



# Family Medicine: What is Our Role in Eliminating Health Disparities by Race?

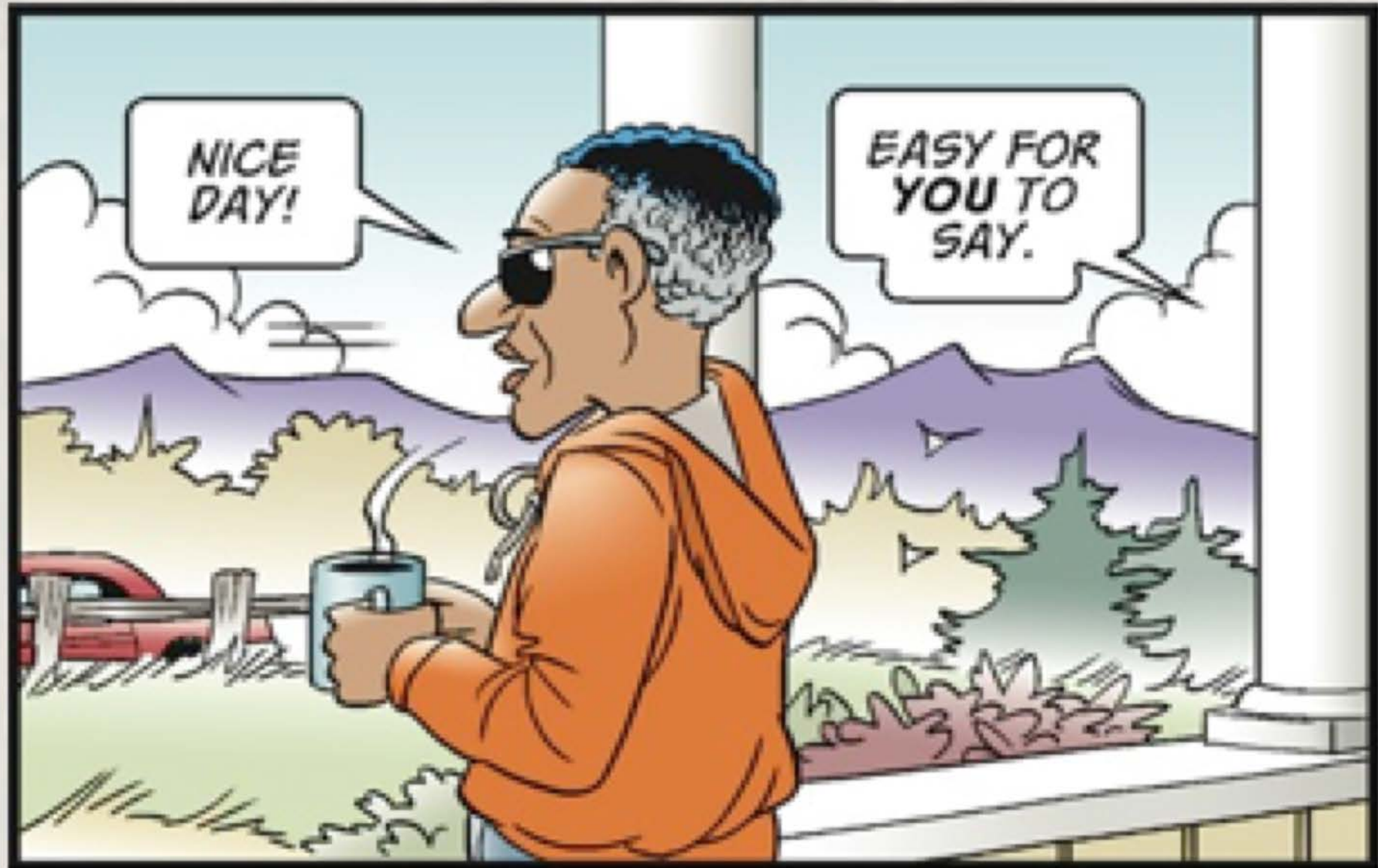
Denise V. Rodgers, MD, FAAFP

RBHS Vice Chancellor for Interprofessional Education

ADFM Annual Conference

February 14, 2019

# Doonesbury



BUT NOT FOR YOU?

NO. MY KIND IS DYING OFF.



MAN, MY PEER  
GROUP'S SURE  
GETTING  
HAMMERED  
LATELY...


WHAT  
PEER  
GROUP'S  
THAT?

MIDDLE-AGE WHITES. THE  
MORTALITY RATE'S SOARING!



THEY'RE CALLED DEATHS OF  
DESPAIR - FROM DRUGS, ALCO-  
HOL OR SUICIDE - DRIVEN BY  
ECONOMIC AND SOCIAL DISTRESS.

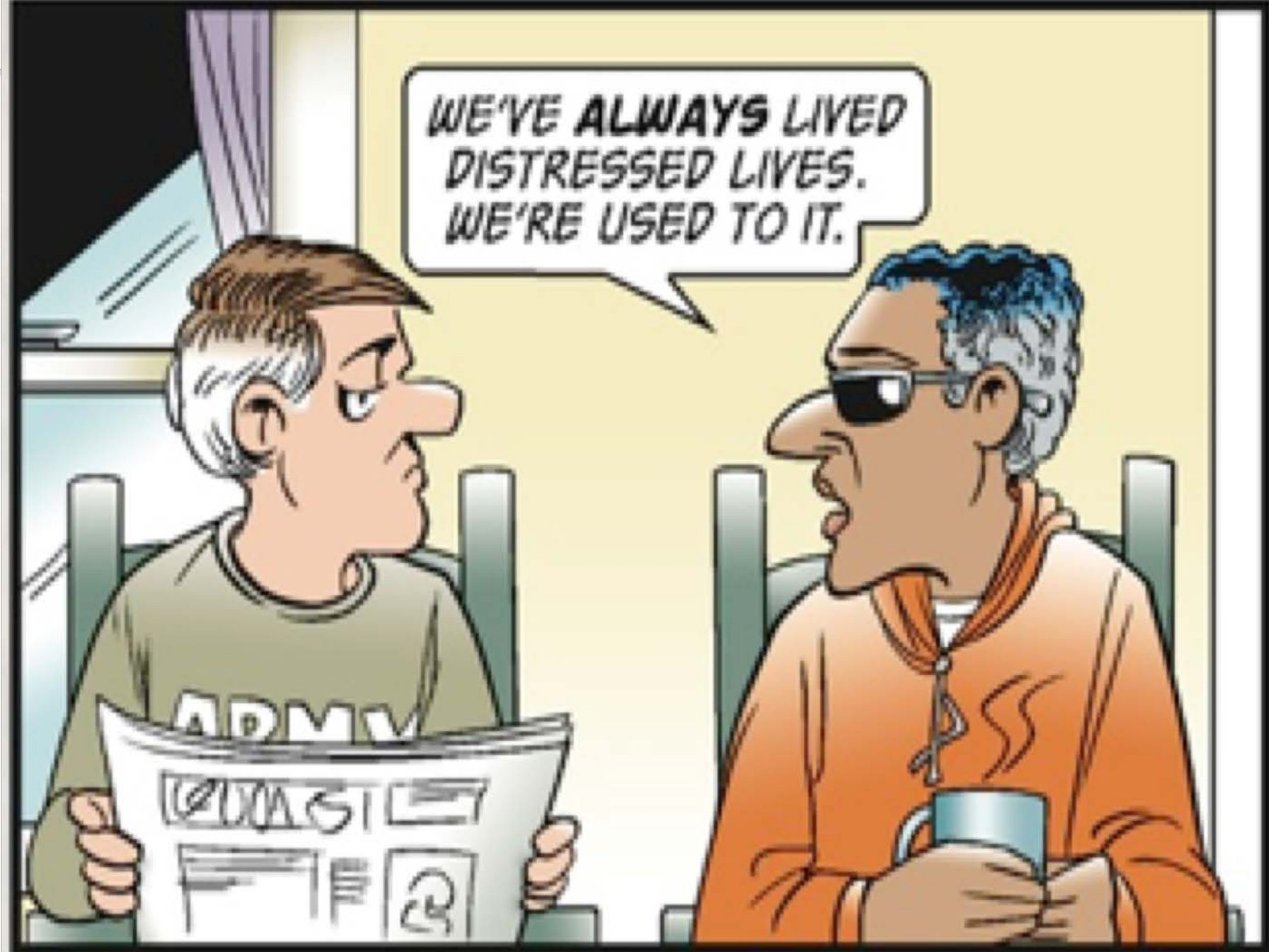




ODDLY, IT DOESN'T  
SEEM TO AFFECT  
BLACKS OR LATINOS.

NOTHIN' ODD  
ABOUT IT, MAN...

WE'VE ALWAYS LIVED  
DISTRESSED LIVES.  
WE'RE USED TO IT.





SO... BLACK  
PRIVILEGE.

ABSOLUTELY. WE'RE  
LUCKY THAT WAY.

ARMY

©B/Mudcat

# Trends in premature mortality in the USA by sex, race, and ethnicity from 1999 to 2014: an analysis of death certificate data

*Meredith S Shiels, Pavel Chernyavskiy, William F Anderson, Ana F Best, Emily A Haozous, Patricia Hartge, Phillip S Rosenberg, David Thomas, Neal D Freedman\*, Amy Berrington de Gonzalez\**

[www.thelancet.com](http://www.thelancet.com) Vol 389 March 11, 2017

**Findings** **Between 1999 and 2014, premature mortality increased in white individuals** and in American Indians and Alaska Natives. Increases were highest in women and those aged 25–30 years. **Among 30-year-olds, annual mortality increases were 2·3% (95% CI 2·1–2·4) for white women, 0·6% (0·5–0·7) for white men,** and 4·3% (3·5–5·0) and 1·9% (1·3–2·5), respectively, for American Indian and Alaska Native women and men. These increases were mainly attributable to accidental deaths (primarily drug poisonings), chronic liver disease and cirrhosis, and suicide. Among individuals aged 25–49 years, an estimated 111 000 excess premature deaths occurred in white individuals and 6600 in American Indians and Alaska Natives during 2000–14. By contrast, premature mortality decreased substantially across all age groups in Hispanic individuals (up to 3·2% per year), black individuals (up to 3·9% per year), and Asians and Pacific Islanders (up to 2·6% per year), mainly because of declines in HIV, cancer, and heart disease deaths, resulting in an estimated 112 000 fewer deaths in Hispanic individuals, 311 000 fewer deaths in black individuals, and 34 000 fewer deaths in Asians and Pacific Islanders aged 25–64 years. During 2011–14, American Indians and Alaska Natives had the highest premature mortality, followed by black individuals.

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(data from 2010 census)

**TOTAL POPULATION** **1,779**

**–WHITE** **92%**

**–BLACK/AA** **5%**

**–HISPANIC** **2%**

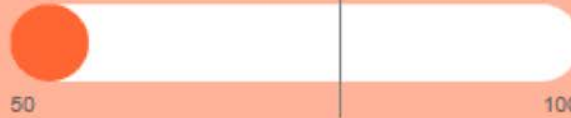
# PER CAPITA INCOME \$15,913

– POVERTY RATE	21%
– POOR FAMILIES	18%
– CHILDREN IN POVERTY	29%
– AGE >65 IN POVERTY	10%



## My Area

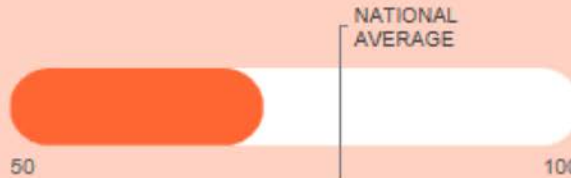
Census Tract  
Reference number: 54045956900



**56.90**  
YEARS



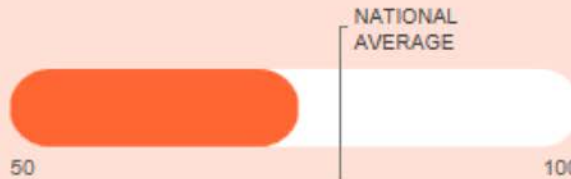
## Logan County



**72.22**  
YEARS



## West Virginia



**75.30**  
YEARS



## United States



**78.80**  
YEARS



# More cities in WV join opioid lawsuits

By COURTNEY HESSLER Mar 17, 2018 (1)



# Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder

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## ABSTRACT

**PURPOSE** The United States is experiencing an epidemic of opioid-related deaths driven by excessive prescribing of opioids, misuse of prescription drugs, and increased use of heroin. Buprenorphine-naloxone is an effective treatment for opioid use disorder and can be provided in office-based settings, but this treatment is unavailable to many patients who could benefit. We sought to describe the geographic distribution and specialties of physicians obtaining waivers from the Drug Enforcement Administration (DEA) to prescribe buprenorphine-naloxone to treat opioid use disorder and to identify potential shortages of physicians.

**METHODS** We linked physicians authorized to prescribe buprenorphine on the July 2012 DEA Drug Addiction Treatment Act (DATA) Waived Physician List to the American Medical Association Physician Masterfile to determine their age, specialty, rural-urban status, and location. We then mapped the location of these physicians and determined their supply for all US counties.

**RESULTS** Sixteen percent of psychiatrists had received a DEA DATA waiver (41.6% of all physicians with waivers) but practiced primarily in urban areas. Only 3.0% of primary care physicians, the largest group of physicians in rural America, had received waivers. Most US counties therefore had no physicians who had obtained waivers to prescribe buprenorphine-naloxone, resulting in more than 30 million persons who were living in counties without access to buprenorphine treatment.

**CONCLUSIONS** In the United States opioid use and related unintentional lethal overdoses continue to rise, particularly in rural areas. Increasing access to office-based treatment of opioid use disorder—particularly in rural America—is a promising strategy to address rising rates of opioid use disorder and unintentional lethal overdoses.

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**Findings Between 1999 and 2014, premature mortality increased** in white individuals and **in American Indians and Alaska Natives**.

Increases were highest in women and those aged 25–30 years. Among 30-year-olds, annual mortality increases were 2·3% (95% CI 2·1–2·4) for white women, 0·6% (0·5–0·7) for white men, and **4·3% (3·5–5·0) and 1·9% (1·3–2·5), respectively, for American Indian and Alaska Native women and men.**

**These increases were mainly attributable to accidental deaths (primarily drug poisonings), chronic liver disease and cirrhosis, and suicide. Among individuals aged 25–49 years, an estimated** 111 000 excess premature deaths occurred in white individuals and **6600 in American Indians and Alaska Natives during 2000–14.**

By contrast, premature mortality decreased substantially across all age groups in Hispanic individuals (up to 3·2% per year), black individuals (up to 3·9% per year), and Asians and Pacific Islanders (up to 2·6% per year), mainly because of declines in HIV, cancer, and heart disease deaths, resulting in an estimated 112 000 fewer deaths in Hispanic individuals, 311 000 fewer deaths in black individuals, and 34 000 fewer deaths in Asians and Pacific Islanders aged 25–64 years. During 2011–14, American Indians and Alaska Natives had the highest premature mortality, followed by black individuals.

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**During 2011–14, American Indians and Alaska Natives had the highest premature mortality, followed by black individuals.**



[https://www.tulsaworld.com/news/education/rural-poverty-a-way-of-life-for-numerous-oklahomans/article\\_aac906a3-cd27-5242-9a47-cf3b8f34a817.html](https://www.tulsaworld.com/news/education/rural-poverty-a-way-of-life-for-numerous-oklahomans/article_aac906a3-cd27-5242-9a47-cf3b8f34a817.html)

American Indian alone	48.6%	1,977
White alone	25.7%	1,046
Hispanic	14.7%	596
Two or more races	11.3%	459
Asian alone	1.2%	48
Black alone	0.02%	1

Wonkblog • Analysis

# The Strawberry Capital of the World is the early death capital of the U.S.: lessons from a landmark dataset



[https://www.washingtonpost.com/business/2018/09/14/wrong-neighborhood-can-take-plus-years-off-your-life-average/?utm\\_term=.af4fbd16be32](https://www.washingtonpost.com/business/2018/09/14/wrong-neighborhood-can-take-plus-years-off-your-life-average/?utm_term=.af4fbd16be32)

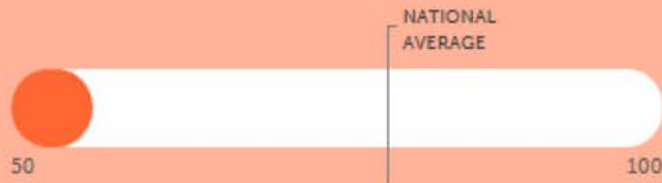


# RUTGERS Life Expectancy in Stilwell, Oklahoma



## My Area

Census Tract  
Reference number: 40001376900



**56.30**

YEARS



## Adair County



**73.87**

YEARS



## Oklahoma



**75.70**

YEARS



## United States



**78.80**

YEARS

	RANK	LIFE EXPECTANCY
 Benin	162	60.0
 Burkina Faso	163	59.9
 Togo	163	59.9
 DR Congo	165	59.8
 Burundi	166	59.6
 Guinea	167	59.0
 Guinea-Bissau	168	58.9
 Eswatini (Swaziland)	168	58.9
 Malawi	170	58.3
 Mali	171	58.2
 Equatorial Guinea	171	58.2
 Mozambique	173	57.6
 South Sudan	174	57.3
 Cameroon	174	57.3
 Somalia	176	55.0
 Nigeria	177	54.5
 Lesotho	178	53.7
 Cote d'Ivoire	179	53.3
 Chad	180	53.1
 Central African Republic	181	52.5
 Angola	182	52.4
 Sierra Leone	183	50.1

# RUTGERS STILWELL, OKLAHOMA POVERTY RATE = 34.2%

	Adair County	Tulsa County	Statewide
Poverty rate (34.2 in Stilwell itself):	27.2%	14.8%	16.6%
Median household income:	\$33,325	\$48,926	\$46,235
Median home value:	\$74,700	\$136,100	\$115,000
High school diploma:	78.5%	88.6%	88.7%
Bachelor's or higher:	12.9%	30.0%	23.8%
Labor force participation (16 years and older):	53.6 %	67.0	61.3
Retail sales per capita:	\$5,535	\$17,032	\$13,174
Population change (last 5 years):	-3.0	+5.9	+4.3

*Source: U.S. Census*

[https://www.tulsaworld.com/news/education/rural-poverty-a-way-of-life-for-numerous-oklahomans/article\\_aac906a3-cd27-5242-9a47-cf3b8f34a817.html](https://www.tulsaworld.com/news/education/rural-poverty-a-way-of-life-for-numerous-oklahomans/article_aac906a3-cd27-5242-9a47-cf3b8f34a817.html)

Rural poverty: Trapped in the cycle

# Rural poverty: 'A way of life' for numerous Oklahomans

Poverty is common experience for many rural Oklahomans

By MICHAEL OVERALL World Staff Writer Aug 7, 2016



Buy

With no air conditioning, Jenifer Wilhite and her family, including her son, Ray Wichita, and her 9-month-old grandchild, Blazton, come to the front porch for relief from the summer heat in Stilwell. MIKE SIMONS/Tulsa World

Stilwell has a large Native American population — **and not African American.** But it's otherwise typical of places that rank in the bottom 25 percent for life expectancy.

