LuAnn Heinen:

Black women in the U S are two and a half to three times more likely to die during or following childbirth than white women. And although black women are almost as likely to be diagnosed with breast cancer as their white counterparts, they're nearly 40% more likely to die from it. Why is this the case in 2020? She's the first female president and dean of Morehouse School of Medicine. In her prior role at Meharry Medical College, she was the youngest medical school dean in the country. In a career of firsts, and more honors and awards than we can name here, Dr. Valerie Montgomery Rice is using her platform, passion, and purpose to promote equity and health care access and health outcomes in the U.S.

I'm Luann Heinen and this is the Business Group on Health podcast, conversations with experts on the most relevant health and well-being issues facing employers. In today's episode, I speak with Valerie Montgomery Rice about the state of health disparities in the U.S. and how we can overcome them to achieve health equity.

Dr. Montgomery Rice, I am so grateful to have you here today because we're going to discuss what I think we all agree is a critically important topic. You know, it's perplexing in some ways, and it's frustrating to many people, and it's something that's been so persistent over time. And the issue, of course, is health disparities. As part of this conversation, I'd love to get to how did we arrive here and how can we fix this? But to have that conversation effectively, we need to start with the basics. What are health disparities?

Dr. Montgomery Rice:

LuAnn, thank you so much for having me on and I'm excited to have this conversation. You are correct. This is a very important topic and it's an old topic to some of us and new to others, so I do think it's sort of good to level set. When we talk about health disparities, we're talking about a higher burden of an illness, or an injury or disability, or even a death rate, that can be experienced by one group relative to another. Maybe it'll help if I give you some examples. Let's talk about breast cancer mortality. African American women have a lower incidence of breast cancer compared to white women. However, when we look at the death rates from breast cancer, we see that breast cancer mortality is about 40% higher for African American women as compared to white women.

So that's what we mean by a disparity. I'll give you another example. If you look at what we call maternal mortality, the chances of you dying in pregnancy. When we look at African American women or black women, American Indian women, or Alaska native women, they have two to three times more likely the chance to die from a pregnancy-related cause than a white woman. Even if their chances of being pregnant was equal, they still have a two to three higher chance of dying. That's what we mean by disparity.

LuAnn Heinen:

We'll get to the data in a moment, the availability or lack of data, but can you share anything from your own experience as a clinician? I know you practiced OB-GYN, specialized in infertility, how do these disparities play out and impact the lives of patients and families?

Dr. Montgomery Rice:

I will look at it from the perspective of infertility, because one of the things that I think people take for granted is that they're going to be able to get pregnant, right? That a man and a woman will meet together and having a family is just one of those given rights. What we began to see early on when I was very actively practicing in the nineties, was that there was a disproportionate number of black women who were having challenges with achieving pregnancy, secondary to fibroid disease and/or tubal

disease, and we began to explore the reasons why. Well, what became obvious to us is that African American women had a higher chance of having fibroid disease or fibroid tumors, benign tumors of the uterus, than white women, which was causing them to have more complications once they were pregnant and also more dysfunction in achieving pregnancy.

And so just for something that you take for granted that you were going to be able to have a baby, we saw a disparity related to this. That was a significant toll on black women. What that meant was that if we saw that one group had a higher incidence of a disease than another, one would think that we would direct resources such as research dollars to understand in the why and to treatment modalities that would correct the abnormality. What we saw early on was that more black women were having hysterectomies for fibroid disease, which then took away their ability to even achieve pregnancy. It is a significant impact on what we take for granted as a common right that a woman would have and that is to have a child. That, of course, increases the amount of stress that the woman would have and, of course, the stress in the family when trying to start a family. So hopefully that gives you an example.

LuAnn Heinen:

Yes, definitely. Are you aware of similar disparities across other, or even all, medical specialties and areas of practice?

Dr. Montgomery Rice:

Sure, if you look at prostate cancer, African American men have a higher rate of prostate cancer and a higher mortality. Again, we are not seeing as much research focused on that area. If you look again at breast cancer, we see that African American women have a higher incidence of a specific type of breast cancer, triple negative breast cancer, and we know that those type of breast cancers where there is triple negative, what you see is a higher risk of mortality. If you look at diabetes, we tend to see a higher incidence of diabetes in some of our Latinx population of women, compared to even African American and to Caucasian women. And so, yes, we see these disparities and it is predicated on the understanding of disease processes, but we also know that there are other factors that impact the ability of early diagnosis and access to care and access to the highest quality of care.

LuAnn Heinen:

I think what I'm hearing you say is that the data exists to illustrate these disparities, but perhaps what we're not seeing is the actions or the analysis as to how to solve the problem and some of the underlying problems. So how, in your view, did we get here? How did we get to this point and what factors have led to, or contributed to, these health disparities?

