



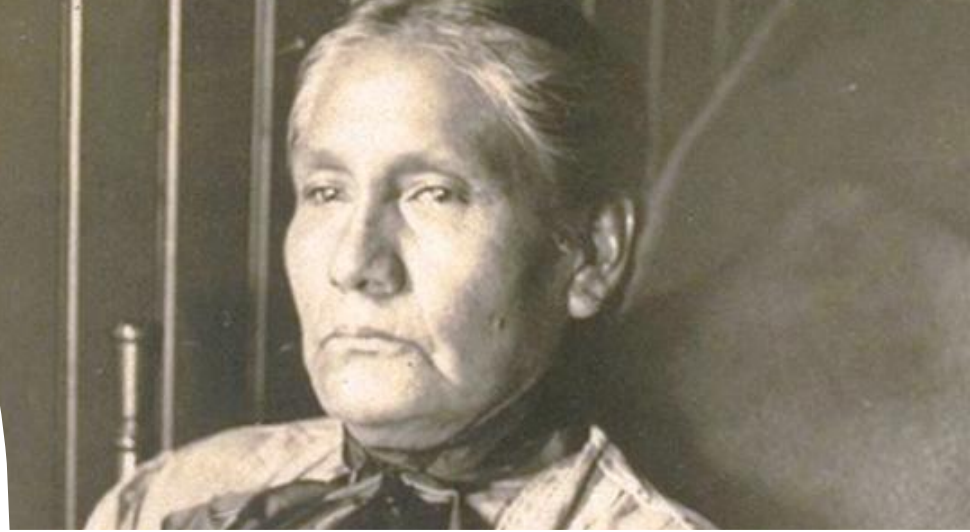
Operationalizing Racial Justice

Doctors for America's Grand Rounds Series
May 2021

Aletha Maybank, MD, MPH
Chief Health Equity Officer, SVP
American Medical Association

Land and Labor Acknowledgement

We acknowledge that we are all living off the stolen ancestral lands of Indigenous peoples for thousands of years. We acknowledge the extraction of brilliance, energy and life for labor forced upon people of African descent for more than 400 years. We celebrate the resilience and strength that all Indigenous people and descendants of Africa have shown in this country and worldwide. We carry our ancestors in us, and we are continually called to be better as we lead this work.



March 2020

EVEN IF RACISM IS A
PUBLIC HEALTH THREAT,
I DON'T SEE OUR
ORGANIZATION HAVING
TO TALK ABOUT IT OR
CHANGE ANYTIME SOON.



COVID-19

TOM
FISH
BURN

© marketoonist.com

“Racism is, perhaps, America’s earliest tradition. Its practice pre-dates the founding of the nation, as settler colonialism and Indigenous genocide powered the land theft that established the United States. And enslaved humans were the capital that generated this stolen land’s economy. In spite of centuries of legal advancements that endeavored to excise racism from the roots of this republic, racism remains a bloodying force, structuring every facet of US life.”

– Boyd, Lindo, Weeks, McLemore

INDIAN LAND FOR SALE

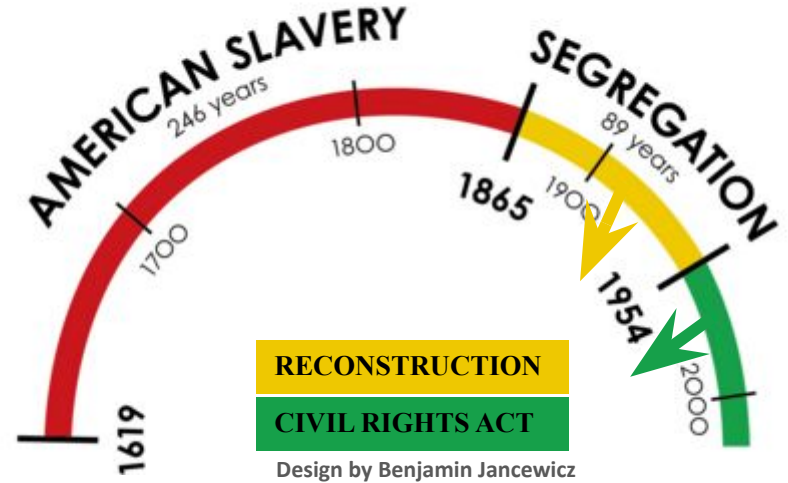
GET A HOME
OF
YOUR OWN
*
EASY PAYMENTS



PERFECT TITLE
*
POSSESSION
WITHIN
THIRTY DAYS

FINE LANDS IN THE WEST

IRRIGATED IRRIGABLE GRAZING AGRICULTURAL DRY FARMING



Racism is a System of power and oppression that **structures opportunities** and **assigns value based on race**, unfairly disadvantaging people of color (racial oppression), while unfairly advantaging Whites (racial privilege & supremacy)

Internalized-Interpersonal-Institutional-Structural

America: Equity and Equality in Health 3

Structural racism and health inequities in the USA: evidence and interventions

Zinzi D Bailey, Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, Mary T Bassett

Despite growing interest in understanding how social factors drive poor health outcomes, many academics, policy makers, scientists, elected officials, journalists, and others responsible for defining and responding to the public discourse remain reluctant to identify racism as a root cause of racial health inequities. In this conceptual report, the third in a Series on equity and equality in health in the USA, we use a contemporary and historical perspective to discuss research and interventions that grapple with the implications of what is known as structural racism on

“...the ways in which historical and contemporary racial inequities in outcomes are perpetuated by social, economic, and political systems, including mutually reinforcing systems of health care, education, housing, employment, the media, and criminal justice. It results in systemic variation in opportunity according to race.”

medical literature or taught to students of health sciences, by focusing on structural racism (panel 1)^{9,11} as a key determinant of population health.^{9,10,12,13} To explore this determinant of health and health equity, we examine a range of disciplines and sectors, including but not limited to medicine, public health, housing, and human

health professionals.^{9,10,12,13} In this report, we examine what constitutes structural racism, explore evidence of how it harms health, and provide examples of interventions that can reduce its impact. Our central argument is that a focus on structural racism is essential to advance health equity and improve population health.



Lancet 2017; 389: 1453–63

See Editorial page 1369

See Comment pages 1376 and 1378

This is the third in a Series of

Panel 2: Pathways between racism and health^{9,11,13,16–18}

Economic injustice and social deprivation^{9,12,32–35}

Examples include residential, educational, and occupational segregation of marginalised, racialised groups to low-quality neighbourhoods, schools, and jobs (both historical de jure discrimination and contemporary de facto discrimination), reduced salary for the same work, and reduced rates of promotion despite similar performance evaluations

Environmental and occupational health inequities^{9,36–38}

Examples include strategic placement of bus garages and toxic waste sites in or close to neighbourhoods where marginalised, racialised groups predominantly reside, selective government failure to prevent lead leaching into drinking water (as in Flint, MI, in 2015–16), and disproportionate exposure of workers of colour to occupational hazards

Psychosocial trauma^{9,35,36,38}

Examples include interpersonal racial discrimination, micro-aggressions (small, often unintentional racial slights and insults, such as a judge asking a black defence attorney “Can you wait outside until your attorney gets here?”), and exposure to racist media coverage, including social media

Targeted marketing of health-harming substances^{9,30,39}

Examples include legal substances such as cigarettes and sugar-sweetened beverages, and illegal substances such as heroin and illicit opioids

Inadequate health care^{9,37,40–45}

Examples include inadequate access to health insurance and health-care facilities, and substandard medical treatment due to implicit or explicit racial bias or discrimination

State-sanctioned violence and alienation from property and traditional lands^{9,23,30,46–48}

Examples include police violence, forced so-called urban renewal (the use of eminent domain to force the relocation of urban communities of colour), and the genocide and forced removal of Native Americans