Those neighborhoods,  
where people expect to  
live the shortest lives,  
consistently meet four  
criteria:

# They're in the bottom 25 percent for income (60.9 %)

They're less educated (56.7 %)

They're in the sprawling [South Census Region](#) that stretches from Oklahoma to Delaware (52.2 %),

They're predominantly black (51.0 %).

They're in the bottom 25 percent for income (60.9 %)

# They're less educated (56.7 %)

They're in the sprawling [South Census Region](#) that stretches from Oklahoma to Delaware (52.2 %),

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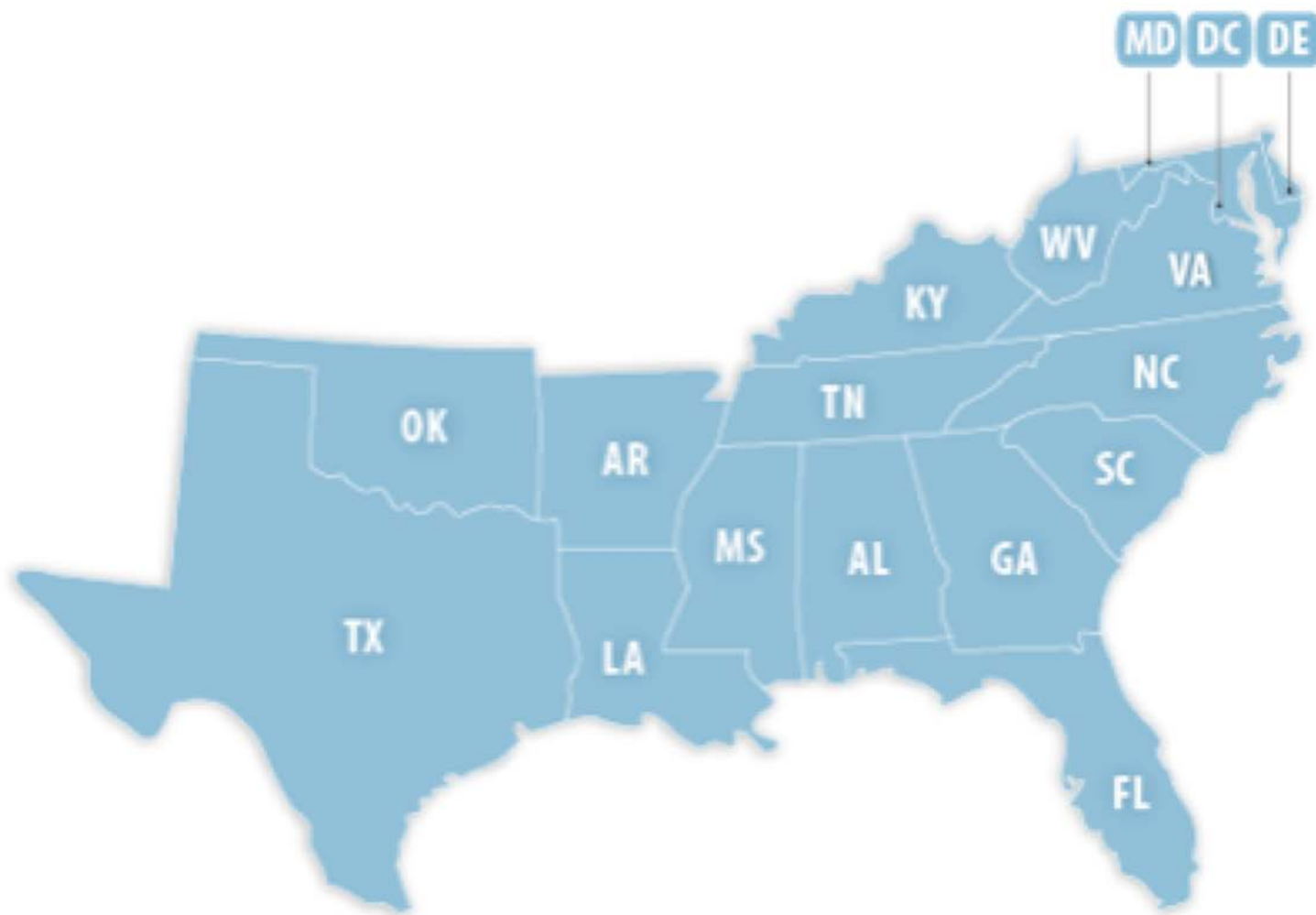
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# US SOUTH CENSUS REGION

Select area on the map:



They're in the bottom 25 percent for income (60.9 %)

They're less educated (56.7 %)

They're in the sprawling [South Census Region](#) that stretches from Oklahoma to Delaware (52.2 %),

**They're predominantly black  
(51.0 %).**

**THIS IS WHAT  
BLACK PRIVILEGE  
LOOKS LIKE**

Volume I  
Executive Summary

Report of the  
Secretary's Task  
Force on

1985-2015



Years of  
Advancing  
Health Equity

# Black & Minority Health

Margaret M. Heckler  
Secretary

U.S. Department of Health and  
Human Services



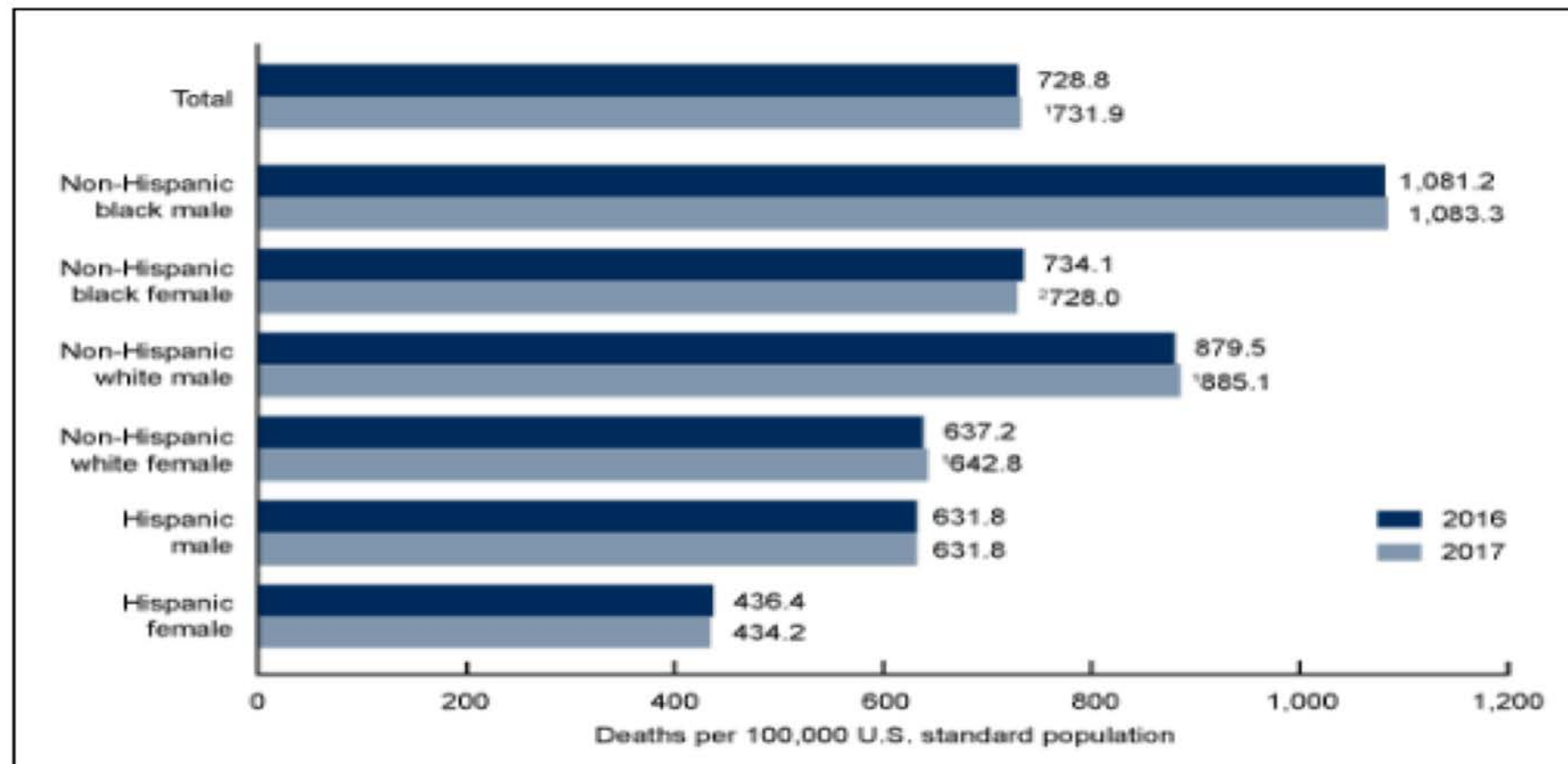
## Six Causes of Excess Mortality Identified in the Heckler Report

- Cancer
- Cardiovascular and Cerebrovascular Diseases
- Chemical Dependency
- Diabetes
- Homicide, Suicide and Accidents
- Infant Mortality

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- Cancer
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  - Homicide, Suicide and Accidents
  - Infant Mortality
- 
- HIV/AIDS

**Figure 2. Age-adjusted death rates, by race and ethnicity and sex: United States, 2016 and 2017**



<sup>1</sup>Statistically significant increase in age-adjusted death rate from 2016 to 2017 ( $p < 0.05$ ).

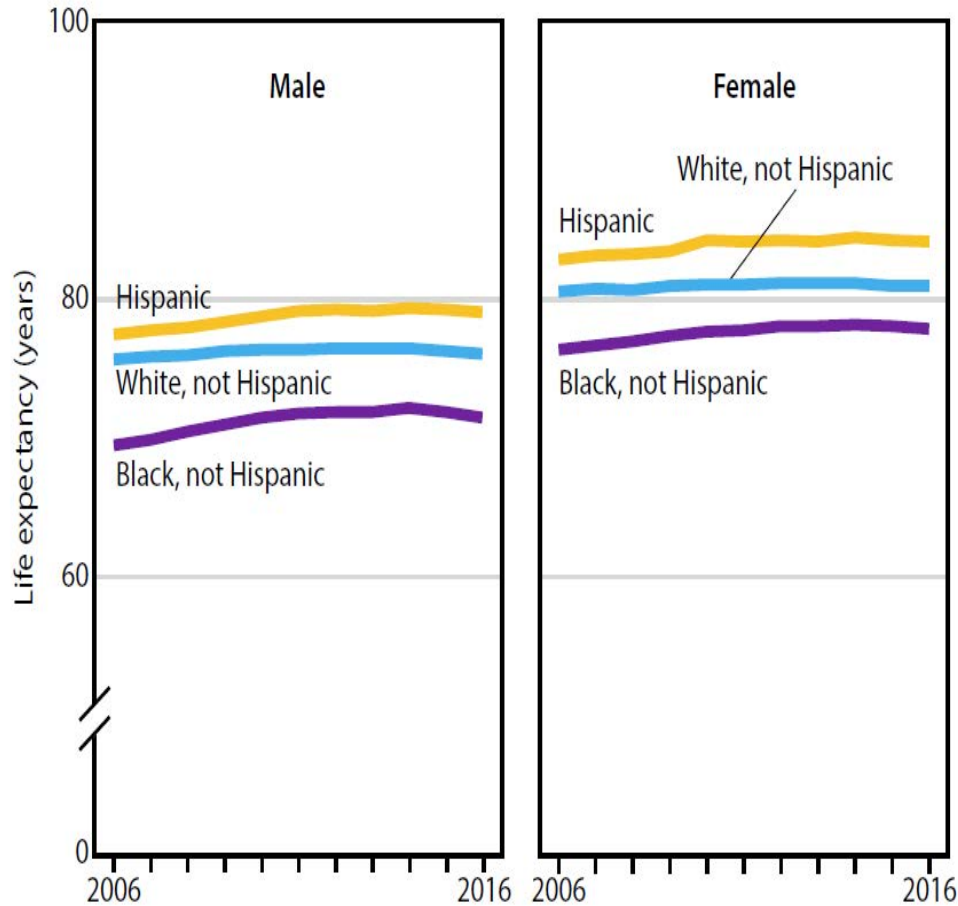
<sup>2</sup>Statistically significant decrease in age-adjusted death rate from 2016 to 2017 ( $p < 0.05$ ).

NOTE: [Access data table for Figure 2](#)

SOURCE: NCHS, National Vital Statistics System, Mortality.



# Life expectancy at birth, by sex and race and Hispanic origin



NOTES: Life expectancy data by Hispanic origin were available starting in 2006 and were corrected to address racial and ethnic misclassification. Life expectancy estimates for 2016 are based on preliminary Medicare data.

SOURCE: NCHS, *Health, United States, 2017*, Figure 1. Data from the National Vital Statistics System (NVSS), Mortality.

# UNITED STATES LIFE EXPECTANCY BY RACE/ETHNICITY 2014

RACE/ETHNICITY	
WHITE	78.8
BLACK	<b>75.2</b>
ASIAN	N/A
AMERICAN INDIAN/AN	N/A
LATINO	81.8

# U.S. CANCER DEATH RATES BY RACE – 2011-16

(per 100,000)

RACE/ETHNICITY	
WHITE	165.4
BLACK	<b>190.6</b>
ASIAN	100.4
AMERICAN INDIAN/AN	148.8
LATINO	113.6

**U.S. LUNG CANCER DEATH RATES BY RACE –  
2011-16 (per 100,000)**

RACE/ETHNICITY	
WHITE	45
BLACK	<b>45.6</b>
ASIAN	22.8
AMERICAN INDIAN/AN	35.4
LATINO	18.3

**U.S. COLON CANCER DEATH RATES BY RACE –  
2011-16 (per 100,000)**

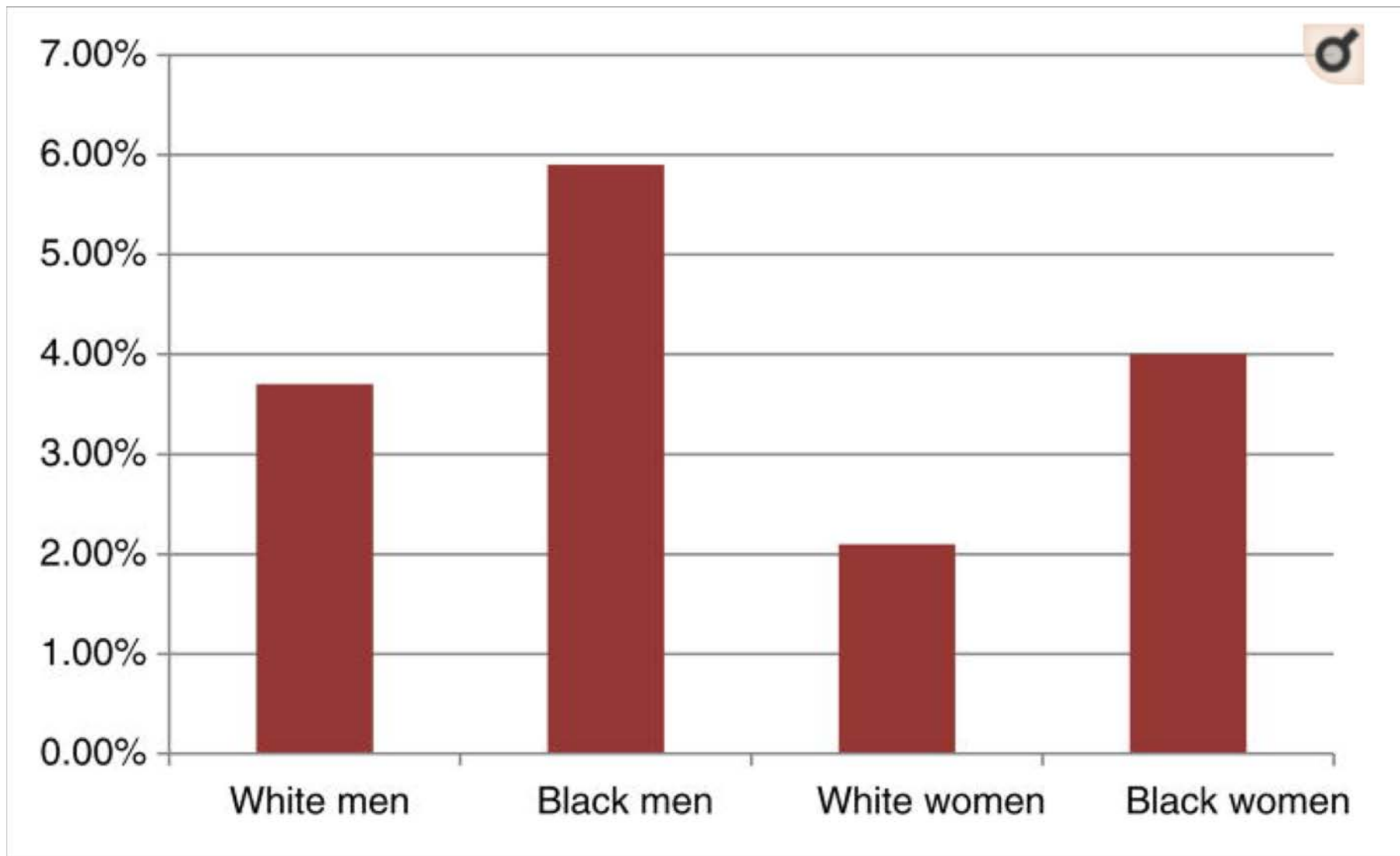
<b>RACE/ETHNICITY</b>	
<b>WHITE</b>	<b>14.0</b>
<b>BLACK</b>	<b>19.4</b>
<b>ASIAN</b>	<b>9.9</b>
<b>AMERICAN INDIAN/AN</b>	<b>15.9</b>
<b>LATINO</b>	<b>11.2</b>