Dr. Montgomery Rice:

That is a very, very loaded question because I'm reminded of something that I heard on one of the news outlets when someone was asking the question is, why do these disparities exist and why is the challenge so different for blacks versus other groups? And I can only take you back to the time of slavery. If you think about this, African Americans are the only racial, ethnic group that has been forced to come to the United States against their own free will and with that came lots of challenges with our ability to be able to, first of all, be recognized as a full human being and also to be granted the rights of access to care and to high-quality care. This played out in the time of slavery. I have been reading off and on for the last five years this book by Harriet Washington, *Medical Apartheid*, and I have to stop reading the book because it really talks about the challenges that African Americans in faced when they

were used for experimentation to improve surgical procedures, women particularly against their will. Or you can read about some of the things that happened with enslaved children when they showed certain disease processes and the experimentation how they were used to advance science and the understanding of the disease processes. And so you began to see those atrocities that people endured, but then the common things that you think about, access to clean water, access to appropriate nutrition, those are the things that lead to chronic disease. We know that people who have diets high in saturated fat and lots of sugar have a higher risk of having diabetes. And so if you imagine that you only had a diet that only consists of that, then you have a higher chance that you're going to develop diabetes, heart disease, etc. If we just look at it from a nutritional perspective, we see the challenges that have gone over multiple generations or why we see more diabetes, more hypertension, more heart disease in people of color. That's how we got here, by first of all not recognizing African Americans as individuals and real people, as for humans in the beginning during slavery, and then not providing access to care and access to quality care. And then even after slavery was over, being denied those benefits, and then the social determinants of having clean water, appropriate living conditions and appropriate nutrition.

LuAnn Heinen:

That was a wonderful, comprehensive look back and sobering. It reminds me of the TED talk that Dr. David Williams of Harvard did a few years ago called, *How Racism Makes Us Sick*. And that TED talk was really impactful for me, not just because of some of the factors you talked about, but also even the more subtle implicit bias that he talked about, or unconscious discrimination that is this an automatic, subtle process. Do you think that factors in to access to care?

Dr. Montgomery Rice:

Dr. David Williams has done a lot of great work. In the talk that you are referring to he talked about how racism makes us sick. I think that one of the things that we are seeing now, is that people are being able to look behind the curtain that's always existed. I will come to COVID-19. So COVID-19 has shown us what happens when people don't have immediate access to care. So think about the number of people early on in the pandemic who could not get access to testing, and the people who now are still somewhat plagued by testing, think about the number of people who, if they were positive, did not have the option to quarantine and work from home and therefore continued to spread the disease because they were an essential worker and/or they had not had a test and so they didn't know that they were positive. Think about the people who live in multigenerational homes. Even though they were using precautions, but because you could be an asymptomatic carrier, they came back and spread it to their families. When you think about the social determinants that are influencing health care, COVID-19 gives us a prime example of what happens when people can't not get access and then cannot get the highest quality of care.

LuAnn Heinen:

Just thinking about the path forward, Dr. Williams' talk was at least four years ago now, where are we now in 2020? Are we at a point of deeper understanding of these problems? Do you sense a greater commitment to change in light of COVID?

Dr. Montgomery Rice:

You know, LuAnn, what I think is different now is that people are definitely willing to listen more. And as my daughter would say, they are now woke. People are seeing things that they have not seen before.

And I think it was because we were all sort of in this stand still moment. Let's take the George Floyd situation. It was in our face and there was no denying that this did not seem right. I think that gave people pause to say, okay, what else have I missed? I am all for us going back and giving history lessons and helping people to understand their biases, whether they're conscious and unconscious, because we all have them, but while I have their attention, I also want to have a conversation about how do we move forward. If you're really woke, then what is it that we should be doing to ensure that we're never back at this place again? The difference I think in answering your question is that people are interested in learning and listening now. Now for us who believe we have some answers, it is how do we help move forward with a constructive solution?

LuAnn Heinen:

You're playing a big role in enacting change for a more equitable and healthy future. Tell us a bit about what you're doing at the Morehouse School of Medicine.

Dr. Montgomery Rice:

Our vision at Morehouse School of Medicine is leading the creation and advancement of health equity. And that's not a new vision, it's been around for a while, but it has become so relevant. Now we're only 45, 46-years-old, so I can't say it's been around that long, but the concept of it for us has been around for a while. When we say health equity, what we really mean is this - giving people what they need, when they need it, and the amount they need to reach their optimal level of health.