Political exclusion^{49,50}

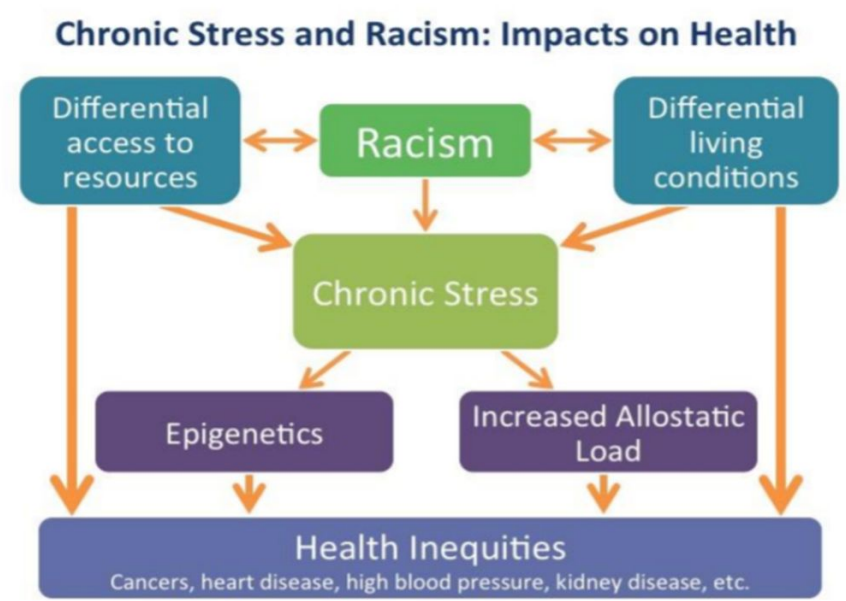
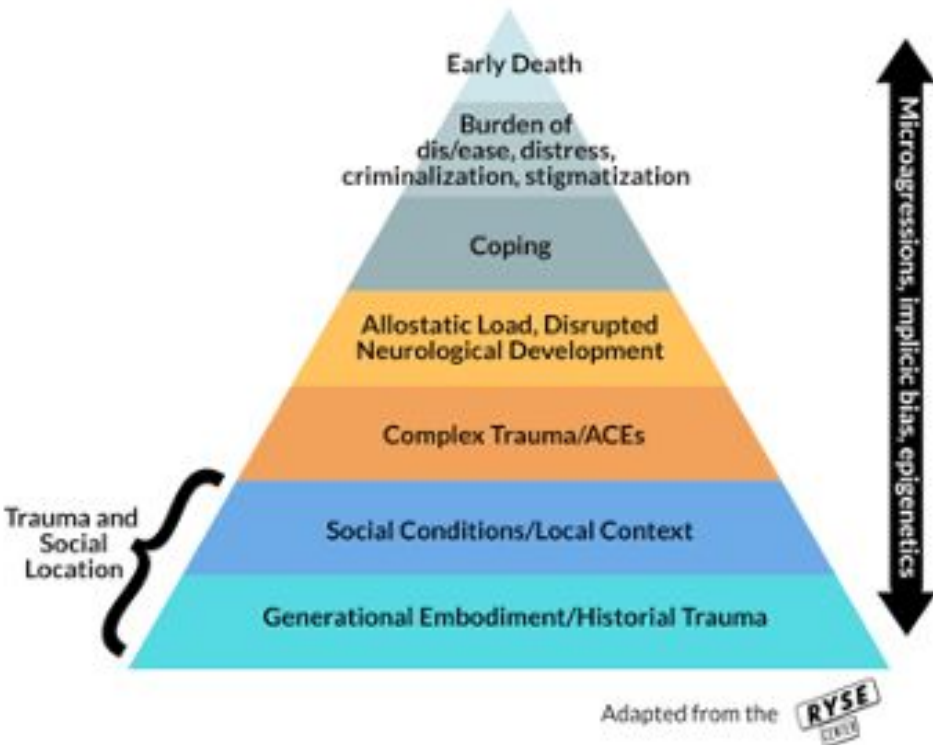
Examples include voter restrictions (eg, for former felons and through identification requirements)

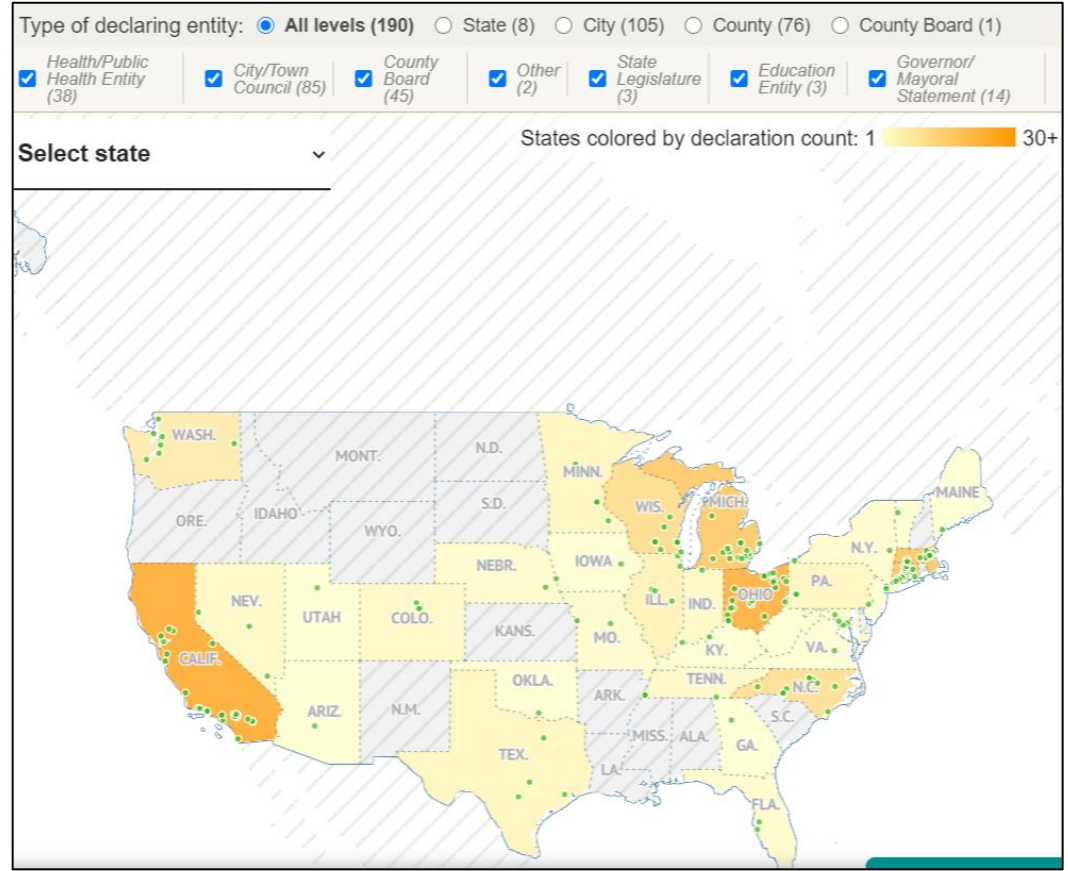
Maladaptive coping behaviours^{9,16,18}

Examples include increased tobacco and alcohol consumption on the part of marginalised, racialised groups

Stereotype threats^{15,18}

Examples include stigma of inferiority, leading to physiological arousal, and an impaired patient-provider relationship





Anti-Racism Policies

Passed and Adopted Policies Fall of 2020:

- Name and act on **Racism as a Public Health Threat**
- Rid our healthcare system of **Racial Essentialism**; recognize race as a social, not a biological, construct
- Support the elimination of **Race as a Proxy for Ancestry, Genetics, & Biology in MedEd, Research, & Clinical Practice**

WE, THE BOARD OF TRUSTEES, STATE THAT:

The AMA recognizes that racism in its systemic, structural, institutional, and interpersonal forms is an urgent threat to public health, the advancement of health equity, and a barrier to excellence in the delivery of medical care.

The AMA opposes all forms of racism.

The AMA denounces police brutality and all forms of racially motivated violence.

The AMA will actively work to dismantle racist and discriminatory policies and practices across all of health care.



HealthAffairs

TOPICS JOURNAL BLOG

HEALTH AFFAIRS BLOG HEALTH EQUITY

RELATED TOPICS:
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| HEALTH EQUITY

Beyond Declarative Advocacy: Moving Organized Medicine And Policy Makers From Position Statements To Anti-Racist Praxis

Rohan Khazanchi, Faith Crittenden, Anna S. Heffron, Emily C. Cleveland Manchanda, Karthik Sivashanker, Aletha Maybank

FEBRUARY 25, 2021 10.1377/hblog20210219.107221




THE LANCET

COMMENT | [VOLUME 396, ISSUE 10249, P451-453, AUGUST 15, 2020](#)

Moving towards anti-racist praxis in medicine

[Joia Crear-Perry](#) ✉ • [Aletha Maybank](#) • [Mia Keeyes](#) • [Nia Mitchell](#) • [Dawn Godbolt](#)

Published: July 17, 2020 • DOI: [https://doi.org/10.1016/S0140-6736\(20\)31543-9](https://doi.org/10.1016/S0140-6736(20)31543-9) •  Check for updates

The World's Leading Medical Journals Don't Write About Racism. That's a Problem



A new study reveals how leading medical journals overlook and ignored racism in publishing research articles. Getty Images © David Sacks

BY RHEA BOYD, NANCY KRIEGER, FERNANDO DE MAIO, AND ALETHA MAYBANK

APRIL 21, 2021 3:36 PM EDT

Rhea Boyd, MD, MPH, is a pediatrician, public health advocate and scholar who writes and teaches on the relationship between structural racism, inequity, and health. Nancy Krieger, PhD, is Professor of Social Epidemiology, American Cancer Society Clinical Research Professor, Department of Social and Behavioral Science, at the Harvard T.H. Chan School of Public Health. Fernando De Maio, PhD, is Director, Health Equity Research and Data Use, at the Center for Health Equity, American Medical Association. Aletha Maybank, MD, MPH, is chief health equity officer and senior vice president at the American Medical Association.