**U.S. BREAST CANCER DEATH RATES BY RACE –  
2011-16 (per 100,000)**

<b>RACE/ETHNICITY</b>	
<b>WHITE</b>	<b>20.6</b>
<b>BLACK</b>	<b>28.9</b>
<b>ASIAN</b>	<b>11.3</b>
<b>AMERICAN INDIAN/AN</b>	<b>14.5</b>
<b>LATINO</b>	<b>14.3</b>

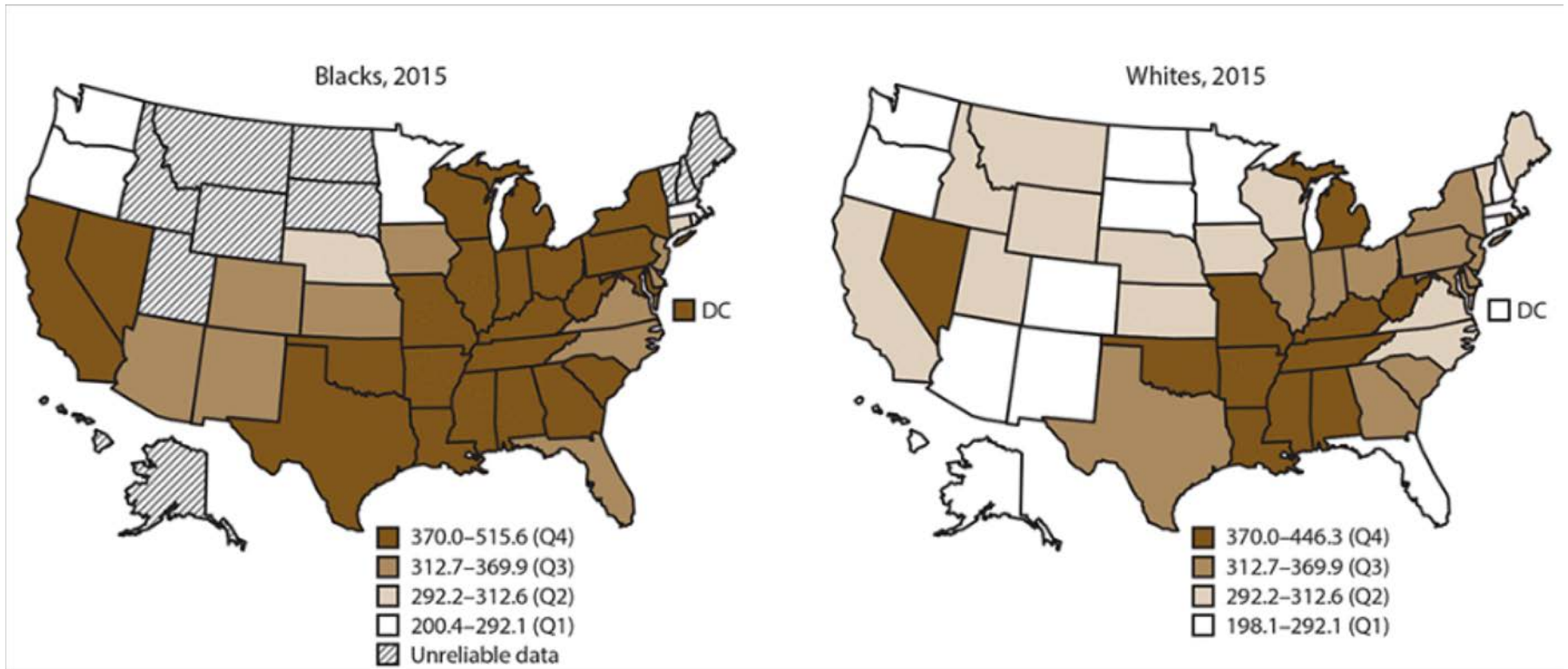
**U.S. PROSTATE CANCER DEATH RATES BY RACE**  
 – 2011-16 (per 100,000)

RACE/ETHNICITY	
WHITE	18.1
BLACK	<b>39.8</b>
ASIAN	8.6
AMERICAN INDIAN/AN	19.1
LATINO	15.9





## Heart Disease Death Rates Among Blacks and Whites Aged ≥35 Years — United States, 1968–2015 (MMWR 3/30/18)



US TOTAL = 396/100,000

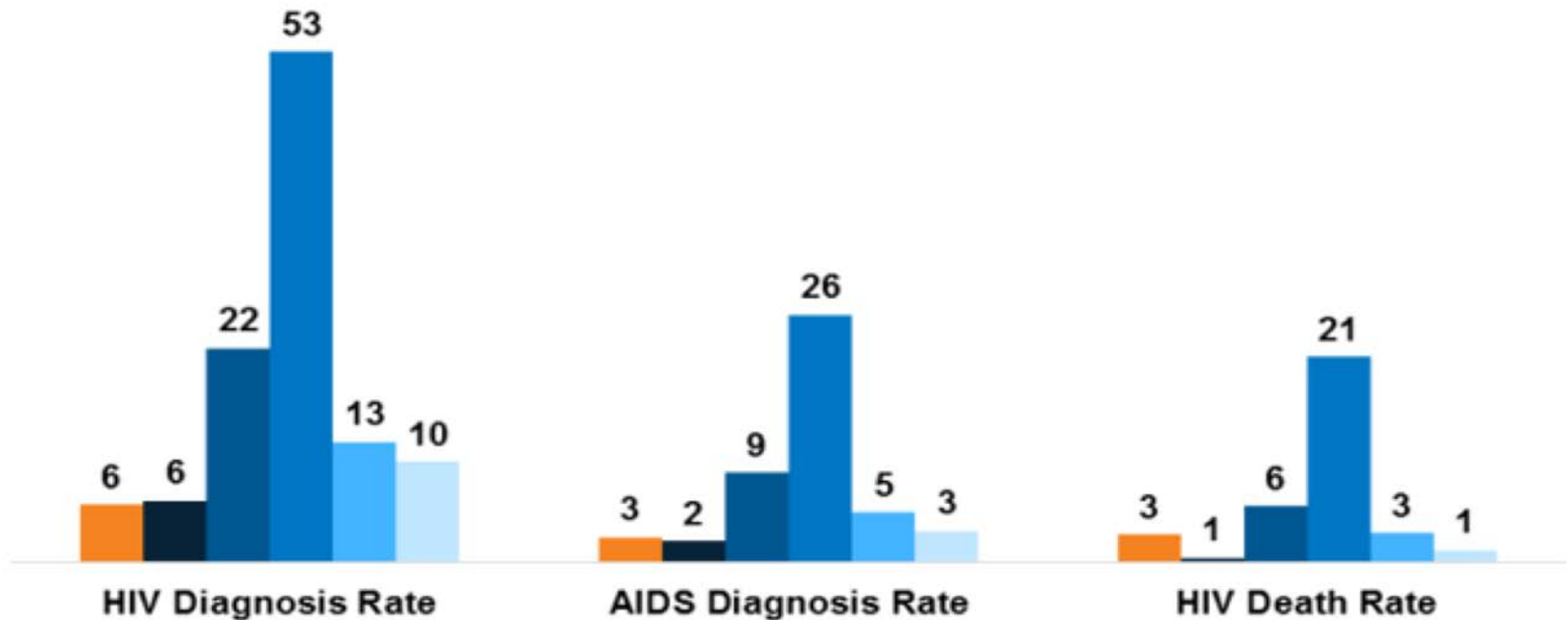
US TOTAL = 326.3/100,000

[https://www.cdc.gov/mmwr/volumes/67/ss/ss6705a1.htm#F1\\_down](https://www.cdc.gov/mmwr/volumes/67/ss/ss6705a1.htm#F1_down)

Figure 7

# HIV or AIDS Diagnosis and Death Rate per 100,000 Among Teens and Adults by Race/Ethnicity

■ White 
 ■ Asian 
 ■ Hispanic 
 ■ Black 
 ■ AIAN 
 ■ NHOPI



NOTE: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons categorized by race were not Hispanic or Latino. Individuals in each race category may, however, include persons whose ethnicity was not reported. Includes individuals ages 13 and older. Data for HIV and AIDS diagnoses are as of 2016; death rate is as of 2015.

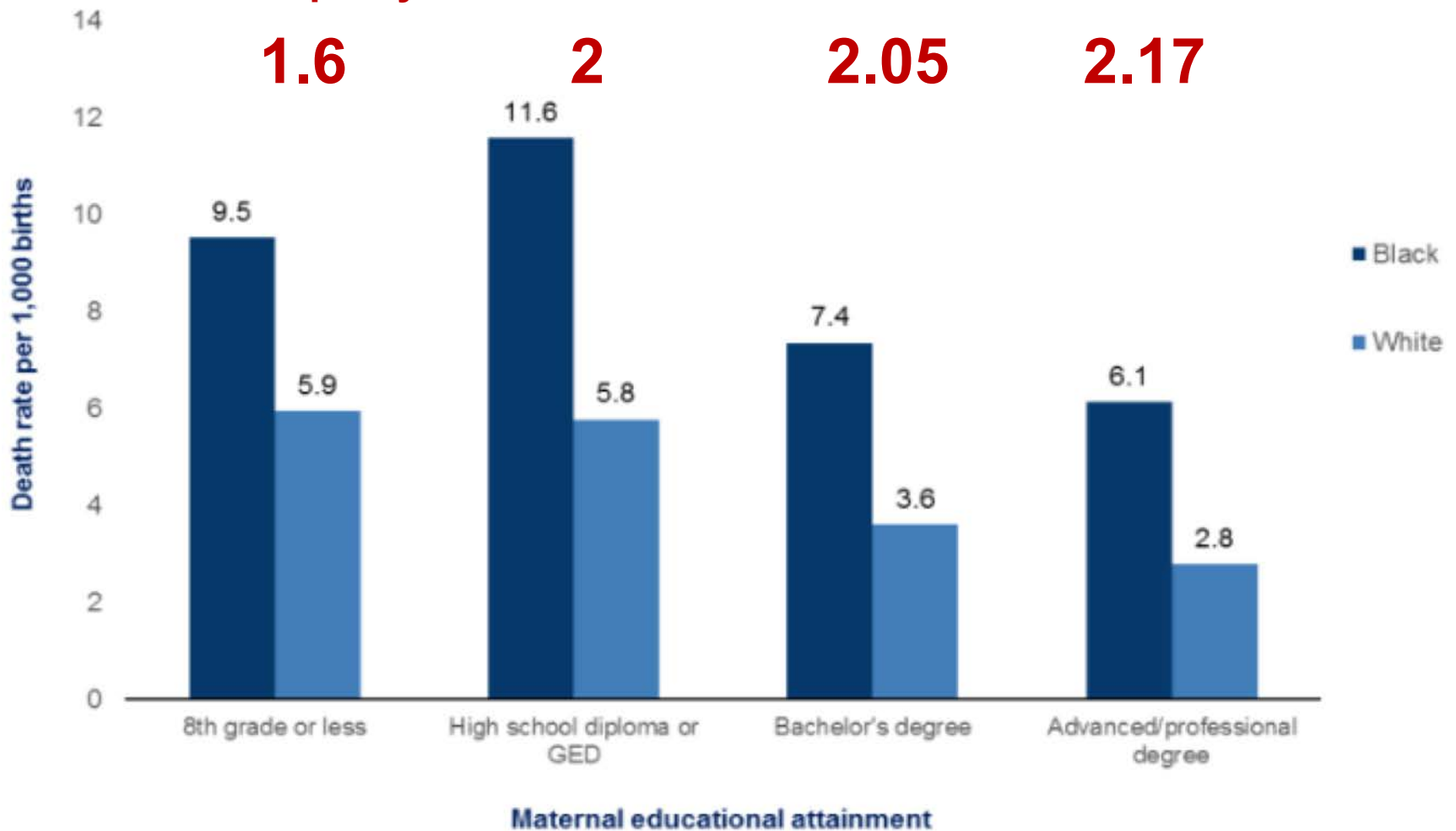
SOURCE: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2016.

# Infant Mortality in the United States by Race

	<u>1970</u>	<u>1980</u>	<u>2016</u>
<b>Overall</b>	<b>20.0</b>	<b>12.6</b>	<b>5.9</b>
<b>White</b>	<b>17.8</b>	<b>11.0</b>	<b>4.8</b>
<b>Black</b>	<b>32.7</b> (1.84)	<b>22.2</b> (2.0x)	<b>11.1</b> (2.3x)

# Infant mortality higher for middle-class blacks than lower-class whites

**B-W Disparity**

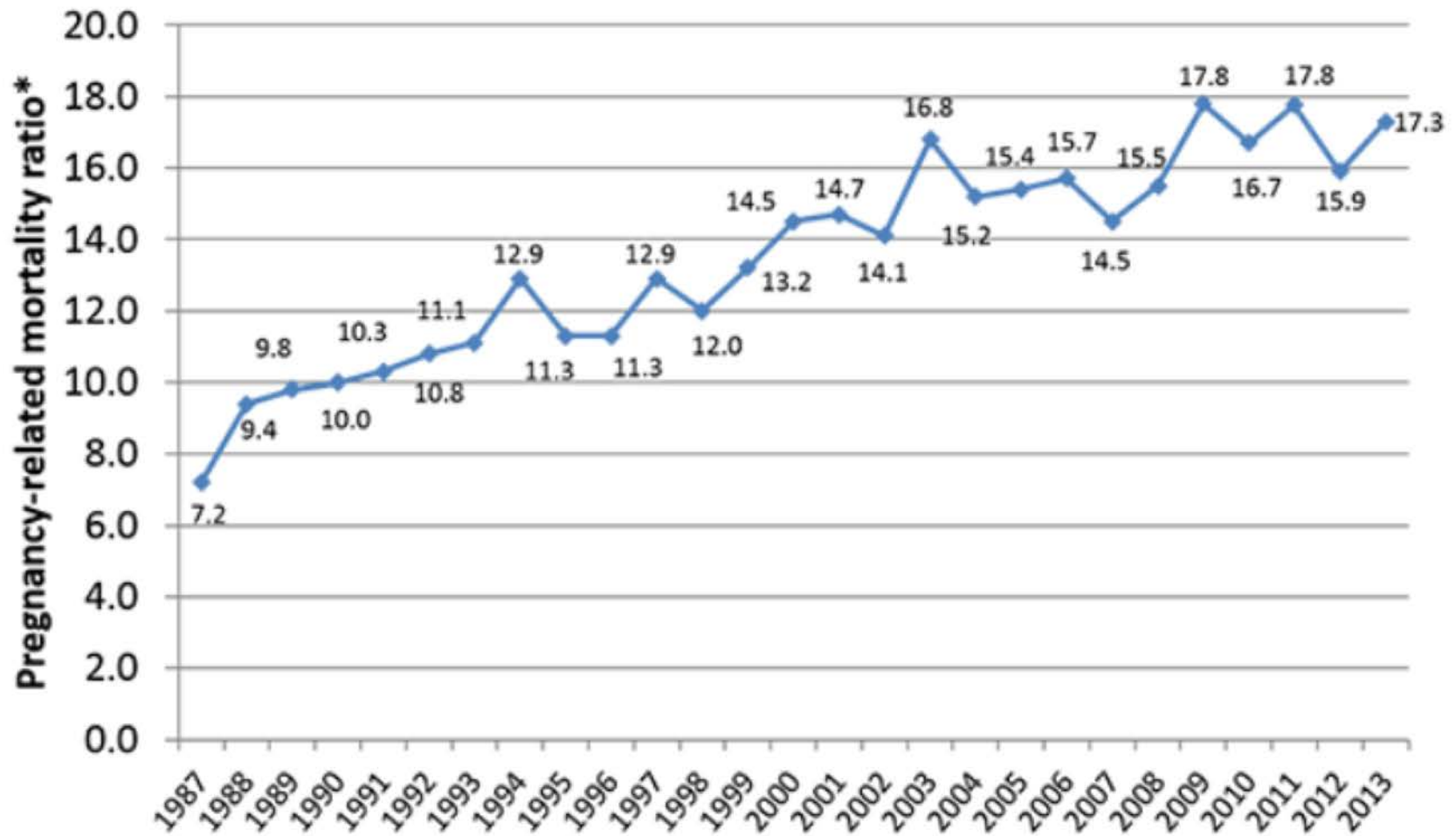


Source: Centers for Disease Control and Prevention (Wonder), Linked Birth / Infant Death Records, 2007 - 2013.

**BROOKINGS**

**IMR for a Black woman with a HS diploma is nearly 2X IMR for a Black woman with an advanced degree.**

## Trends in pregnancy-related mortality in the United States: 1987–2013



\*Note: Number of pregnancy-related deaths per 100,000 live births per year.

# Maternal mortality and morbidity in the United States of America

Priya Agrawal <sup>a</sup>

a. Merck for Mothers, Merck & Co. Inc., 1 Merck Drive, Mail Stop WS2A-56, Whitehouse Station, New Jersey, 08889, United States of America.

