This podcast is available for private, noncommercial use only. Advertising, which is incorporated into, placed in association with, or targeted toward the content of this podcast without the expressed approval and knowledge of the American Academy of Pediatrics podcast developers is forbidden. You may not edit, modify, or redistribute this podcast.