IDEAS

Medicine's Privileged Gatekeepers: Producing Harmful Ignorance About Racism And Health

Nancy Krieger, Rhea W. Boyd, Fernando De Maio, Aletha Maybank

APRIL 20, 2021

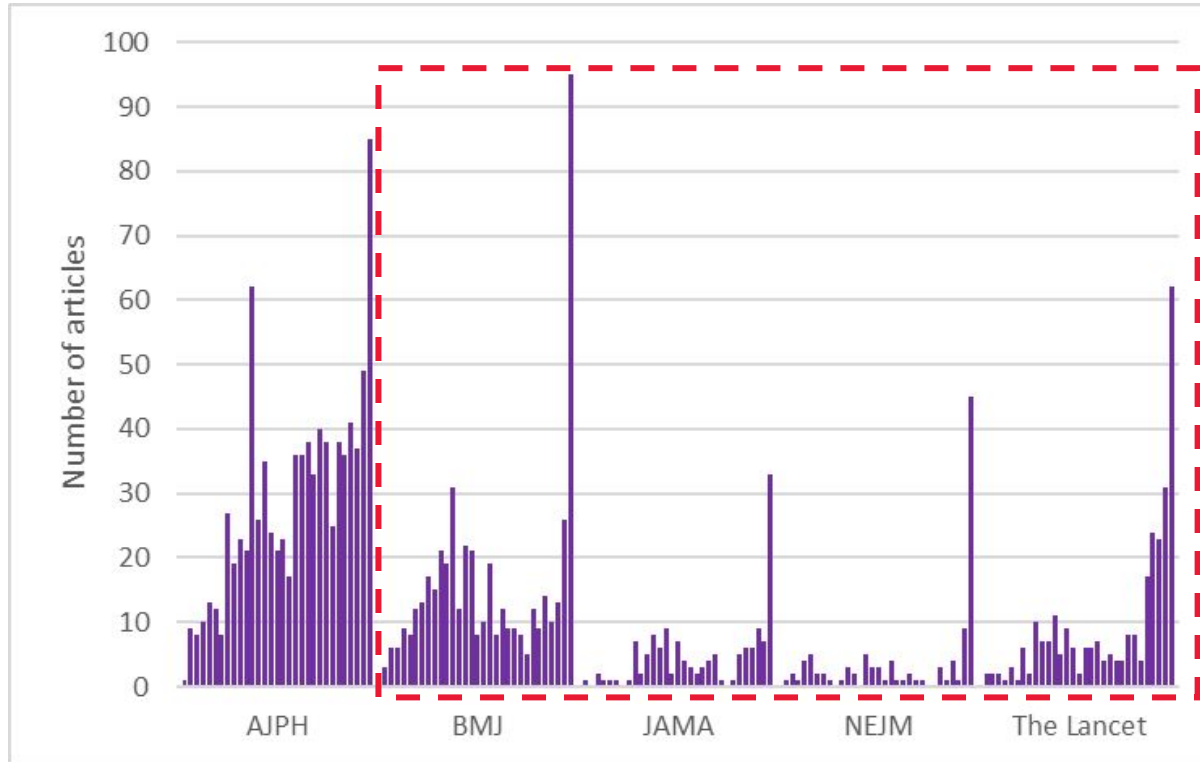
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[Ignorance is neither neutral nor benign](#), especially when it cloaks evidence of harm. And when ignorance is produced and entrenched by gatekeeper medical institutions, as has been the case with obfuscation of [at least 200 years of knowledge](#) about [racism and health](#), the damage is compounded. The racialized inequities exposed this past year—involving [COVID-19, police brutality, environmental injustice, attacks on democratic governance, and more](#)—have sparked mainstream awareness of structural racism and heightened scrutiny of the roles of scientific institutions in perpetuating ignorance about how racism harms health.

A dramatic increase in number of articles including the word “racism” in 2020...



<https://www.healthaffairs.org/doi/10.1377/hblog20210415.305480/full>

Yet for the medical journals, the vast majority of articles were commentaries and viewpoints – not empirical studies

	AJPH	BMJ	JAMA	NEJM	The Lancet
Total # of articles ⁽¹⁾	14,192	78,545	40,411	43,378	63,971
Total # of articles that included the word "racism" anywhere in the text ⁽²⁾	891	644	145	109	315
Total # of articles that included the word "racism" anywhere in the text and available for analysis	891	475	141	109	288
Total # of commentaries / viewpoints / letters ⁽³⁾	356 (40%)	455 (96%)	130 (92%)	105 (96%)	259 (90%)
Total # of empirical studies (Intro, Methods, Results, Discussion or review with significant data component) ⁽³⁾	535 (60%)	20 (4%)	11 (8%)	4 (4%)	29 (10%)

Source: Authors' analysis. AJPH = American Journal of Public Health; BMJ = British Medical Journal; JAMA = Journal of the American Medical Association; NEJM = New England Journal of Medicine. Notes: (1) PubMed results by journal. (2) Obtained from each journal's website, searching for "racism" anywhere in the title, abstract, or text. For BMJ, the actual number of pieces (articles, letters, etc.) containing "racism" may be less than the total reported, since some files contain more than one piece and all pieces in the file may turn up in the search, even if not all the individual pieces in the file contain "racism." (3) Primarily for BMJ, we were unable to obtain copies of some articles due to incomplete library coverage and other issues. (4) Manually coded, except for AJPH, which categorizes and displays articles by type on its website

Whiteness and White Supremacy

- *“And if you know from experience the toll that racism takes, you may have decided early on not to listen. At best, it is a distraction, a theft of energy and time; at worst, a form of gaslighting”*
- *“The most insidious part is that the podcast distorts, deflects, and ultimately denies the harm of structural racism—even while imploring us to acknowledge it. It tells people who have suffered because of racism that they haven’t. It re-assures white listeners that they are good people if they have good intentions.”*

Lance Gravlee – 3.27.21



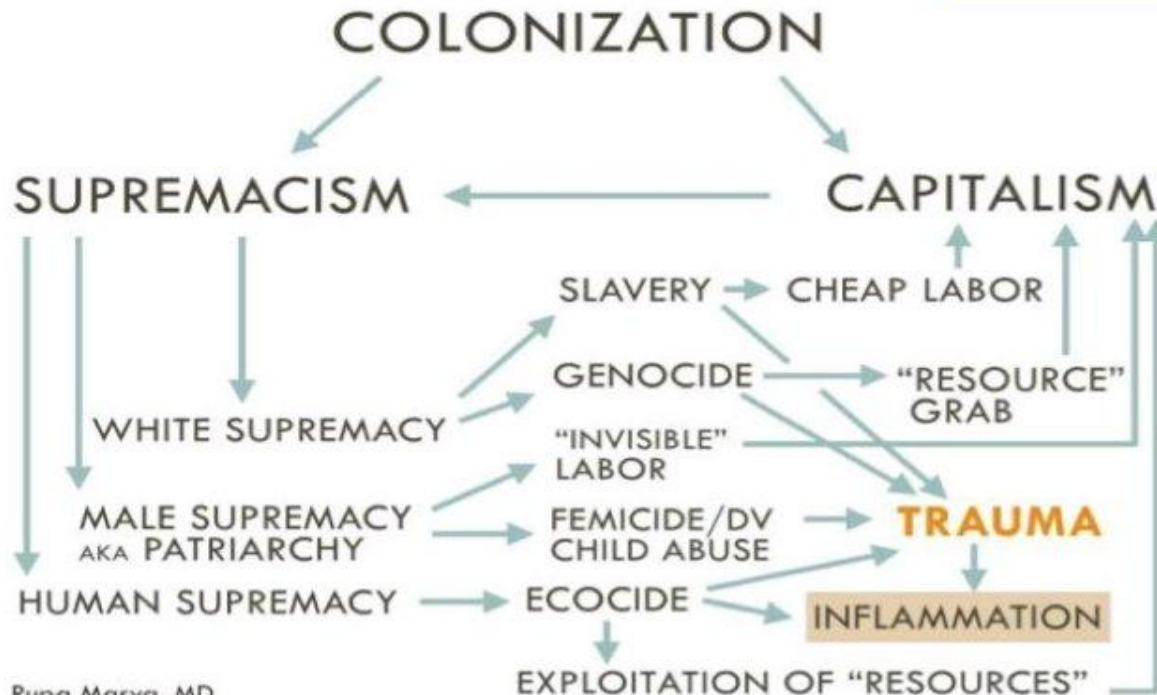
March 27, 2021

How Whiteness Works: JAMA and the Refusals of White Supremacy

By Clarence C. Gravlee

In late February, the *Journal of the American Medical Association* published an episode of its *JAMA Clinical Reviews* podcast titled, “Structural Racism for Doctors—What Is It?” In an accompanying tweet, the journal offered this eye-popping teaser: “No physician is racist, so how can there be structural racism in health care?” The answer, they promised, was in *JAMA*’s “user-friendly podcast,” a 15-minute conversation between two (white) physicians, host Ed Livingston and guest Mitchell Katz, editors in the *JAMA* network of journals.