Correspondence to Priya Agrawal (email: [priya.agrawal@merck.com](mailto:priya.agrawal@merck.com)).

*Bulletin of the World Health Organization* 2015;93:135. doi:  
<http://dx.doi.org/10.2471/BLT.14.148627>

## Maternal mortality and morbidity in the USA

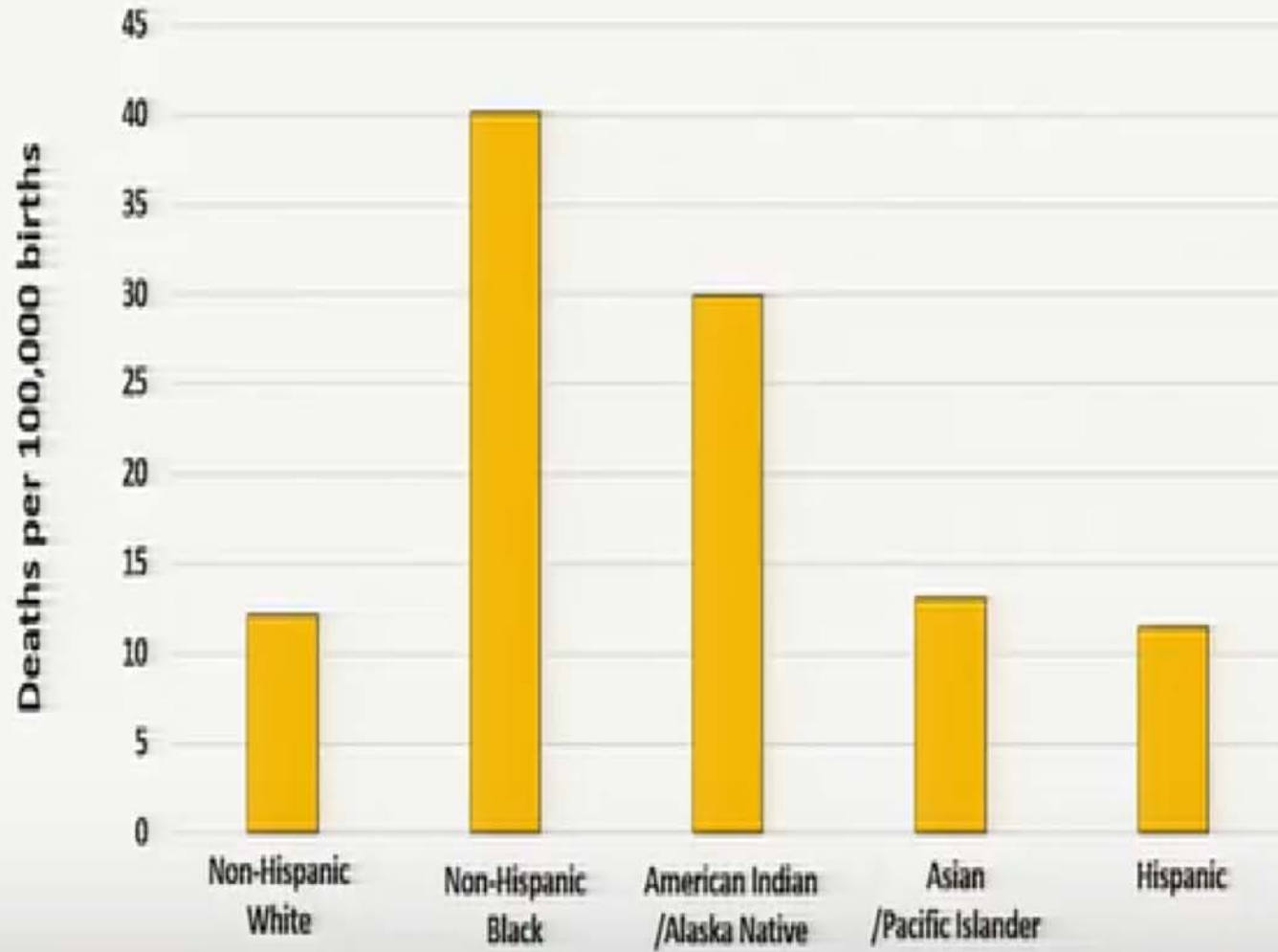
- Maternal mortality ratio in 1990  
**12/100,000**
- Maternal mortality ratio in 2013  
**28/100,000**
- Approximately half of maternal deaths are preventable

## Maternal mortality and morbidity in the USA

- **1200 fatal complications of pregnancy yearly**
- **60,000 near fatal complications of pregnancy yearly**



# PREGNANCY RELATED MORTALITY BY RACE/ETHNICITY 2006-2013

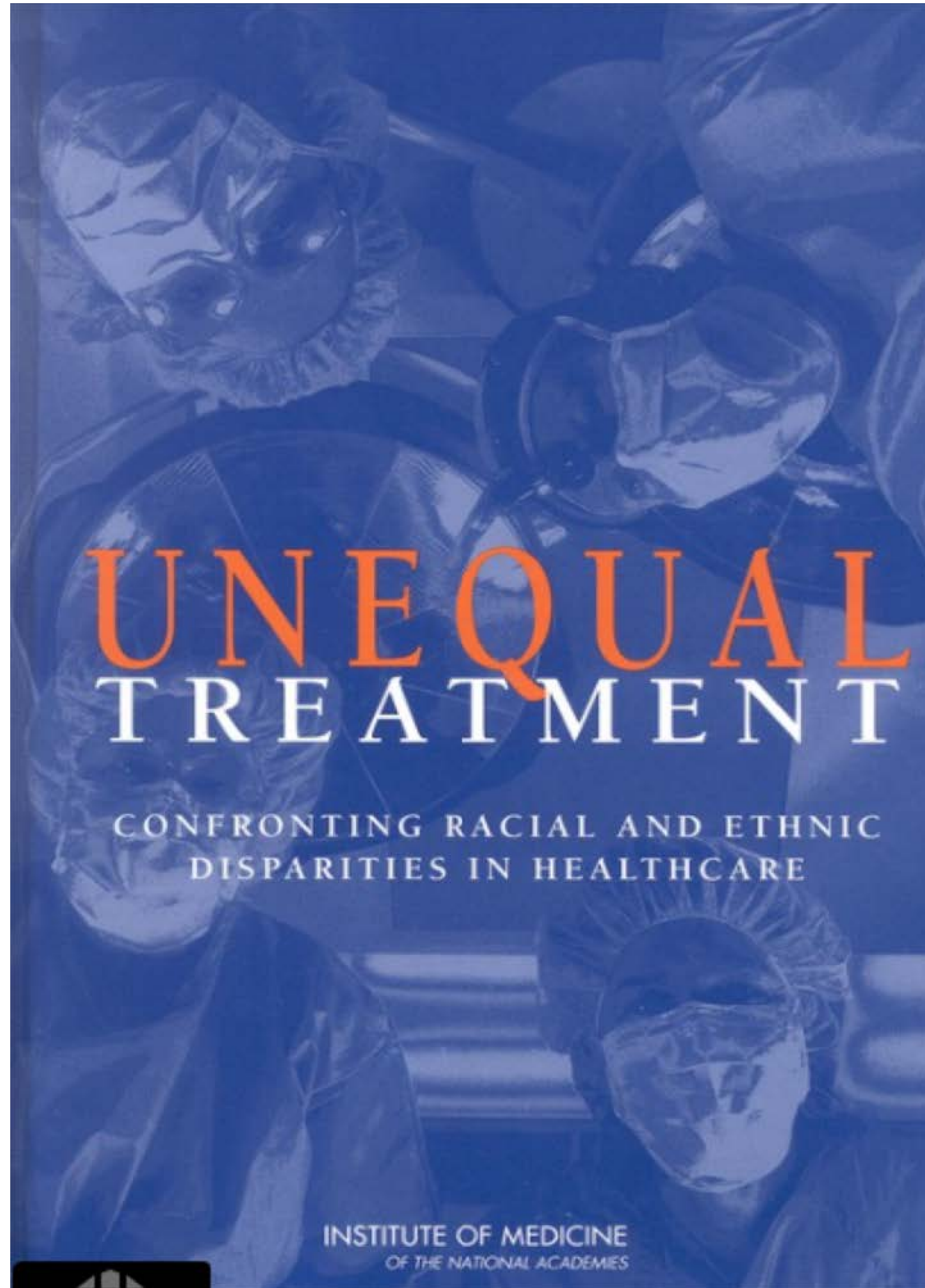


Data from the Pregnancy Mortality Surveillance System

## During 2011-2013 the pregnancy-related maternal mortality ratio was:

- 12.7 deaths per 100,000 live births for white women
- 43.5 deaths per 100,000 live births for black women
- 14.4 deaths per 100,000 live births for women of other races

*We need to routinely ask women of childbearing age who present for medical care if they have given birth within the past 42 days in order to help prevent maternal mortality.*



***“Evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services. These disparities are associated with socioeconomic differences and tend to diminish significantly, and in a few cases, disappear altogether when socioeconomic factors are controlled.”***

***“The majority of studies, however, find that racial and ethnic disparities remain even after adjustment for socioeconomic differences and other healthcare access related factors.”***

IOM Report - Unequal Treatment (2003)

**Finding 2-1: Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life.**



CMS Office of Minority Health in  
collaboration with the RAND Corporation



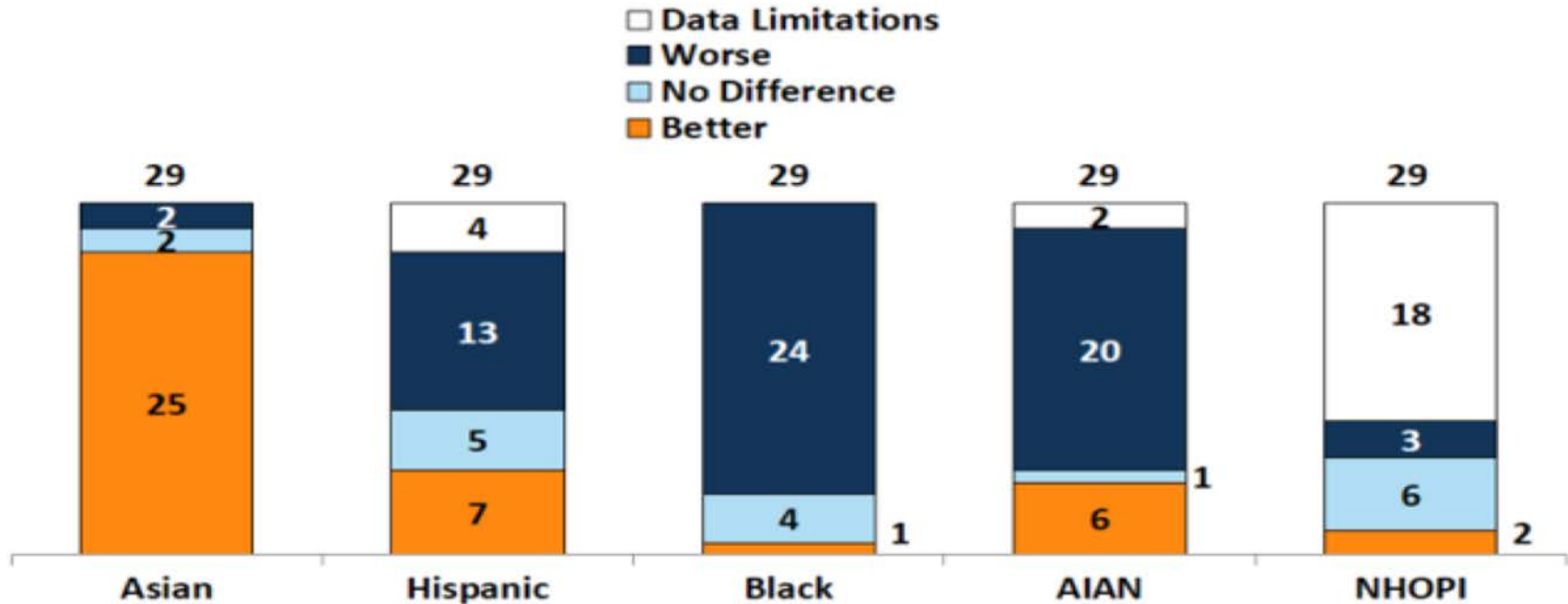
## Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage

April 2018



Exhibit 3.1

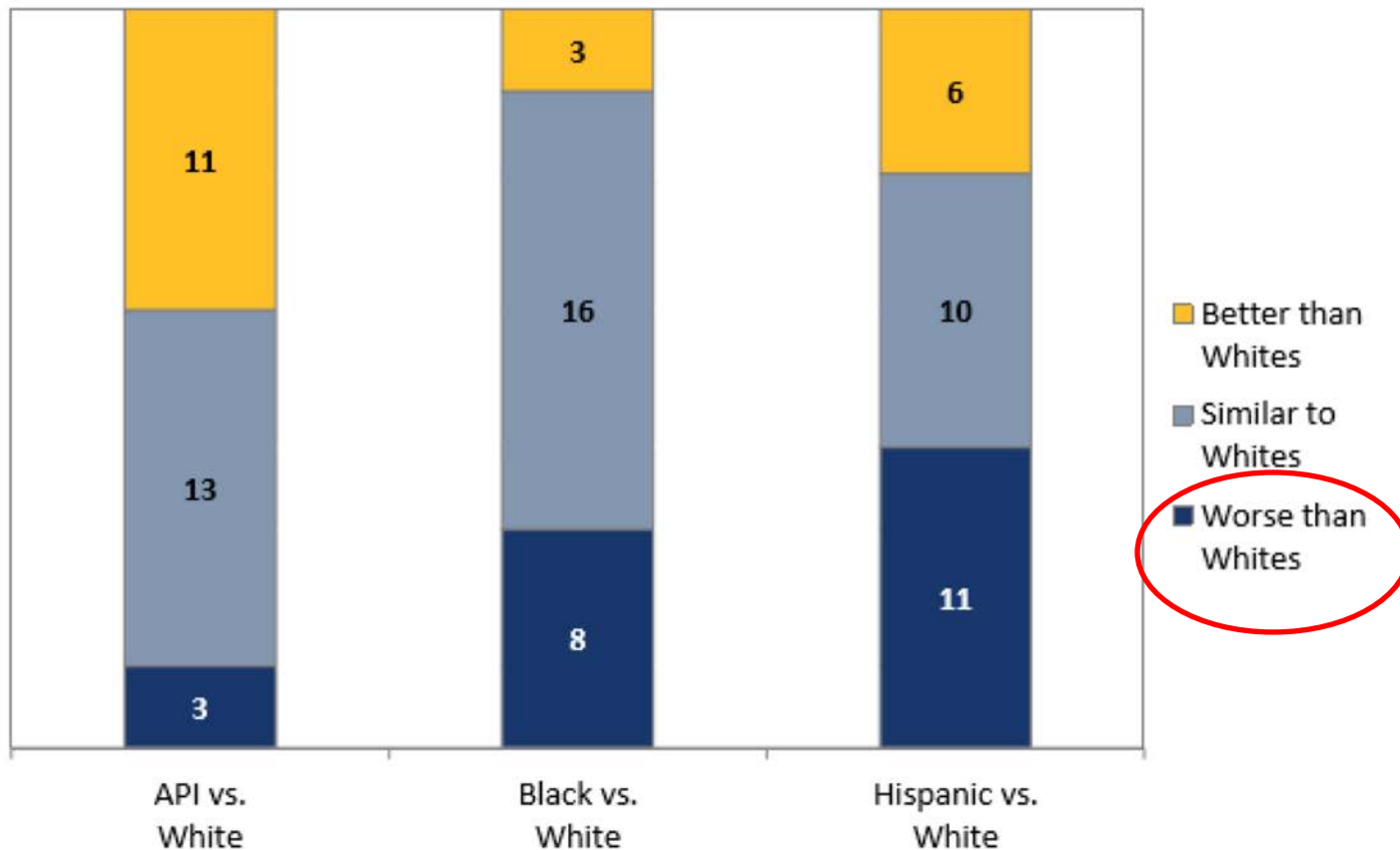
## Number of Health Status and Outcome Measures for which Groups fared Better, the Same, or Worse Compared to Whites



Note: Better or Worse indicates a statistically significant difference from White population at the  $p < 0.05$  level. No difference indicates there was no statistically significant difference. Data limitations indicates data are not available separately for a racial/ethnic group, insufficient data for a reliable estimate, or comparisons not possible to Whites due to overlapping samples. AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

### Figure 2. Racial and Ethnic Disparities in Care: All Clinical Care Measures

Number of clinical care measures (out of 27) for which members of selected groups experienced care that was worse than, similar to, or better than the care experienced by Whites in 2016



What is the role of family physicians in advocating for appropriate healthcare for poor and minority patients?

**What are social  
determinants of health?**

The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

([Social Determinants of Health Key Concepts](#), World Health Organization).