And in doing that, we believe that there are multiple ways we can support people and empower people to achieve health equity. It begins first for us as a medical school and who we educate and train. So we educate and train physicians, public health professionals and researchers, and we've expanded that platform. The who is important because we have a significant number of our students, over 80% of them, are underrepresented minorities. That was why we were founded. We know we have a strong track record for those students going back and practicing in underserved and undervalued communities, whether they are urban or rural. We also believe in the promise of science. So our researchers work on problems like the disproportionate risk of diabetes. If you are a Latinx or the increase in maternal mortality rates in African American women, or why is it that we see a higher rate of prostate cancer in African American men? They work on those diseases that disproportionately impact these communities so that we can create solutions and therapies that are going to give them the greatest chance of success and achieving health equity. We also were in a process, and we are so excited about this, as it relates to the COVID-19 issue, is that we were the recipient of the $40 million grant by HHS. That grant has allowed us to be what we called a COVID-19 resiliency network. That network is about creating resources to communicate, connect, and collaborate with communities of colors and other vulnerable communities that are impacted by the COVID-19 pandemic. Now we're not going out there telling them what they need. We're actually going there and saying, how can we partner, and our community partners in those high-risk populations. And that we believe is what is going to create the right type of solutions that meet the communities where they are, is going to make sure that our education material is linguistically and culturally relevant and appropriate, is going to mean that people have ready access to the resources because they are going to be community derived and community present. What we're going to do is serve as a connector for access to best practices and opportunities. Those are just a short list of things that we're doing. I guess I should also add that we have two significant projects, and one of them is *The Just Project* where we and five other hubs, three of them being the other three historical black medical schools in Tuskegee and Hampton, where we have been selected and funded through a grant to provide testing for the other 105 undergraduate HBCUs. We've also been selected as a clinical trial site for the COVID-19 vaccine. So we are doing a lot in this space.

LuAnn Heinen:

That is fantastic. I had no idea you had so much going on in additional to the original and the core mission of increasing the representation of black and other minority physicians. Can we look back and chat about why it's important to have more black doctors and what the impact is on patients?

Dr. Montgomery Rice:

Yes, I am reminded of what happens in a classroom. What happens in a classroom when you're sitting next to someone and you are learning about a disease process, the professors often ask you to think about who that end user would be of this great intervention, a pharmaceutical therapy that you're coming up with, who is impacted most by this disease. You can learn all of the physiology and the pathophysiology that's associated, but it doesn't become real to you until you can really visualize that patient. So when we're in the classroom and you're learning and people start talking about exercise or eating nutritiously, etc., and the physician writes your prescription, if you don't understand why patient's compliance is not as high as you might expect, it might be because you are not really culturally aware of what are the circumstances that may be influencing that patient's decision.

Well, when we put our students in small groups, we try to help them to be more culturally competent by learning from each other. Because for me, who was raised in a single-parent household versus someone who was raised in a two-parent household, there may have been economical factors that may have influenced my decision to write this patient that prescription versus your decision to write this patient that prescription and my expectations of whether or not this patient is going to be compliant. When you go into those small groups and you're discussing that, that is how educate and train a more culturally sensitive provider. I get to bring my life story to the table, you get to bring your life story to the table, and we figure out how we leverage that for the good of the patient.

So when you have diverse population, particularly black doctors there, we know that that changes the conversation. We have seen it in our small group settings, whether you're talking about gun violence, whether you're talking about diabetes or heart disease, we've seen it throughout. It matters to have diversity in the classroom. We also know that it helps you to increase patient's compliance if they see doctors who looked like them. Several studies have shown that black male patients are much more compliant when they have a black male doctor. A recent study that really concerned us came out in the proceedings of the National Academy of Science and it looked at 1.8 million births in the state of Florida over about a 15-year period of time, and it showed a significantly higher mortality for black babies if they were cared for by white physicians, as compared to black physicians.

Many of us are trying to delve down to see the why of that. It may be back to something that you said early on, unconscious and conscious biases that occurred in that perinatal period between that provider and that mother, and then what happened at the delivery that may have influenced the outcome, and then what happens in that first year of life of that child. Those are the type of things that began to be very concerning when you look at them on a population health scale, but they all get back to the same point, is that diversity in the health care profession matters because it helps to save lives.

LuAnn Heinen:

It matters in education as well. In the classroom, a shortage of black male teachers and role models is impacting kids all the way up from K through 12, as well.

Dr. Montgomery Rice:

Again, if you think about it as a black mother who has a black son, I can tell you when my son was in the third grade, I'll never forget this, the teachers started trying to label him with the attention deficit

disorder. I talked to five of my girlfriends who had black sons. They were all having the same challenge. Now, it can't be that the five black boys that were in the classroom at this school and in the multiple classrooms, they were the only ones with attention deficit disorder. What you had was unconscious bias. And we see this in the education system, because what we see is three times the rate of suspension for African American boys by the fifth grade as compared to white boys. We see this in the number of them who are delayed in their education. We see this and we believe that it is most likely secondary to unconscious bias and is sometimes conscious bias. So if you have more black male teachers in the classroom, that would help, but also if you have more black male teachers interacting with the majority teachers who were there and helping them to have a different set of expectations and perspectives about black male children, we may see some different outcomes.