“To understand the root causes of the pathologies we see today, which impact all of us but affect Brown, Black and Poor people more intensely, we have to examine the foundations of this society which began with COLONIZATION.... Colonization was the way the extractive economic system of Capitalism came to this land, supported by systems of supremacy and domination which are a necessary part to keep wealth and power accumulated in the hands of the colonizers and ultimately their financiers.” — [Dr. Rupa Marva](#)



Rupa Marva, MD



Seeing the Water: Seven Values Targets for Anti-Racism Action

August 25th, 2020

You know the old saying, "It's hard for a fish to see the water in which it swims?" That's

- Narrow focus on the individual
- A-historical stance
- Myth of meritocracy
- Myth of a zero-sum game
- Limited future orientation
- Myth of American exceptionalism
- **White supremacist ideology** (false notion of the hierarchy of human value based on skin color with being on top)

Privilege

"In my class and place, I did not recognize myself as a racist because I was taught to see racism only in individual acts of meanness by members of my group, never in invisible systems conferring unsought racial dominance on my group from birth."

"For me, white privilege has turned out to be an elusive and fugitive subject. The pressure to avoid it is great, for in facing it I must give up the myth of meritocracy. If these things are true, this is not such a free country; one's life is not what one makes it; many doors open for certain people through no virtues of their own."

Peggy McIntosh, 1988
White Privilege:
Unpacking the Invisible Knapsack

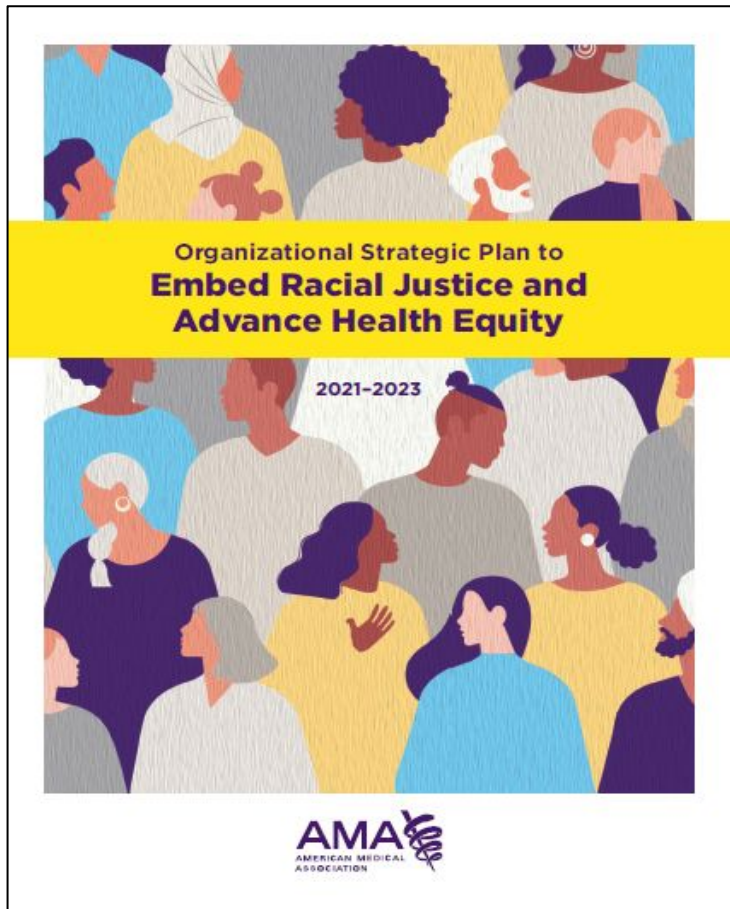


Our roles...

- Naming and calling out white supremacy, racism, and other ideologies and systems of supremacy and oppression
- Making visible, not only the mere descriptive inequities, and how these ideologies and systems operate to cause harm and work to concentrate power (and wealth) within our institutions and away from the neighborhoods and communities we serve

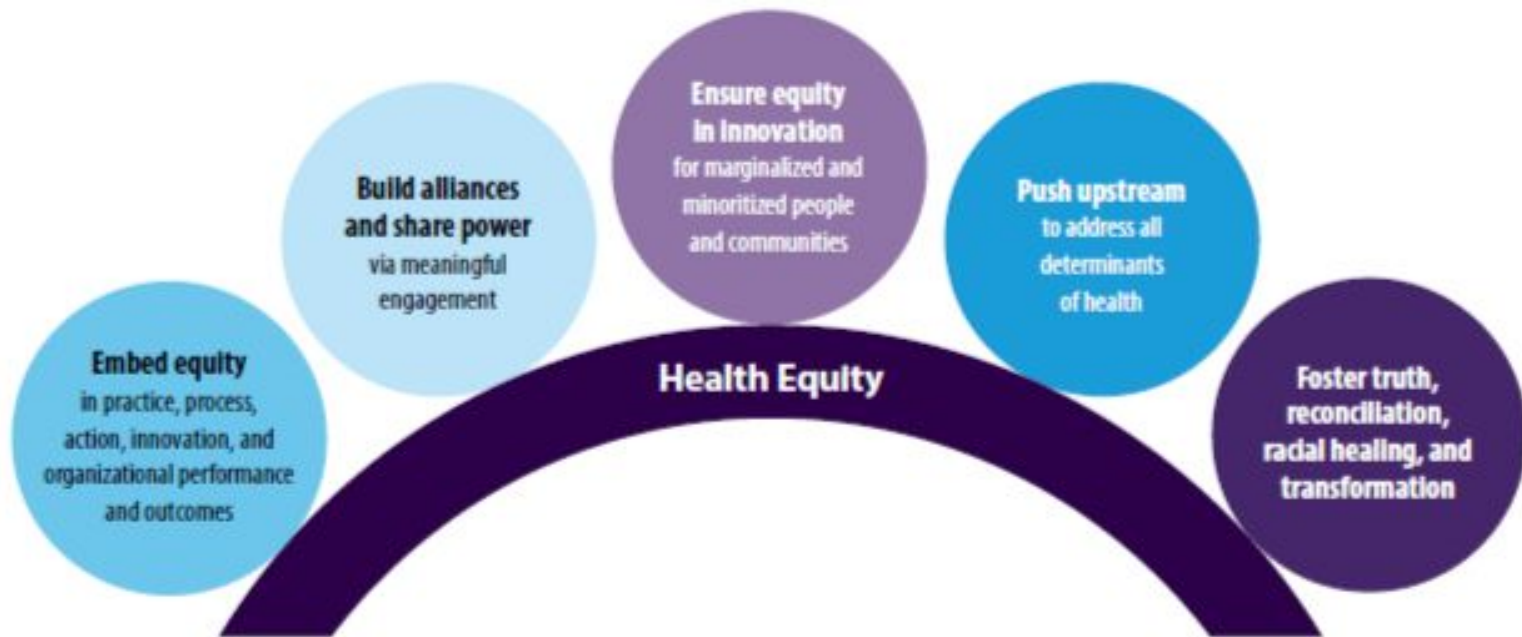
Then what...

- How do we inspire power held by a few to be and do differently beyond their own self-interests and own experiences, and to really care?