<b>Total</b>	<b>\$57,617</b>
<b>Asian</b>	<b>\$80,720</b>
<b>White</b>	<b>\$63,155</b>
<b>Hispanic</b>	<b>\$46,882</b>
<b>Black</b>	<b>\$38,555</b>

# Distribution of Family Income, 1963-2016

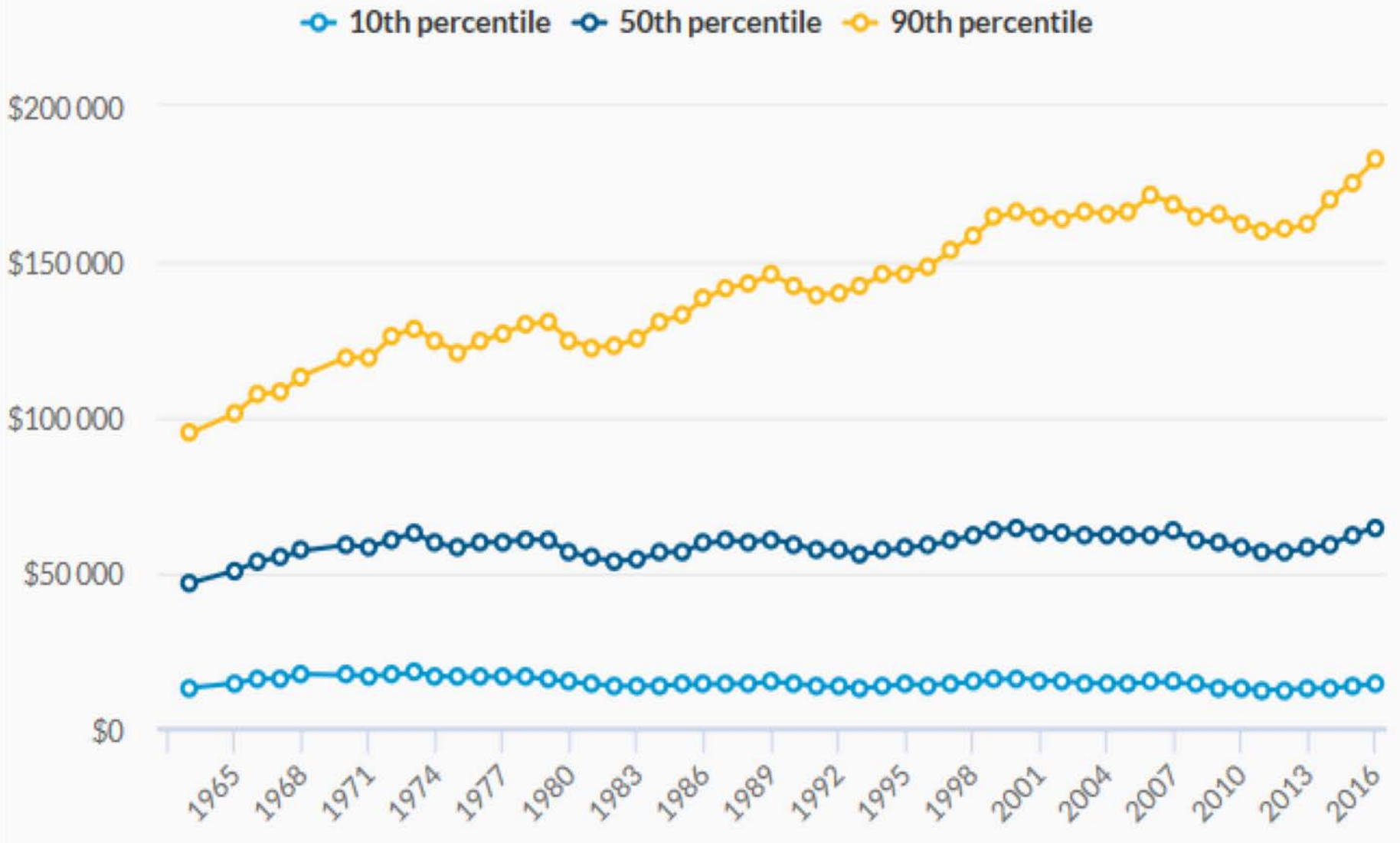
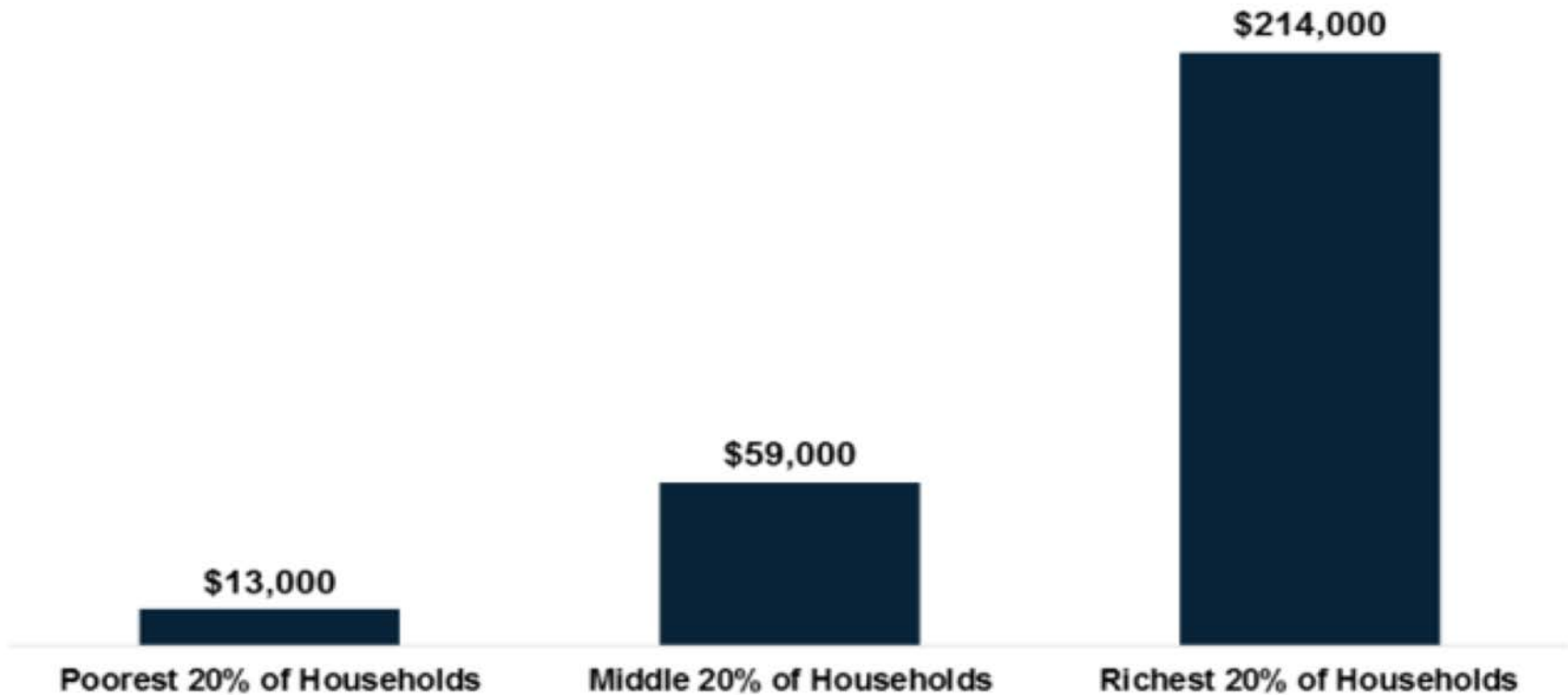


Figure 3

## Gaps Between Average Annual Income of Richest and Poorest Households in the United States, 2016



SOURCE: Semega, Jessica L., et al. "Income and Poverty in the United States: 2016." *Current Population Reports*. United States Census Bureau, September 2017, <https://www.census.gov/content/dam/Census/library/publications/2017/demo/P60-259.pdf>.



# FAMILY EARNINGS BY RACE

10th Percentile

YEAR	WHITE	BLACK	HISPANIC	ASIAN
2011	\$9,999	\$0	\$0	\$15,000
2012	\$10,000	\$0	\$0	\$13,200
2013	\$12,000	\$0	\$1,000	\$19,000

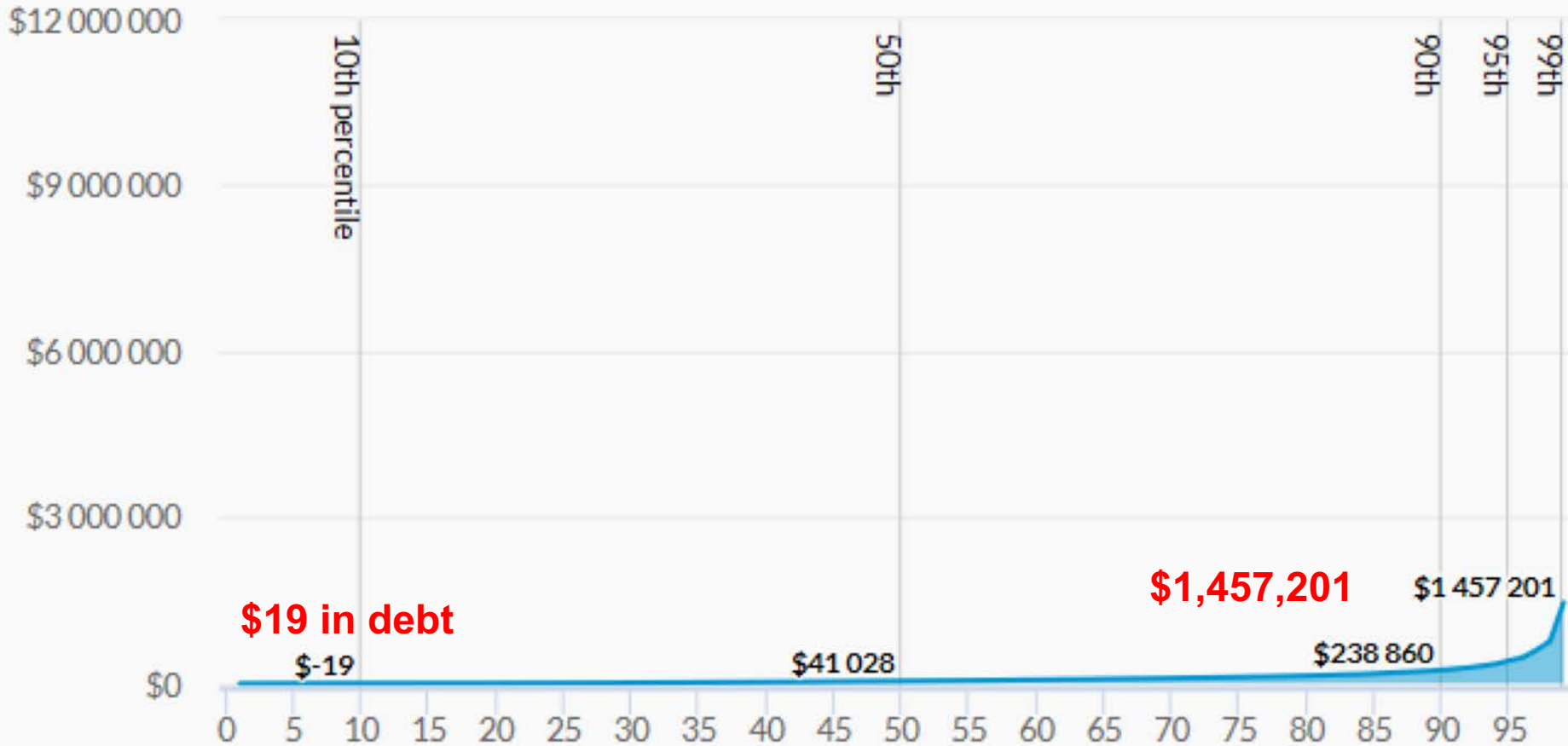
Source: The U.S. Census Bureau, Current Population Survey, March ASEC

Notes: Calculations done by Chris Wimer and JaeHyun Nam, Columbia University.