LuAnn Heinen:

So back to health care, there's a lot of buzz about cultural competency and how important it is. How can health plans, delivery systems, even employers think about cultural competency? Is it something we can create a checklist for? And I love how you talked about learning from each other in a classroom setting. Short of that, once you've got physicians in a network or in other kinds of post medical school situations, what can we do to ensure cultural competency?

Dr. Montgomery Rice:

When you talk about insurers, they need to ask the basic question of who do they have in their network. Do they have a diverse platform of providers in the network? Have they done the data analytics to understand the patient population that each of their providers care for? And do they do the analysis to determine if they are having the expected outcomes in those patients? And if they don't, have they asked the question of why? Can they begin to tease out if there is unconscious and conscious bias in prescribing and care delivery? One of the things I'm reminded of when I ran the Center for Women's Health Research or when I started the clinical trial site at the University of Kansas years ago, we clearly did not see as many patients of color being offered to participate in clinical trial research. Even those trials that were identified to help with certain diseases, even trials that were cancer trials that were you looking at wonderful therapies that were cutting edge. When a black patient came with that same cancer compared to a white patient, that black patient was less likely to be offered the opportunity to participate in a clinical trial, even though they both had the same disease. Now, the way that you get beyond that is that you have, first of all, training and education and unconscious and conscious bias. So insurers could require that as a part of being on their panels, for physicians to be on a certain panel they would have to have that. Then they ought to have data analytics that looks at the patient demographics that providers are caring for, and they ought to be looking at the outcomes and ensuring that the known clinical pathways that lead to improved outcomes of diseases that they're being followed. When they are not, they need to have sort of processes in place that lead to corrected behavior.

LuAnn Heinen:

If you had to identify a milestone that would signify progress, we're making progress in reducing health care disparities, what would that be?

Dr. Montgomery Rice:

One milestone that would say we're making a difference? You know, I will tell you the first milestone that we did make a difference with was in the Affordable Care Act it required that the demographics, race and ethnicity, was at least captured in the medical record. And so now we have information that

delineates, we can do data analytics and look at diseases by race, ethnicity, gender, etc. One of the milestones for me would be the next level of discernment and saying, and we actually have done this part where many people have done this where they know which by zip code, by county, by state, and we're doing this with COVID-19, that we are seeing the disproportionate impact of COVID-19 in these groups. A milestone for me would be the allocation of resources to address the obvious. The obvious with the COVID-19 would be ensuring access to testing in a disproportionate manner to other areas that are not as woefully impacted. So it would be allocation of resources when you know that there is a gap.

LuAnn Heinen:

So we've got the data, we need to understand what it's telling us, and we need to allocate resources accordingly.

Dr. Montgomery Rice:

Yes, allocate resources.

LuAnn Heinen:

You're doing so many wonderful things with vaccine testing with the COVID-19 resiliency network and with the education of culturally competent future physicians. What is your philosophy about what's important for you as a leader of the Morehouse School of Medicine and how you use your platform?

Dr. Montgomery Rice:

I have been very fortunate to be able to develop a platform that allows people to hear, and now I think people are truly listening. I think that one of the advantages of being at Morehouse School of Medicine in this turbulent time is that people are generally interested in figuring out how we can move beyond this. I'm reminded of one of the quotes of Martin Luther King, and I may not get it exactly right, but it says something like every society has its protectors of the status quo and as fraternities of the indifferent who are notorious for sleeping through revolutions, but today our very survival depends on our ability to stay awake, to adjust to new ideas, to remain vigilant in the face of the challenge of change. I have always viewed myself as a change agent. It is hard to be an agent though if people were not willing to listen. So people have moved beyond just hearing, now they're listening, now they're awoke. And so now what we have to do is work with people to put together a strategy that leads to change, and to also look at policies that lead to sustainability. For every unexpected change, there's an opportunity for something wonderful. I believe that a lot of wonderfulness is going to come from this period of time because people are willing to engage. So I will continue to use my platform by, yes, sharing with people the history, speaking to people about where we are, but also craft the solutions with them about how to move us forward.

LuAnn Heinen:

I've been speaking with Dr. Valerie Montgomery Rice, president and dean of Morehouse School of Medicine, about her passion for achieving health equity and why now may be the time to make the real progress that has eluded us for so long. Dr. Montgomery Rice was recently featured in the *Wall Street Journal's* Future of Everything series. Our listeners can learn more about her work in the article entitled, "Why We Need More Black Doctors - And How to Get There."

We just started this podcast in 2020 and if you are listening on iTunes, we'd welcome your review. This podcast is produced by Business Group on Health with Connected Social Media. I'm LuAnn Heinen. Thanks for listening.