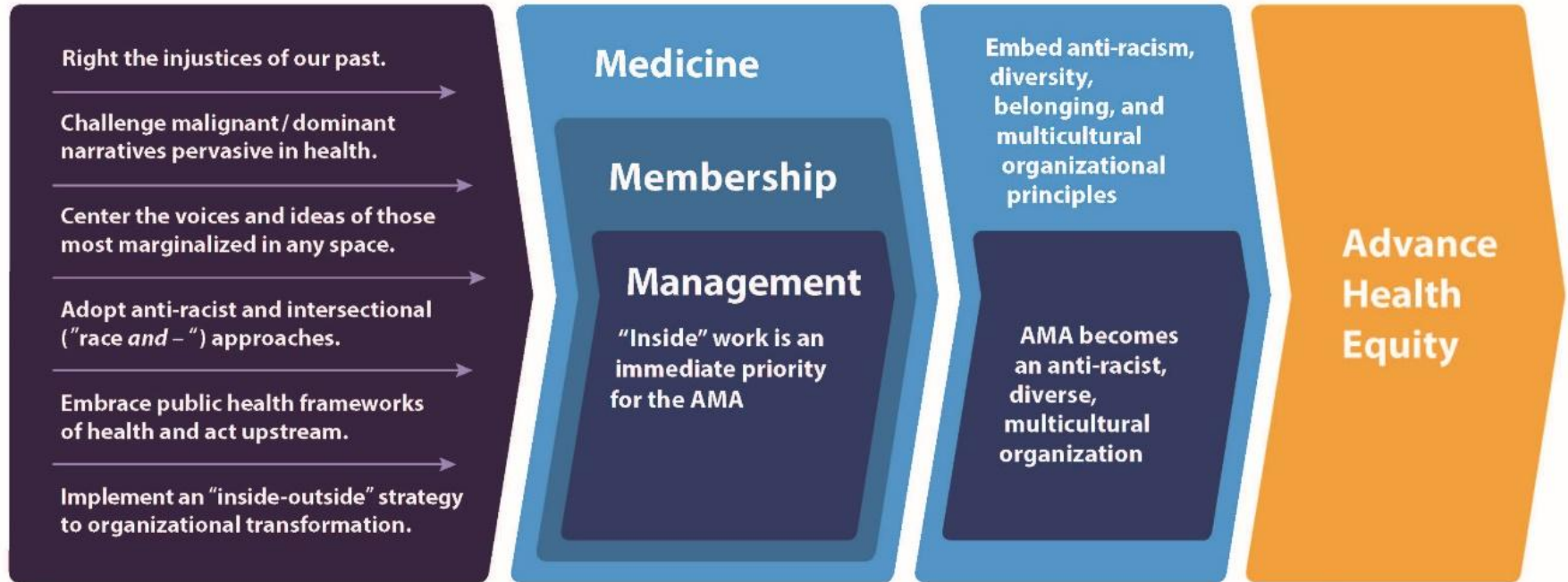


“These are the times to grow our souls. Each of us is called upon to embrace the conviction that despite the powers and principalities bent on commodifying all our human relationships, we have the power within us to create the world anew.”


Grace Lee Boggs, human rights leader, activist, and daughter of Chinese immigrants, Seeds of Change
AMA | Physicians' powerful ally in patient care



Theories of Change Needed to Center Equity



Embed



Lase Ajayi, MD
Member since 2013

“We will be really misled if we think
we can change society without
changing ourselves.”



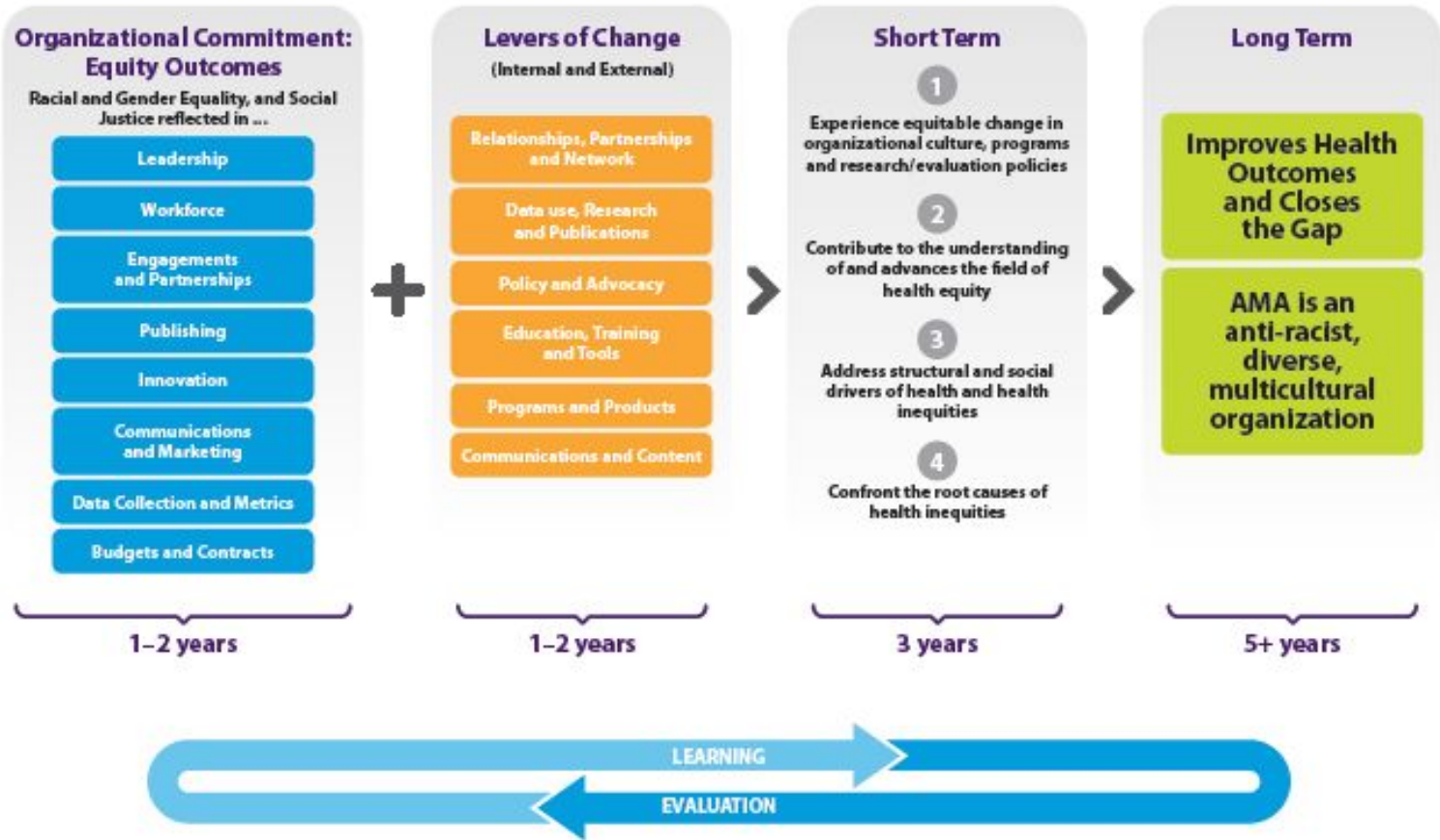
Alice Walker
2018 National Women's Studies Association

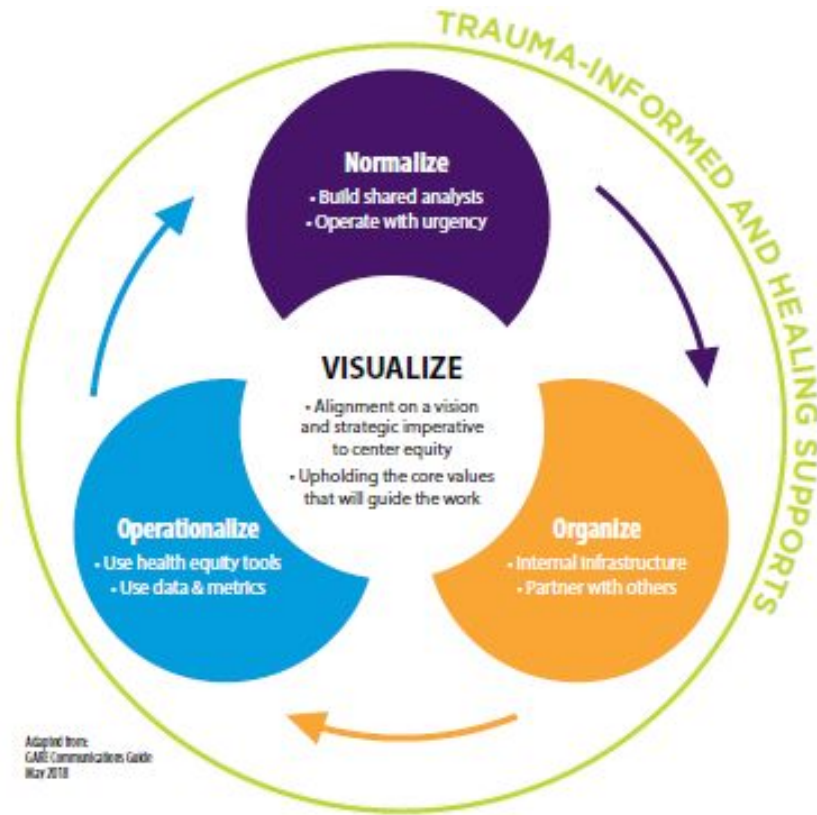
Embed racial and social justice throughout the AMA