Earnings include salaries, wages, self-employment, and farm income

# Distribution of Family Wealth, 1963-2016

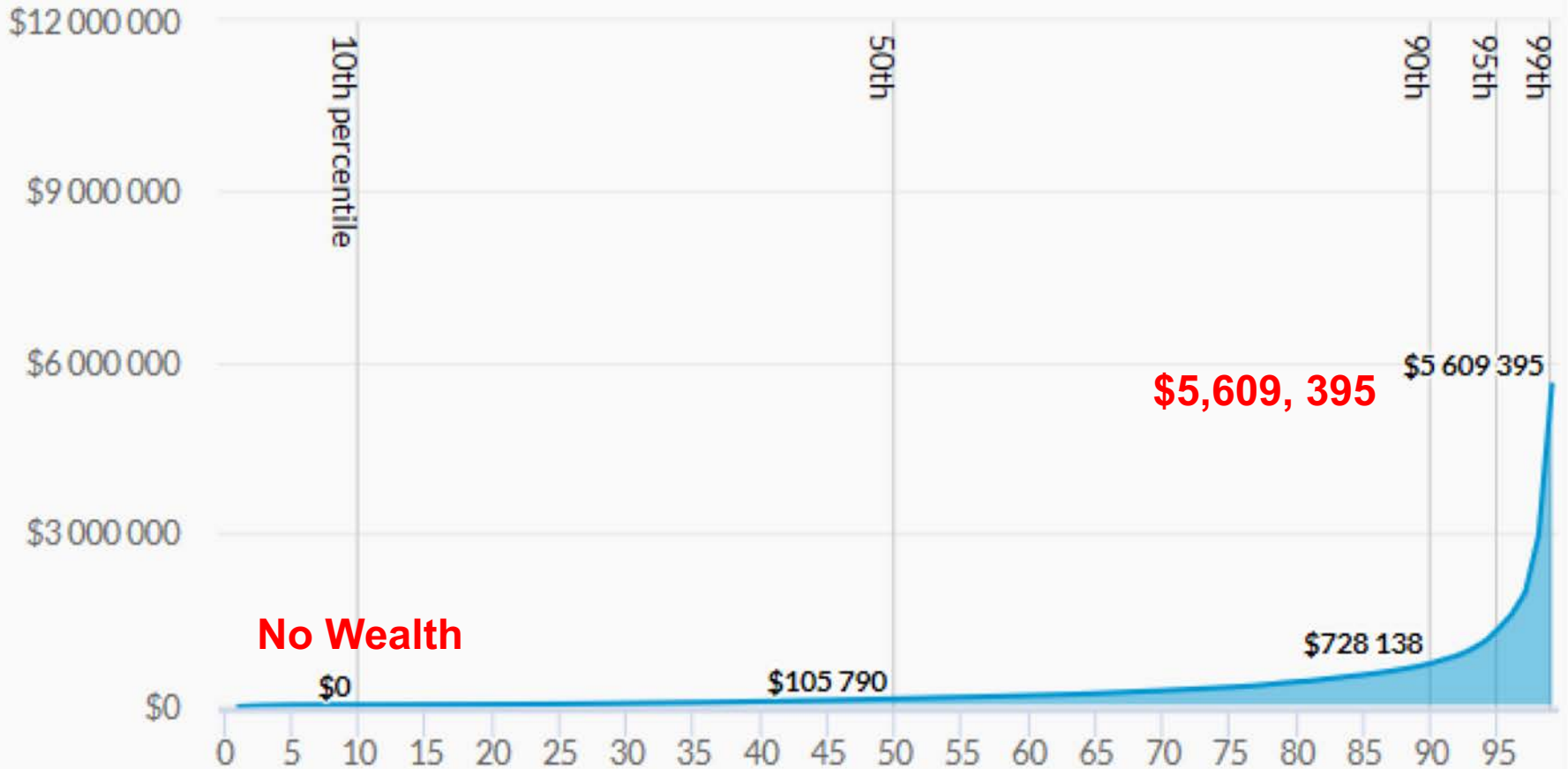
Click and drag to zoom



1963 1983 1989 1992 1995 1998 2001 2004 2007 2010 2013 2016

# Distribution of Family Wealth, 1963-2016

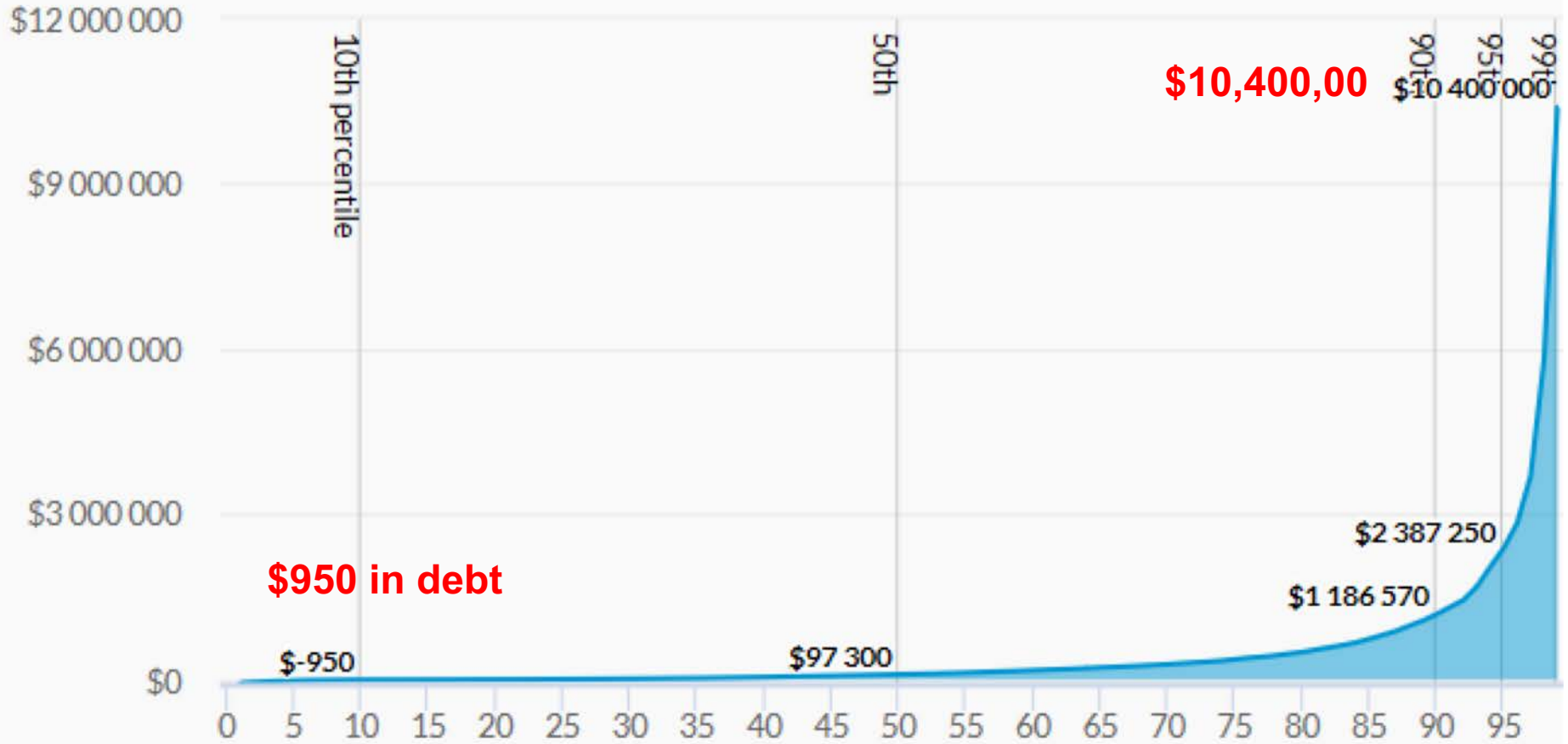
Click and drag to zoom



1963 1983 1989 1992 1995 1998 2001 2004 2007 2010 2013 2016

# Distribution of Family Wealth, 1963-2016

Click and drag to zoom



1963

1983

1989

1992

1995

1998

2001

2004

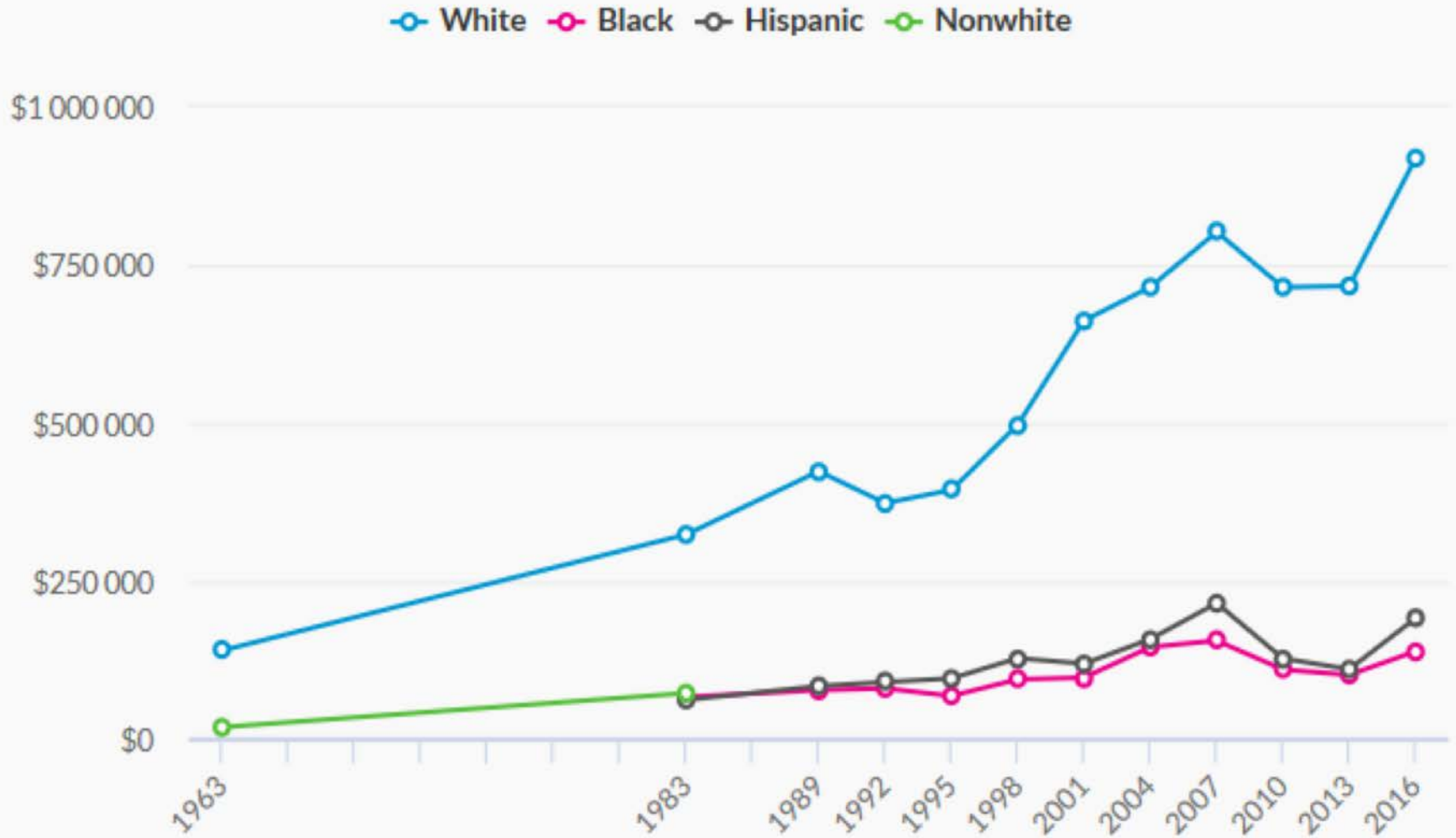
2007

2010

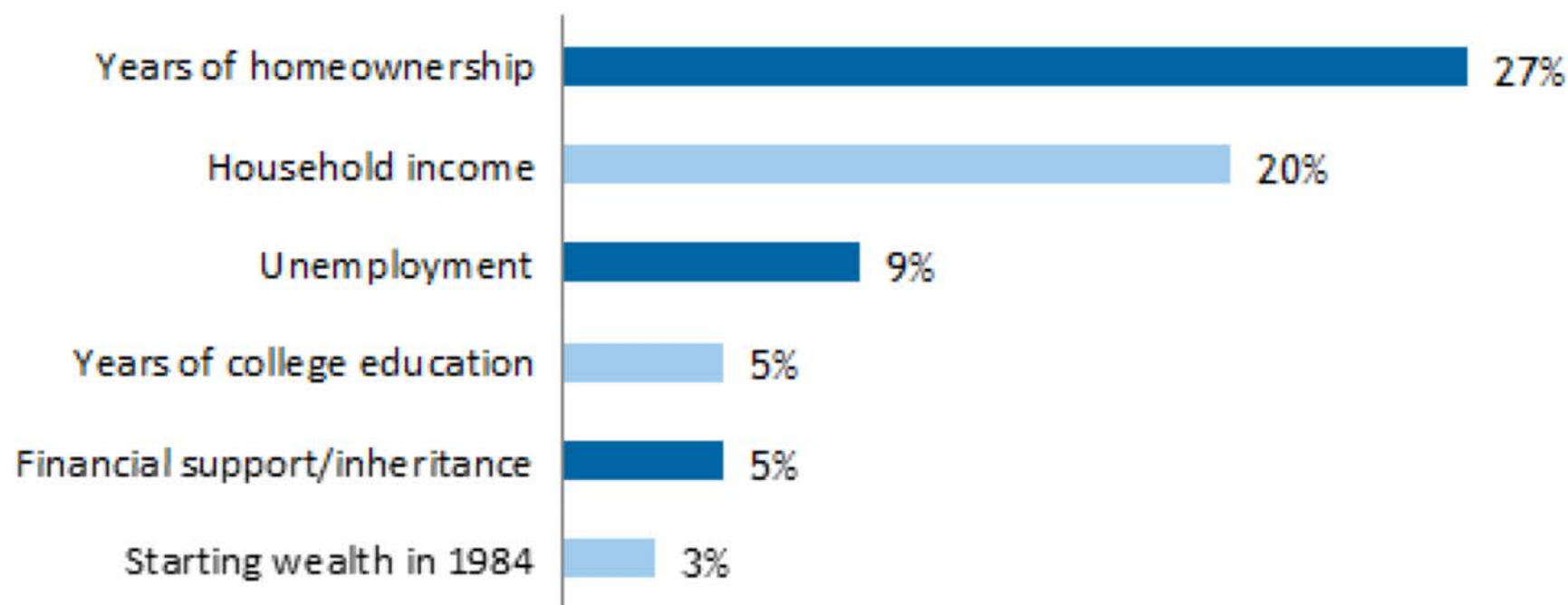
2013

2016

# Average Family Wealth by Race/Ethnicity, 1963-2016

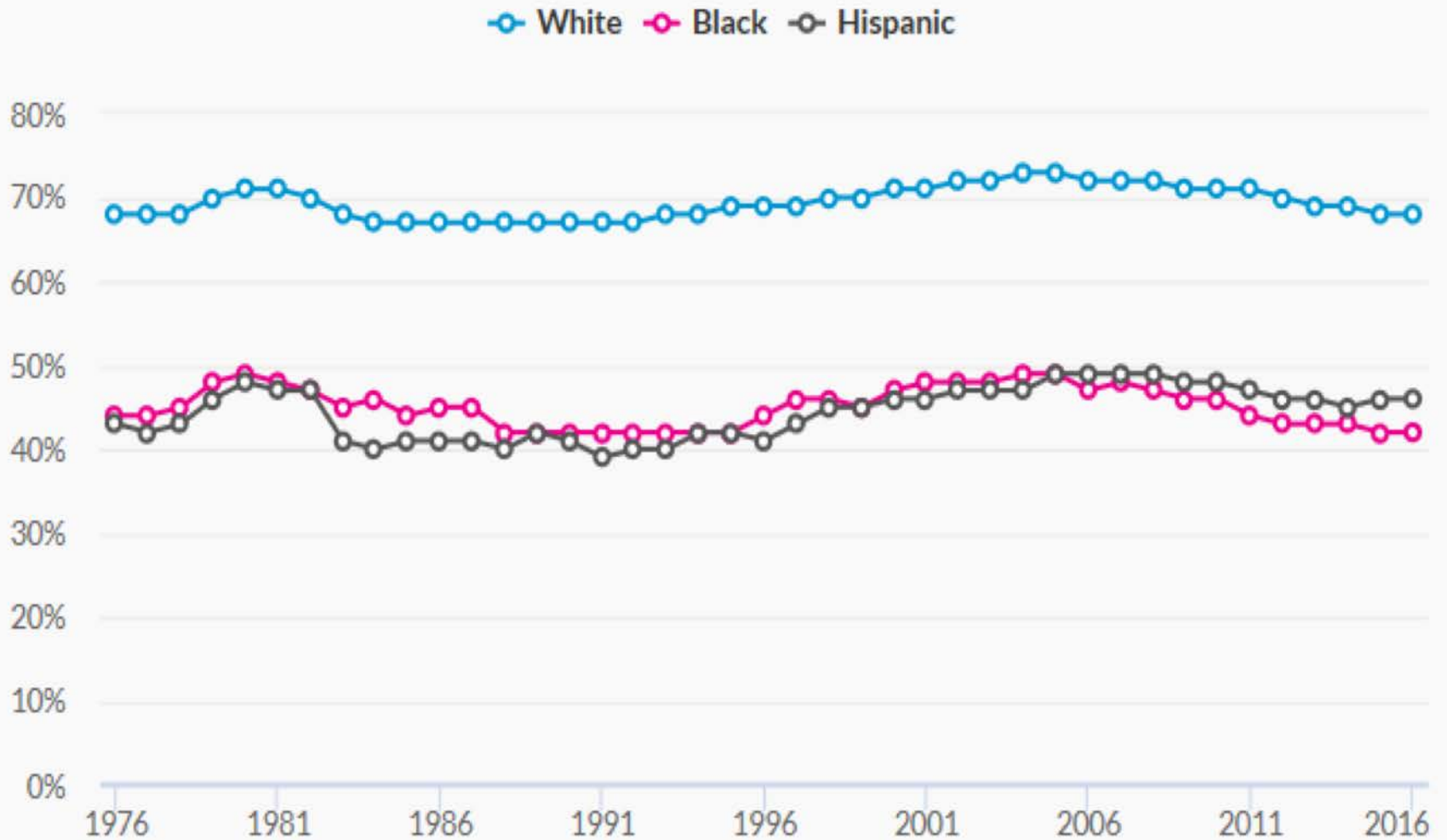


## Top factors driving the wealth gap between whites and blacks in a recent study of 1,700 working-age households from 1984 through 2009



Source: IASP 2013

# Homeownership Rate by Race/Ethnicity, 1976-2016\*



## Disparity in Life Spans of the Rich and the Poor is Growing

(NYT Headline 02/12/16)

- Life Expectancy for the bottom 10% of male wage earners born in 1920 = **72.9 years**
- Life Expectancy for the top 10% of male wage earners born in 1920 = **79.1 years**

**Gap = 6.2 years**



## Disparity in Life Spans of the Rich and the Poor is Growing

(NYT Headline 02/12/16)

- Life Expectancy for the bottom 10% of male wage earners born in 1950 = **73.6 years**
- Life Expectancy for the top 10% of male wage earners born in 1950 = **87.2years**

**Gap = 13.6 years**

## Life Expectancy at age 25, by sex and education United States 2006

- Men Without a High School Diploma 47 years
- Men With a HS Diploma or GED 51 years
- Men With Some College 52 years
- Men With a Bachelor's or higher 56 years

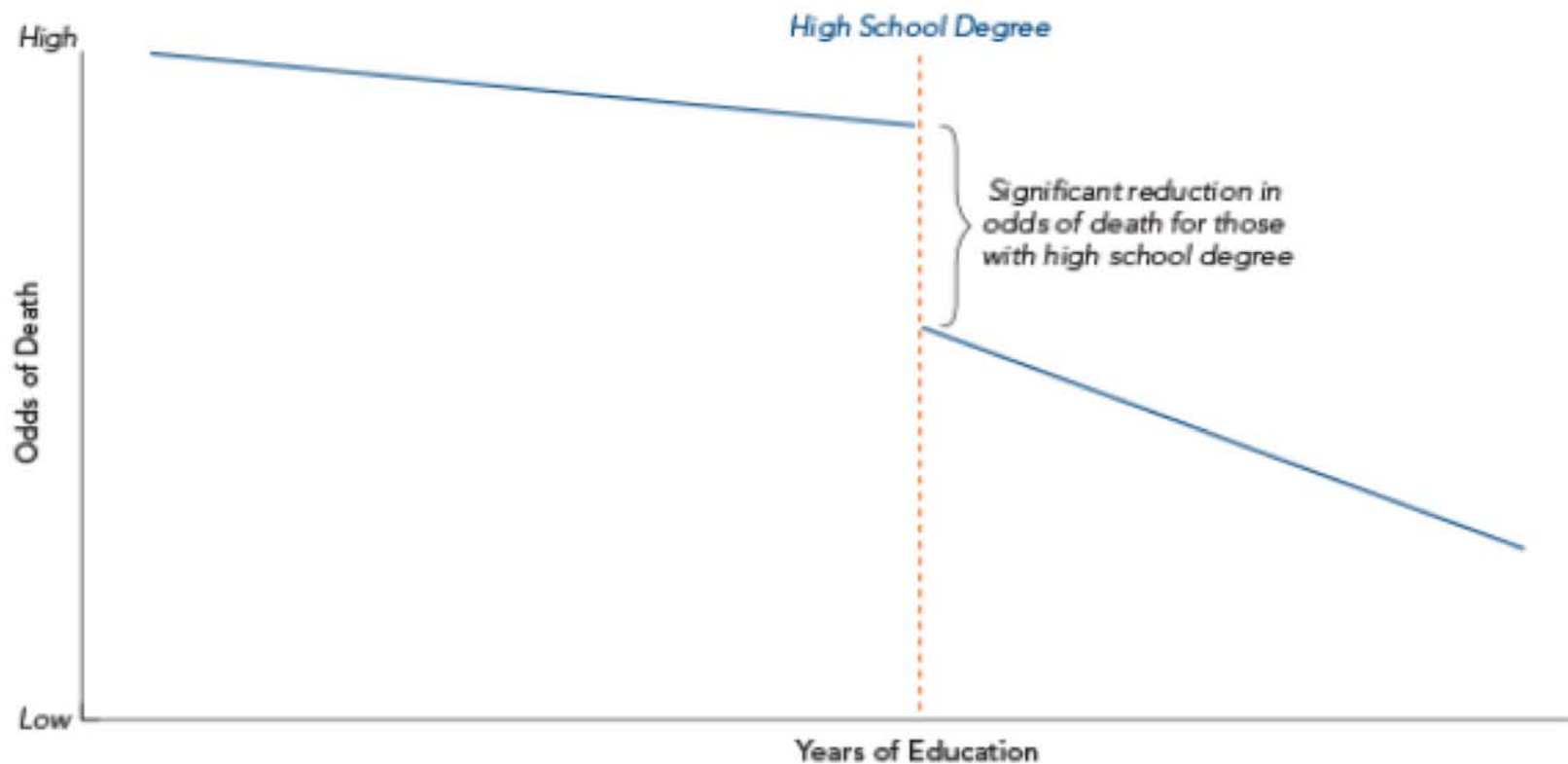
(9 year gap)

# Life Expectancy at age 25, by sex and education United States 2006

- Women Without a HS Diploma 52 years
- Women With a HS Diploma or GED 57 years
- Women With Some College 58 years
- Women With Bachelor's or higher 60 years

(8 year gap)

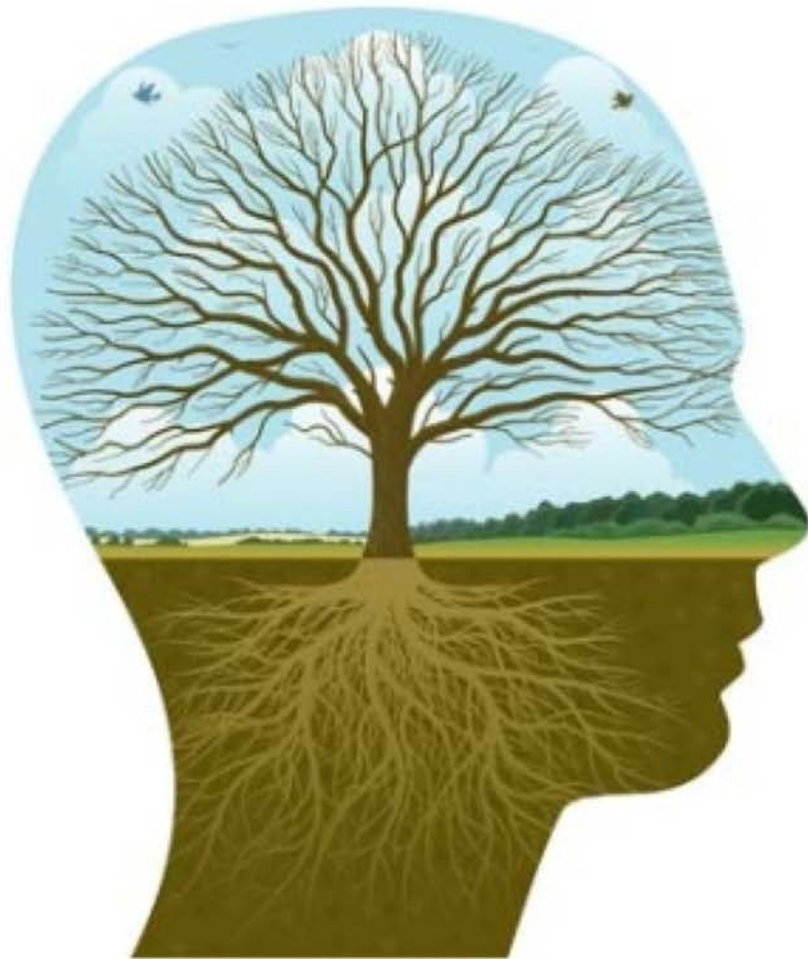
# Relationship Between Educational Attainment and Mortality for U.S. Adults



**Source:** Jennifer Karas Montez et al., "Educational Attainment and Adult Mortality in the United States: A Systematic Analysis of Functional Form," *Demography* 49, no. 1 (2012): 315-36..