Enterprise culture, systems, policies, and practices

- Build the AMA's capacity to understand and operationalize anti-racism equity strategies via training and tool development
- Ensure equitable structures, processes and accountability in the AMA's workforce, contracts and budgeting, communications and publishing
- Integrate trauma – informed lens and approaches
- Assess organizational change (culture, policy, process) over time

Figure 10. AMA's Health Equity Logic Model





Visualize

*All employees experience just treatment that is ensured by **equitable** policies and practices. Employees are **satisfied** with all aspects of their work and the AMA as a whole, experience a sense of **true belonging**, and feel a deep fulfillment from the role they play in carrying out the enterprise mission.*

AMA Enterprise Values

- **Integrity:** We act in an ethical fashion, demonstrating integrity and honesty in everything we do in our workplace and in society.
- **Trust:** We work with transparency and follow through with commitments to develop trusting relationships with our colleagues, collaborators and stakeholders.
- **Respect:** We treat each individual with dignity, valuing all perspectives and appreciating the rich diversity of our colleagues and collaborators.
- **Impact/ Results:** We strive for excellence in execution that drives meaningful change and positive outcomes.
- **Innovation:** We value new ideas, commit to evolving our approach and challenge the status quo.
- **Agility:** We demonstrate the flexibility and pace necessary to lead change, adapt, and fulfill our vision.
- **Collaboration:** We value all voices and share power with our colleagues and collaborators to bring the right expertise to an issue and achieve goals.
- **Equity:** We center the voices of the most marginalized in shaping policies and practices toward improving the health of the nation.



Build

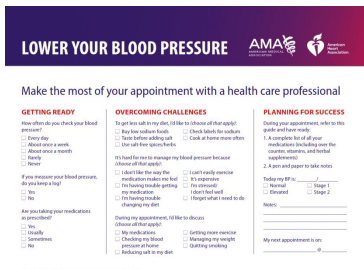
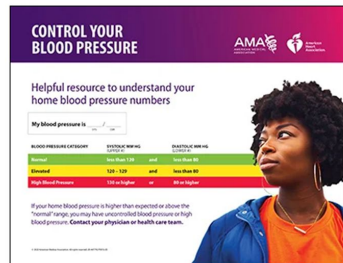
Saby Karuppiah, MD
Member since 2008

Build alliances and share power with historically marginalized and minoritized physicians and other stakeholders

- Develop structures and processes to consistently center the experiences and ideas of historically marginalized (women, LGBTQ+, people with disabilities, International Medical Graduates) and minoritized (Black, Indigenous, Latinx, Asian, and other people of color) physicians
- Establish a coalition of multidisciplinary, multisectoral equity experts in health care and public health to collectively advocate for justice in health



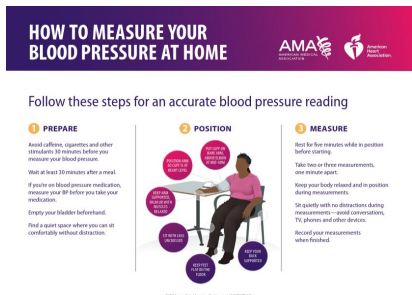
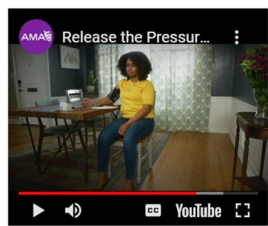
Option 1: Set A BP Goal With A Health Care Professional



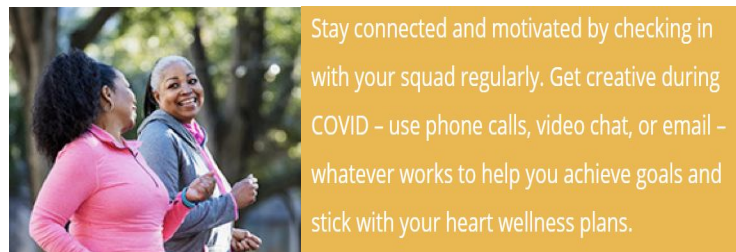
Option 3: Activate Your Wellness Plan



Option 2: Monitor Your BP At Home



Option 4: Make Self-Care A Group Thang!





Push

Kevin McKinney, MD
Member since 1989

Moving upstream requires...

Population Health Management/Medicine

Goal: Improve outcomes for defined, usually high and/or rising risk patient/member populations, by, in part, addressing social needs

Advance equity & Racial justice
Cross-sector and coordinated action

Key stakeholders:

- Individuals with lived experience,
- Service providers (e.g. healthcare systems, human & social service providers, including schools, legal services, etc)
- Those who pay and support these service providers (e.g. health plans,)

Community Health

Goal: Improve outcomes and health, social & economic conditions (social determinants of health) for defined geographic areas

Advance equity & Racial justice
Cross-section and coordinated action

Key Stakeholders:

- Neighborhood associations
- Community organizations & coalitions
- Place-based collaboratives & integrators
- Banks & CDFIs
- Employers & unions
- Public health departments & other public agencies
- Housing, food, transportation systems
- Local legislators

Societal (Public) Health

Goal: Improve public health & structural determinants of health equity through policies, laws, community mobilization, & formal & informal methods of accountability.

Advance equity & Racial justice
Cross-sector and coordinated action

Key Stakeholders:

- Advocates
 - Organizers
 - Policymakers
 - Legislators
 - Public agency administrators
- at regional, state, national and international levels

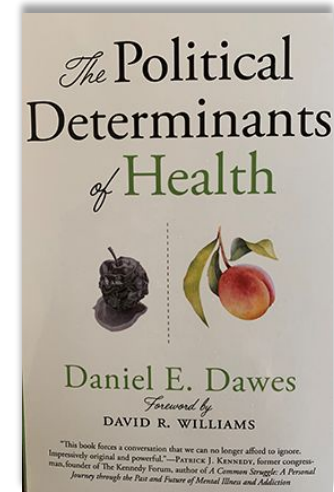
Push upstream to address all determinants of health and the root causes of inequities

- Strengthen physicians' knowledge of public health and structural/social drivers of health and inequities
- Empower physicians and health systems to dismantle structural racism and intersecting systems of oppression
- Equip physicians and health systems to improve services, technology, partnerships, and payment models that advance public health and health equity

Medical Justice in Advocacy Fellowship



- Identify physician leaders in communities seeking to advance racial and health justice in their local communities and/or nationally
- Provide fellows ongoing support to engage in institutional and political advocacy
- Create opportunities shared learning and mutual support amongst the Fellows

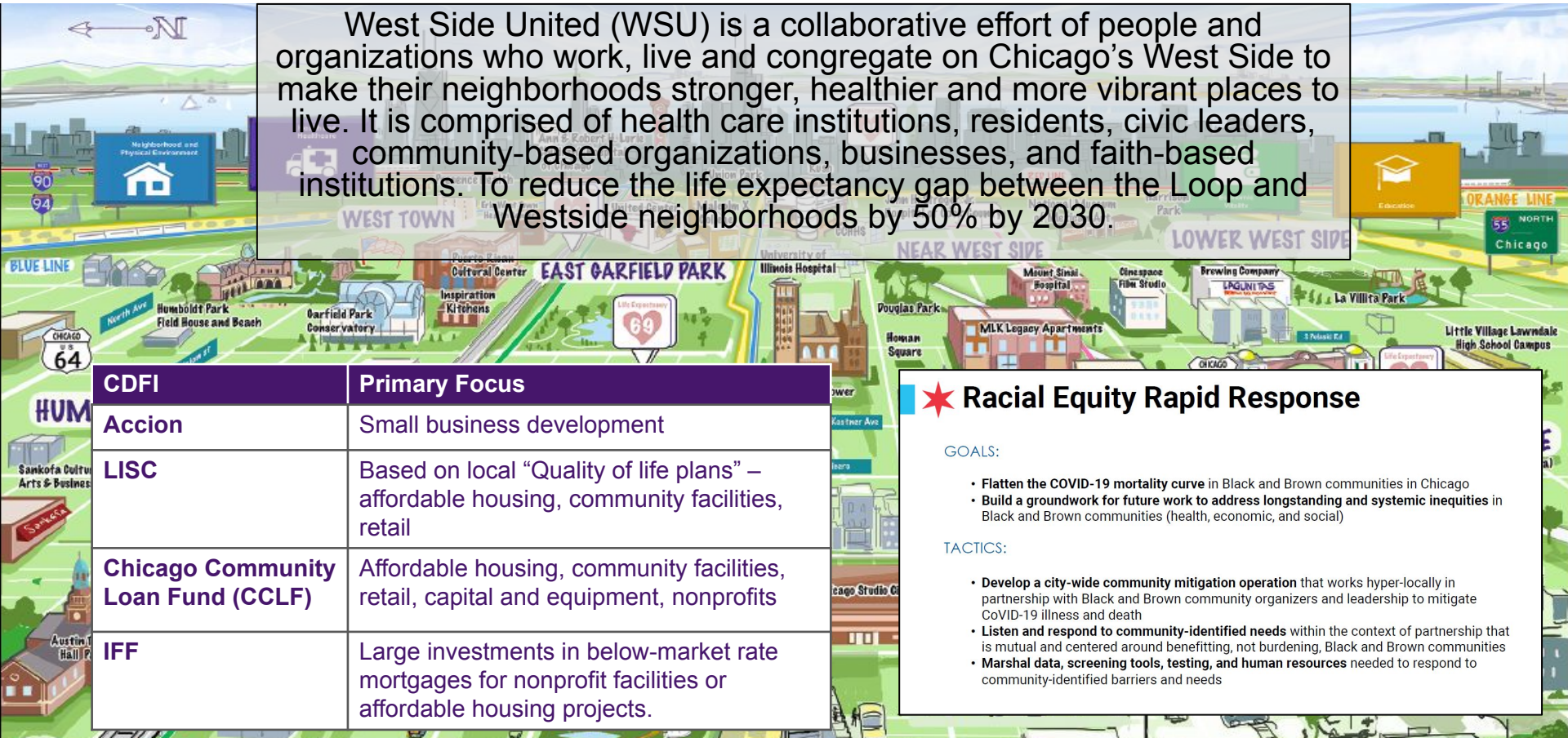


Women's Wellness Equity and Leadership Program (WEL)

- AAP led program & funded by the Physician's Foundation
- AMA one of 10 organizations
- 50 WEL Scholars
- 18-month program meant to build the leadership of early to mid-level women physicians

AMA 2021 WEL Cohort

- Dr. Janet West
- Dr. Elizabeth Homan Sandoval
- Dr. Hillary Johnson-Jahangir
- Dr Brenda Anders Pring
- Dr. Susan Matulevicius



West Side United – Partnership & Social Impact Investment for Health & Wellness

Ensure



Betty Chu, MD
Member since 1997

Ensure equitable structures and opportunities in innovation

- Embed racial justice and health equity within existing AMA health care innovation efforts
- Equip the health care innovation sector to advance equity and justice
- Center, integrate, and amplify historically marginalized and Black, Indigenous, Latinx and people of color who are health care investors and innovators
- Engage in cross-sector collaboration and advocacy efforts

Organize

AMA External Equity & Innovation Advisory Group

- Support problem-solving, decision-making, stakeholder engagement, collaboration, and communication related to AMA's equity and innovation strategy
- Quarterly meetings started in October 2020 facilitated by CHE with opportunity for connection with AMA innovation leaders

Name	Title
Courtney D. Cogburn , PhD, MSW	Professor, Columbia University
Abner Mason	Founder & CEO, ConsejoSano
Shantanu Nundy , MD, MBA	Chief Medical Officer, Accolade Health
Urmimala Sarkar , MD	Professor & Co-Founder, UCSF SOLVE Health Tech
Nathalie Molina Nino	Founder & Investor, O ³
Ivor Braden Horn , MD, MPH, FAAP	Physician Investor, Researcher, Advisor
Ivelyse Andino	Founder & CEO, Radical Health
Sandee Kastrul	President & Co-Founder, i.c.stars
Chris Gibbons , MD, MPH	Founder & CEO, Greystone Group & Chief Health Innovation Officer, FCC
Lisa Fitzpatrick , MD, MPH, MPA	Founder & CEO, Grapevine Health, Co-Chair, CTA/CHI HEAL Coalition
Andrey Ostrovsky , MD	Managing Partner, Social Innovation Ventures

Foster

Siobhan Wescott, MD
Member since 2013

No set of commitments to anti-racism can begin without an honest assessment of an institution's own history and present practices.

- In the early years following the Civil War, the AMA **declined to embrace a policy of nondiscrimination** and excluded an integrated local medical society through selective enforcement of membership standards;
- From the 1870s through the late 1960s, the AMA failed to take action against AMA affiliated state and local medical associations that **openly practiced racial exclusion in their memberships**—practices that functionally excluded most Black physicians from membership in the AMA, in turn excluded Black physicians from receiving hospital privileges;
- In the early decades of the 20th century, the AMA **listed Black physicians as “colored” in its national physician directory** and was slow to remove the designation in response to protests from the National Medical Association (NMA);
- The Flexner Report of 1910, commissioned by the AMA's Council of Medical Education along with other Foundation partners, **contributed to the closure of five of the seven Black Medical Schools and all three women medical schools**.
- The AMA **was silent in debates over the Civil Rights Act of 1964** and put off repeated NMA requests to support efforts to amend the Hill-Burton Act's “separate but equal” provision, which **allowed construction of segregated hospital facilities with federal funds**.

Foster pathways for truth, racial healing, reconciliation, and transformation for the AMA's past

- Amplify and integrate often “invisible-ized” narratives of historically marginalized physicians and patients in all that we do
- Quantify the effects of AMA's policy and process decisions that excluded, discriminated, and harmed
- Repair and cultivate a healing journey for those harms

Repairing those wrongs is also a vital part of healing

- *Address material and personal losses inflicted on the people experiencing prejudice and injustice*
- *Focus on ways for all of us to heal from the wounds of the past, to build mutually respectful relationships and trust*
- *Send a strong signal that the organization is committed to righting historical wrongs*



AMA's Apology

*"....on behalf of the American Medical Association, I unequivocally apologize for our past behavior. We pledge to do everything in our **power to right the wrongs** that were done by our organization to African-American physicians and their families and their patients.*

So yes, this history is still being written.

*It noted that, "The [AMA's] expression of regret is the culmination of rigorous introspection. ... There are those who say that apologies can't change the past, and they have a point. The hope is that they will change the future." We recognize that our apology is a **modest first step toward healing and reconciliation**. Just as Churchill said in 1942 after the "Battle of Egypt,"*

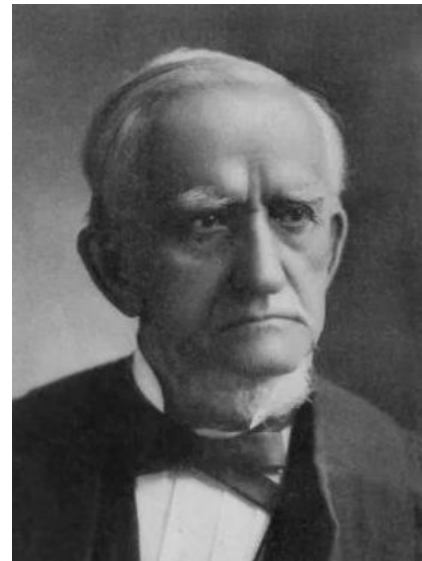
This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning."

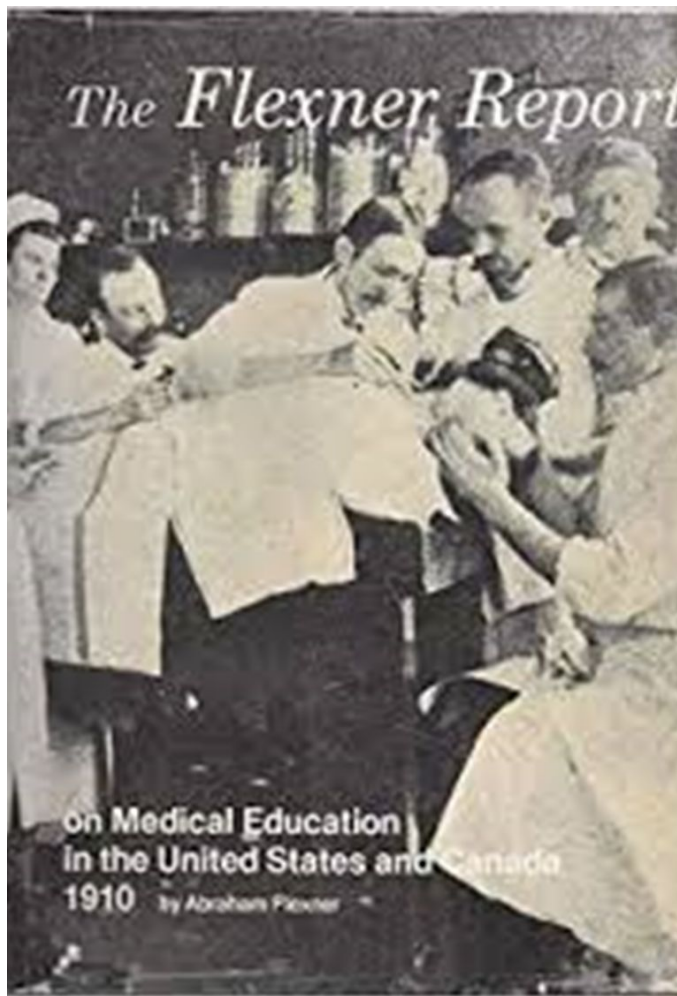
Ronald M. Davis, MD, AMA Immediate Past President @ National Medical Association (NMA) Annual Meeting, Atlanta, Georgia, July 30, 2008