# Understanding the role of unconscious bias and racism

# What Is Unconscious Bias?



We all have shortcuts, “schemas” that help us make sense of the world. But our shortcuts sometimes make us misinterpret things. That’s unconscious bias.

Racism

is

Prejudice

Plus

Power



**WHO  
NEEDS  
NIGGERS**

**BACK TO  
THE  
TREES,  
BOOGIES**





**SOUTHERN WHITES ARE  
THE NEGROES' BEST  
FRIENDS BUT  
NO INTEGRATION**



**WE WANT TO  
KEEP OUR  
SCHOOL WHITE**

**WE WANT TO  
KEEP OUR  
SCHOOL WHITE**

**WE ONLY  
WANT  
WHITE  
CHILDREN**

**WE WANT  
TO  
KEEP  
IT  
WHITE**

**WE WANT  
TO  
KEEP  
IT  
WHITE**

**WE WANT  
TO  
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**WE WANT  
TO  
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IT  
WHITE**

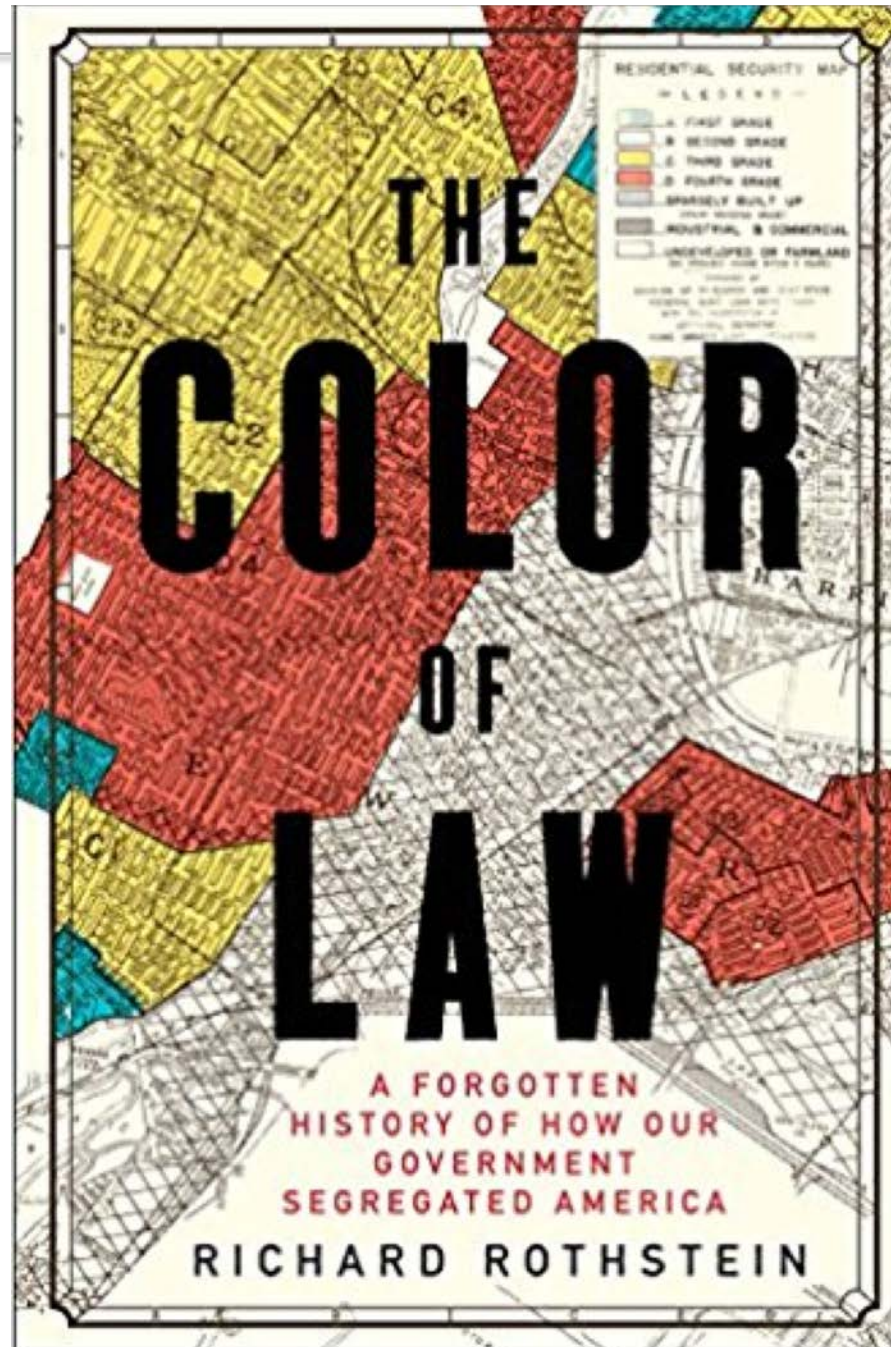


**“Until justice is blind to color, until education is unaware of race, until opportunity is unconcerned with the color of men's skins, emancipation will be a proclamation but not a fact.”**

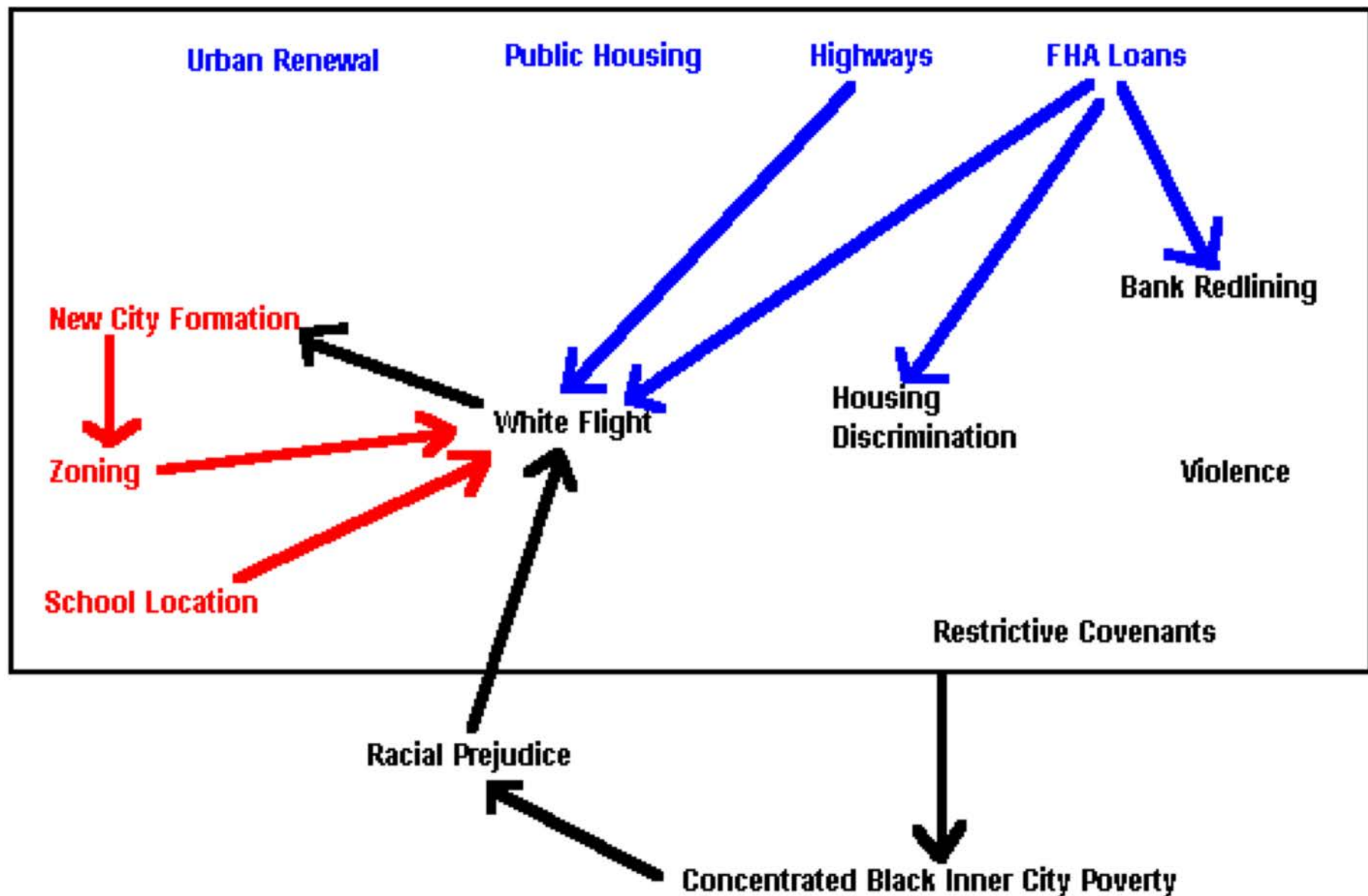
President Lyndon B. Johnson

A black and white photograph showing a large, white rectangular sign with bold, black, sans-serif text. The sign is mounted on a wooden post and is the central focus of the image. In the background, two American flags are visible, one on the left and one on the right, both appearing to be flying. The background also consists of bare trees and utility poles, suggesting a rural or suburban setting. The overall tone of the image is somber and provocative.

**WE WANT WHITE  
TENANTS IN OUR  
WHITE COMMUNITY**



## Causes of Residential Racial Segregation



## America: Equity and Equality in Health 3

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

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



**“...RESIDENTIAL SEGREGATION IS ASSOCIATED WITH ADVERSE BIRTH OUTCOMES, INCREASED EXPOSURE TO AIR POLLUTANTS, DECREASED LONGEVITY, INCREASED RISK OF CHRONIC DISEASE AND INCREASED RATES OF HOMICIDE AND OTHER CRIMES”**

***“RESIDENTIAL SEGREGATION  
ALSO SYSTEMATICALLY SHAPES  
HEALTH-CARE ACCESS,  
UTILISATION, AND QUALITY AT THE  
NEIGHBOUROOD, HEALTH-CARE  
SYSTEM, PROVIDER AND  
INDIVIDUAL LEVELS”***





EXCEPT FOR A FEW  
OUTLIERS... RACISM  
IS OVER!

SUPREME  
COURT

STOP  
AND  
FRISK

STERLING

CLIVEN  
BUNDY

TRAYVON  
MARTIN

PAULA  
DEEN

RACISM  
IN AMERICA

4/30  
DARKO  
COWARD  
DAILY TRIBUNE  
CARTOONS.COM  
© 2014



 **BAMA-GARE**

Coming soon to a clinic near you



People made Nazi-style salutes during a white nationalist rally in downtown Pikeville. Protesters gathered to protest the rally. **Alex Slitz** - [aslitz@herald-leader.com](mailto:aslitz@herald-leader.com)





Evelyn Hockstein/For The Washington Post via Getty Images

Ben, a 21-year-old KKK member is seen in Emancipation Park prior to the Unite the Right rally in Charlottesville, Virginia, Aug. 12, 2017.





Charlottesville, VA August 12, 2017

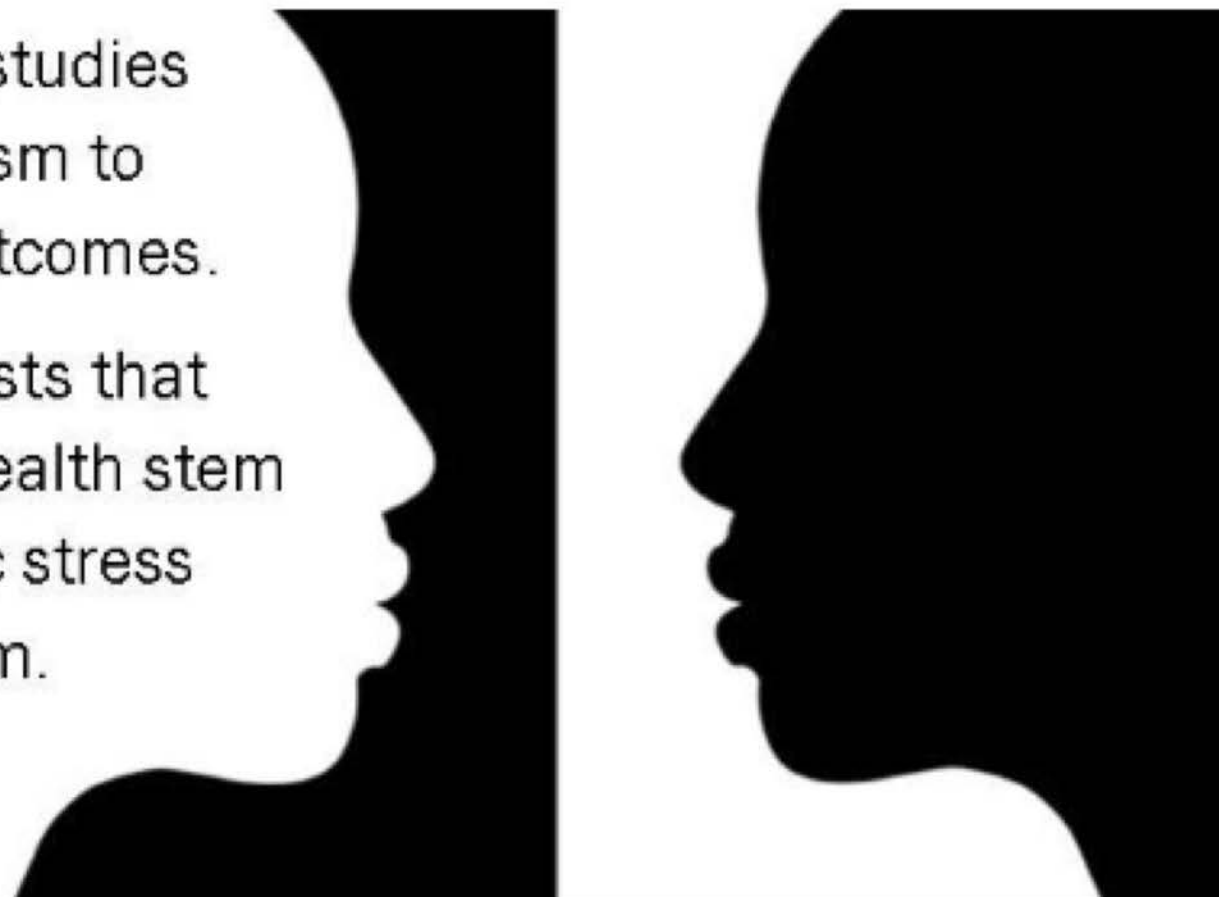


Dylann Roof

## HOW RACISM MAKES US SICK

More than 100 studies have linked racism to worse health outcomes.

Research suggests that differences in health stem from the chronic stress caused by racism.



YOU, ME AND THEM: EXPERIENCING DISCRIMINATION IN AMERICA

# How Racism May Cause Black Mothers To Suffer The Death Of Their Infants

December 20, 2017 · 5:01 AM ET

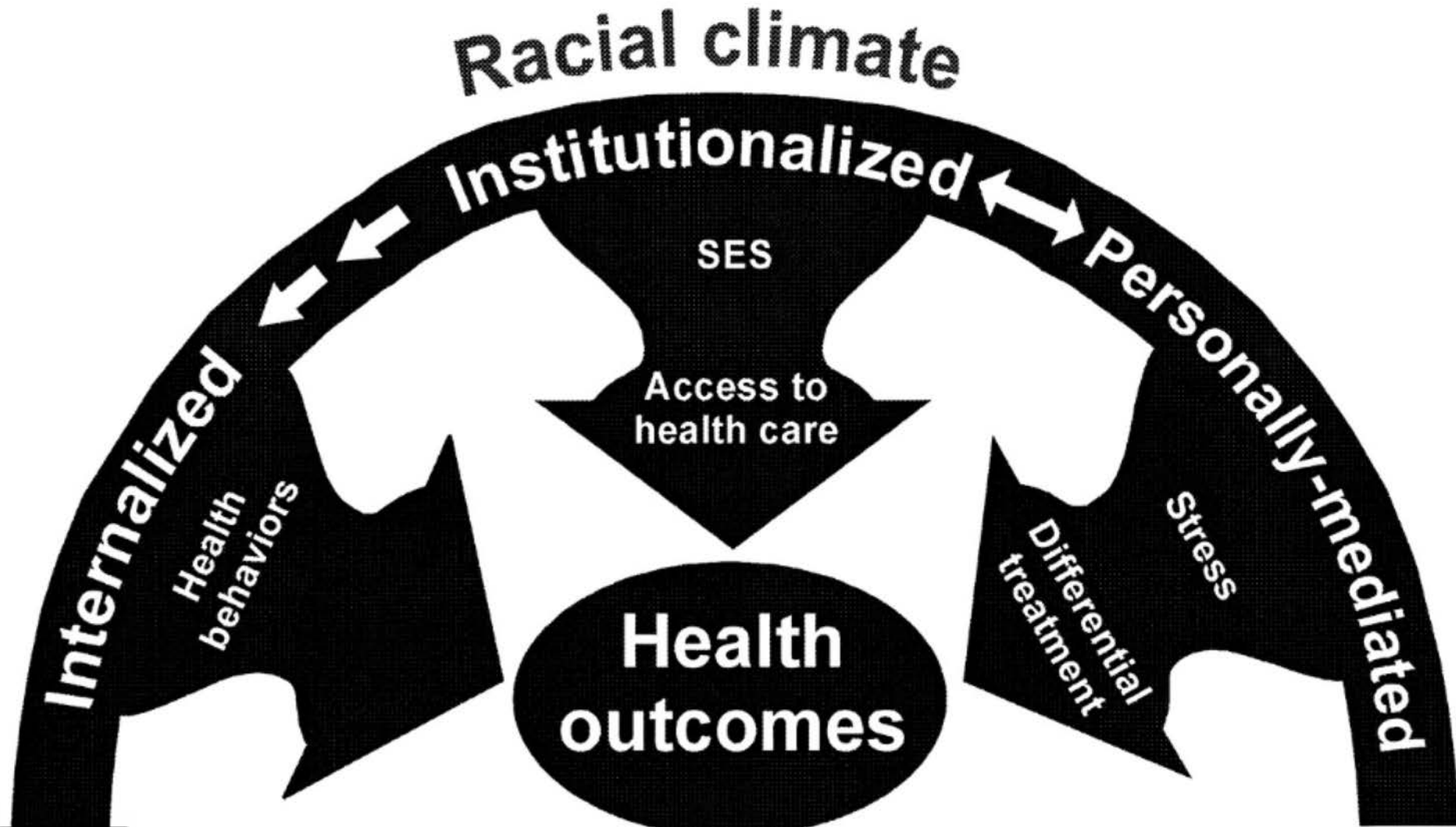
Heard on [Morning Edition](#)

RHITU CHATTERJEE



REBECCA DAVIS

# The Impacts of Racism on Health



“People know about the Klan and the overt racism, but the killing of one's soul little by little, day after day, is a lot worse than someone coming in your house and lynching you.

**Samuel L. Jackson**

[https://www.brainyquote.com/quotes/samuel\\_l\\_jackson\\_425874?src=t\\_racism](https://www.brainyquote.com/quotes/samuel_l_jackson_425874?src=t_racism)



The plague of racism is insidious, entering into our minds as smoothly and quietly and invisibly as floating airborne microbes enter into our bodies to find lifelong purchase in our bloodstreams.

(Maya Angelou)

TEACHING ABOUT RACIAL  
HEALTH DISPARITIES WITHOUT  
TALKING ABOUT RACISM

IS LIKE

TEACHING ABOUT LUNG  
CANCER WITHOUT TALKING  
ABOUT SMOKING



Toolkit for  
**TEACHING ABOUT RACISM**  
in the Context of Persistent Health and Healthcare Disparities

<https://resourcelibrary.stfm.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=cf40991e-96e9-3e15-ef15-7be20cb04dc1&forceDialog=0>



You can't really know where you are  
going until you know where you  
have been.

— *Maya Angelou* —







# FAMILY MEDICINE IN PERSPECTIVE

by I.R. McWhinney, M.D.

New England Journal of Medicine

July 24, 1975 293:176-181

*“Family physicians have in common the fact that they obtain fulfillment from personal relations more than from the technical aspects of medicine. Their commitment is to a group of people more than to a body of knowledge. **Their experience gives them a distinctive perspective of illness that includes its personal and social context.**”*

*“To such a physician, problems become interesting and important not only for their own sake but because they are Mr. Smith’s or Mrs. Jones’s problem. **Very often in such relations there is not even a very clear distinction between a medical problem and a nonmedical one. The patient defines the problem.**”*



*“...many general practitioners found that their world view was being gradually changed by their experience. They saw many illnesses that could not be fitted into the neat categories that they had learned. They learned that illness is intimately related to the personality and the life experience of the patient. **They learned the inseparability of the patient and environment.**”*

TECHNICAL REPORT

American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

# Mediators and Adverse Effects of Child Poverty in the United States

John M. Pascoe, MD, MPH, FAAP, David L. Wood, MD, MPH, FAAP, James H. Duffee, MD, MPH, FAAP, Alice Kuo, MD, PhD, MEd, FAAP, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COUNCIL ON COMMUNITY PEDIATRICS

PEDIATRICS Volume 137 , number 4 , April 2016

## Mediators and Adverse Effects of Child Poverty in the United States

**“Within families, poverty is associated with intimate partner violence, maternal depression, single-parent families, and parental substance abuse, all of which are risk factors for child maltreatment.”**

Pascoe JM, Wood DL, Duffee JH, et al. AAP Committee on Psychosocial Aspects of Child and Family Health, Council on Community Pediatrics. Mediators and Sverse Effects of Child Poverty in the United States. *Pediatrics*. 2016;137(4):e20160340

**“Fifty years ago, the U.S. came together and nearly eliminated poverty in the elderly, it's time to do the same for children.”**

AAP President Benard P. Dreyer, MD, FAAP.



**FIGHTING**  
FOR  
**FAMILY MEDICINE**





**FIGHTING**  
FOR  
**FAMILY MEDICINE**



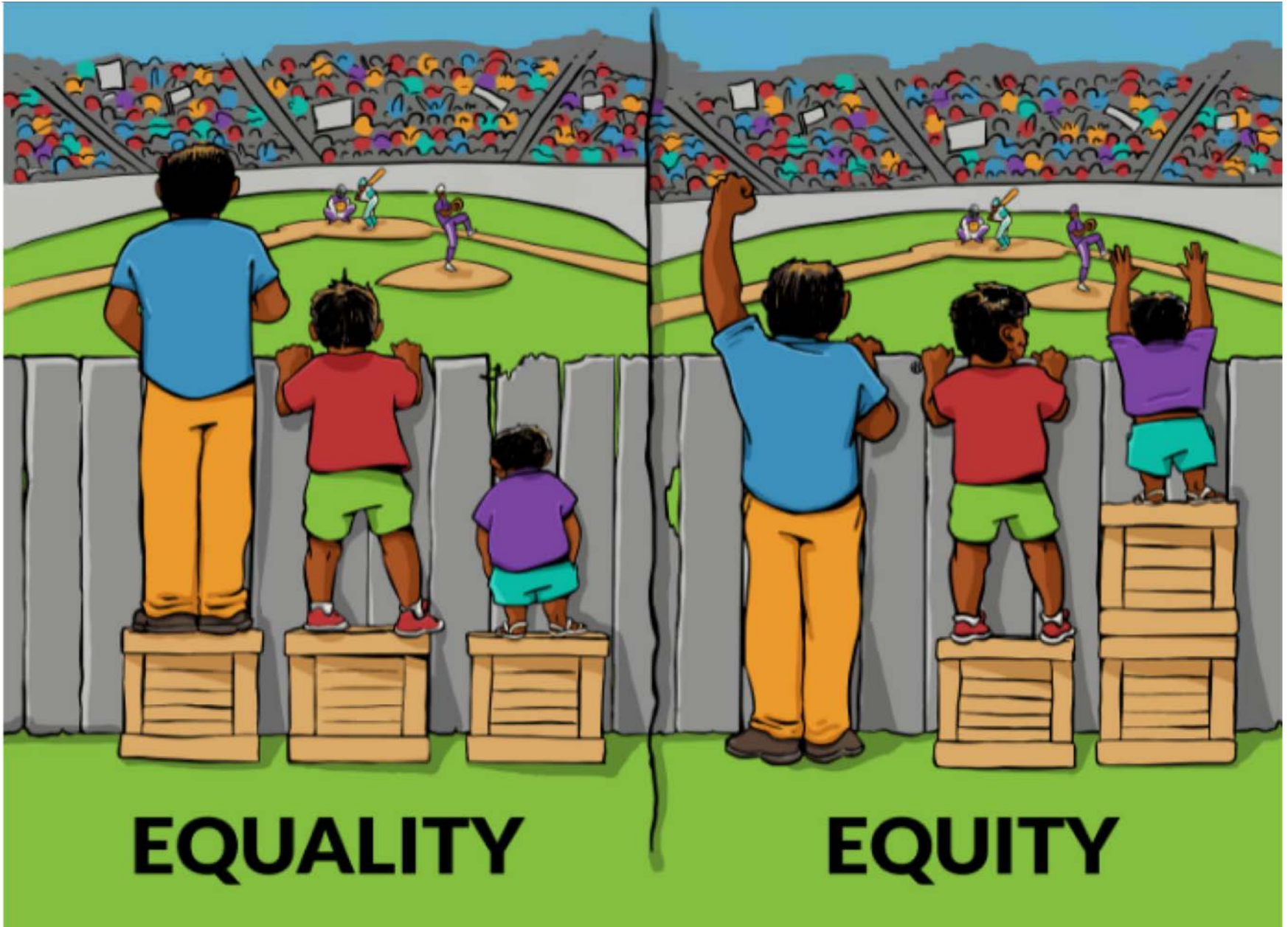
**ALL AMERICANS, PARTICULARLY THOSE MOST IN NEED**



**10** **REDUCED  
INEQUALITIES**



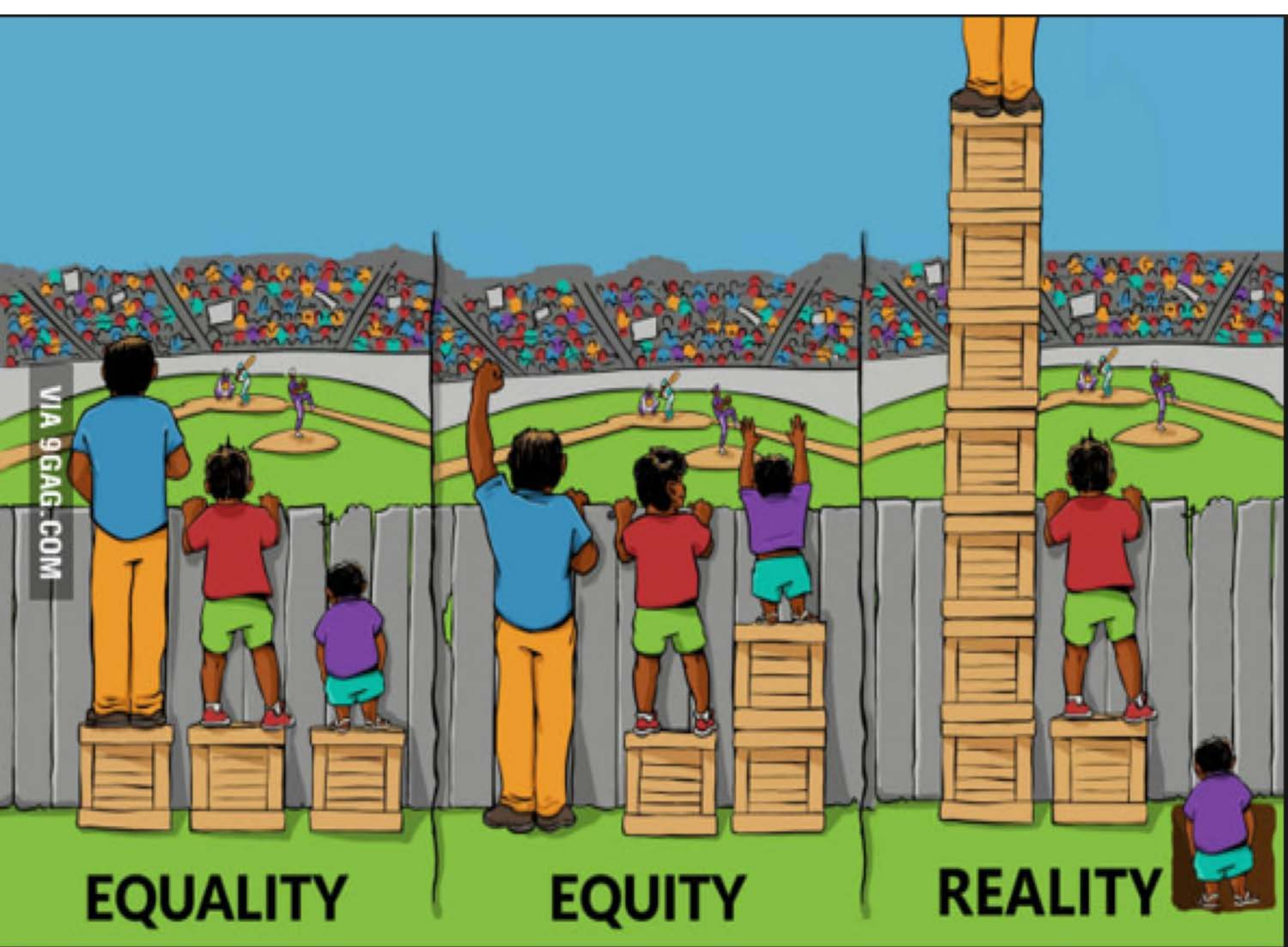




**EQUALITY**

**EQUITY**

VIA 9GAG.COM



**EQUALITY**

**EQUITY**

**REALITY**



**1** NO  
POVERTY



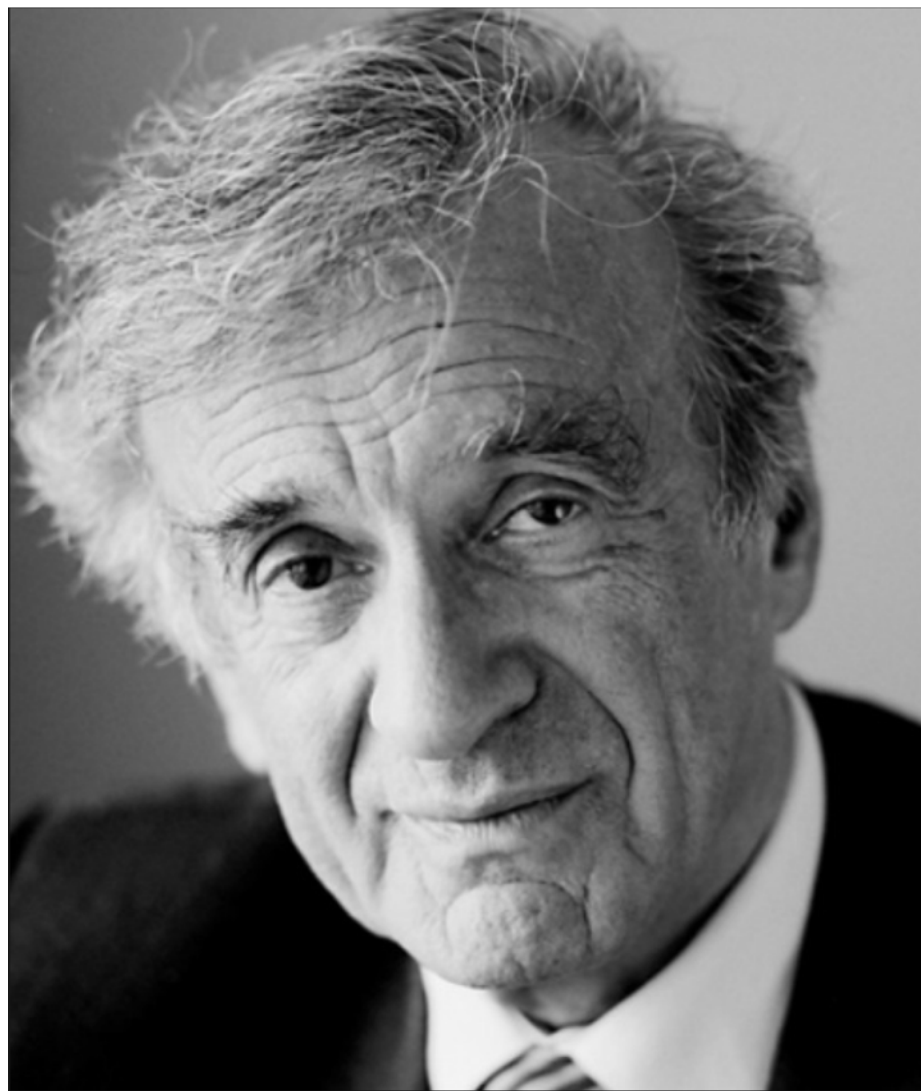
“There is nothing new about poverty.  
What is new is that we now have  
the techniques and the resources  
to get rid of poverty.  
The real question is  
whether we have the will.”

*Rev. Dr. Martin Luther King, Jr.*

“Remaining Awake through the Great Revolution”  
*Speech delivered 31 March 1968, 4 days before his death*

[monologuesofdissent.blogspot.com](http://monologuesofdissent.blogspot.com)

# Bearing Witness



“I swore never to be silent  
whenever and wherever  
human beings endure  
suffering and humiliation.  
We must always take sides.  
Neutrality helps the oppressor,  
never the victim.  
Silence encourages  
the tormentor,  
never the tormented.”

– Elie Wiesel

Photo Credit: Sergey Bermeniev/npr  
HistoryByZim.com



# Could where you live influence *how long you live?*

People living just a few blocks apart may have vastly different opportunities to live a long life in part because of their neighborhood. Unfortunately, significant gaps in life expectancy persist across many United States cities, towns, ZIP codes and neighborhoods. The latest estimates of life expectancy reveal differences down to the census tract level. Explore how life expectancy in America compares with life expectancy in your area, and resources to help everyone have the opportunity to live a longer, healthier life.

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