Nathan Davis

“Father of AMA” and Founding Editor of JAMA

- *“Explicitly exclude women and Black physicians from representation in our House of Delegates, thus appeasing many state and local medical societies who barred all but white men from their membership.”*
 - *“I had the bust and display of Dr. Davis **removed from public view and placed in our archives** where they will rightly serve as educational materials. Additionally, the AMA has **removed the name of Nathan Davis from an award** we give annually to honor individuals for outstanding government service.”*
 - *“These are two small but necessary steps toward reconciling the AMA’s past and laying the groundwork for our future.”*
- James Madara, CEO AMA, Reckoning with medicine’s history of racism (AMA Viewpoint – 2.17.21)





JAMA
Network | **Open.**



Original Investigation | Medical Education

Projected Estimates of African American Medical Graduates of Closed Historically Black Medical Schools

Kendall M. Campbell, MD; Irma Corral, PhD, MPH; Jhojana L. Infante Linares, MS; Dmitry Tumin, PhD

Abstract

IMPORTANCE There continue to be low numbers of underrepresented minorities, including African Americans, in academic medicine. Historically Black medical colleges and universities are major sources of training for medical school graduates who are African American or who belong to other underrepresented minority groups. Several historically Black medical schools were closed during the period surrounding the 1910 Flexner report. The implications of these school closures with regard to the number of African American medical school graduates have not been fully examined.

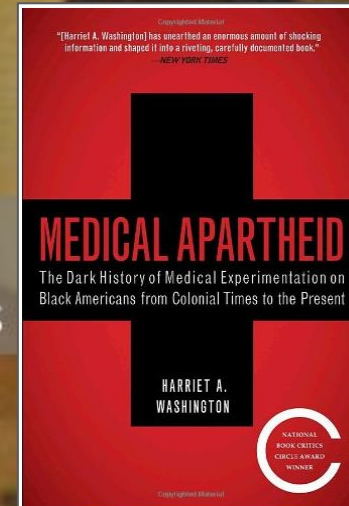
Key Points

Question What are the projected estimates of the number of African American students who would have graduated from historically Black medical schools that were closed during the period surrounding the publication of the 1910 Flexner report?



J. Marion Simms – Former AMA President

Dark History of Medical Experimentation on Black Americans





Reparations for Black American descendants of persons enslaved in the U.S. and their potential impact on SARS-CoV-2 transmission

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ARTICLE INFO

Keywords:

Racism
COVID-19
Reparations
Mathematical model
Health disparities
Risk structure

ABSTRACT

Background: In the United States, Black Americans are suffering from a significantly disproportionate incidence of COVID-19. Going beyond mere epidemiological tallying, the potential for racial-justice interventions, including reparations payments, to ameliorate these disparities has not been adequately explored.

Methods: We compared the COVID-19 time-varying R_t curves of relatively disparate polities in terms of social equity (South Korea vs. Louisiana). Next, we considered a range of reproductive ratios to back-calculate the transmission rates β_{t-1} for 4 cells of the simplified next-generation matrix (from which R_0 is calculated for structured models) for the outbreak in Louisiana. Lastly, we considered the potential structural effects monetary payments as reparations for Black American descendants of persons enslaved in the U.S. would have had on pre-intervention β_{t-1} and consequently R_0 .

Results: Once their respective epidemics begin to propagate, Louisiana displays R_t values with an absolute difference of 1.3–2.5 compared to South Korea. It also takes Louisiana more than twice as long to bring R_t below 1. Reasoning through the consequences of increased equity via matrix transmission models, we demonstrate how the benefits of a successful reparations program (reflected in the ratio $\beta_{t-1}/\beta_{t-1,0}$) could reduce R_0 by 31–68%.

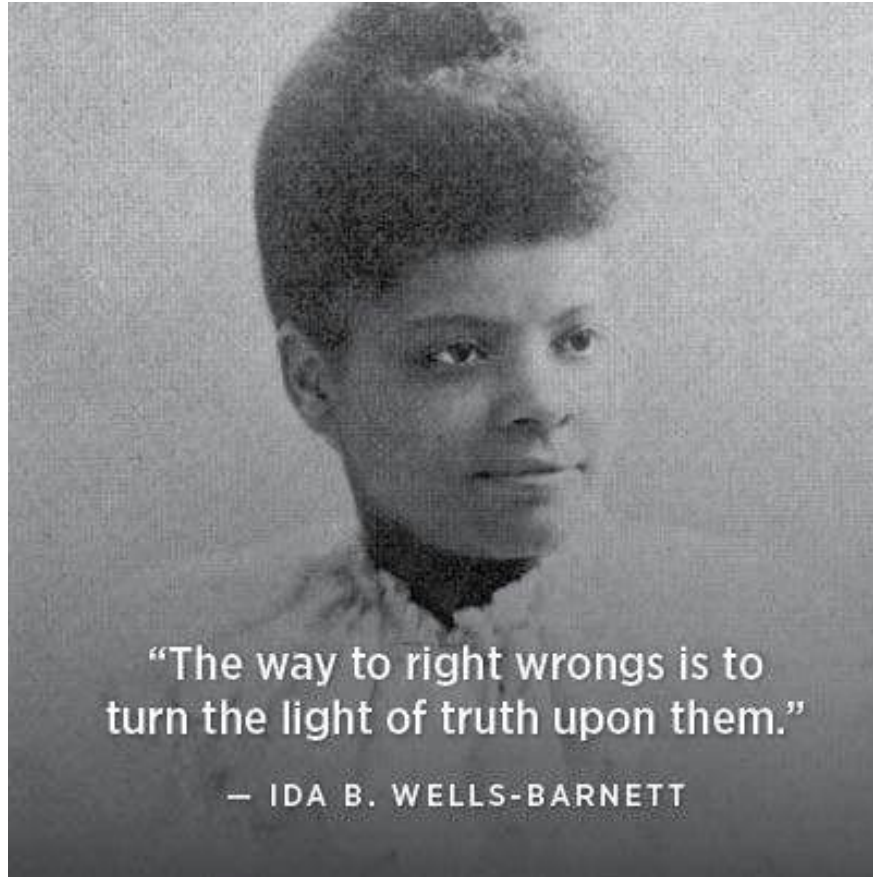
Discussion: While there are compelling moral and historical arguments for racial-justice interventions such as reparations, our study considers potential health benefits in the form of reduced SARS-CoV-2 transmission risk. A restitutive program targeted towards Black individuals would not only decrease COVID-19 risk for recipients of the wealth redistribution; the mitigating effects would also be distributed across racial groups, benefiting the population at large.

- There are compelling moral and historical arguments for racial-justice interventions, including **reparations**
- This study considers additional benefits in the form of reduced COVID-19 transmission.
- Analyzed a program of reparations that aim to close the racial wealth gap between Black American descendants of persons enslaved in the U.S. and white Americans via monetary payments in the amount of
- \$250,000 per individual or
 - \$800,000 per household

“A restitutive program targeted towards Black individuals would not only decrease COVID-19 risk for recipients of the wealth redistribution; the mitigating effects would also be distributed across racial groups, benefiting the population at large.”

“But all our phrasing—race relations, racial chasm, racial justice, racial profiling, white privilege, even white supremacy—serves to obscure that racism is a visceral experience, that it dislodges brains, blocks airways, rips muscle, extracts organs, cracks bones, breaks teeth. You must never look away from this. **You must always remember that the sociology, the history, the economics, the graphs, the charts, the regressions all land, with great violence, upon the body.**”

Ta-Nehisi Coates, *Between the World and Me*



“The way to right wrongs is to
turn the light of truth upon them.”

— IDA B. WELLS-BARNETT



Physicians' powerful ally in patient care