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Exposing and Disposing of Latent and Residual Racism
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In my lifetime, America has gone from overt, society-wide, institutionalized racism to a public rejection of all forms of bigotry. Without doubt, there is still racism in America, but it is not as it once was. Although, we have made progress, there is work yet to be done. As I have thought about this article, I realized how difficult it is, sometimes, for us to recognize racism in the most liberal of us who have intellectually rejected racism for all of our adult lives. Recently, as my wife and I watched the movie, McFarland, again, we saw overt bigotry turn to acceptance and love. I wondered if at the end of this discussion it will not be possible for us to examine our own hearts by how we respond to children who are different from us and who are not our own. Maybe it will be through the "receiving" of children that we will finally remove bigotry and racism from our hearts.

There are large communities of scholars, leaders and advocates who are working to eliminate unrecognized prejudice within our society. This is prejudice which is so spontaneous and deeply ingrained that it is not even recognized by those who practice it. In the movie, Driving Miss Daisy, Miss Daisy denied being prejudiced when it was obvious by her attitudes, words and actions that she was racist. Ridding ourselves and society of this kind of bigotry will be done first by identifying how pervasive it remains and second to expose how harmful it is to those who are the object of racism, prejudice and bigotry.

One remarkable step in this effort is the Frank Bryant, Jr., MD, family. With roots deep in Southeast Texas and in San Antonio, Texas, this family's story is memorialized in The Frank Bryant, Jr. MD, Memorial Lecture in Medical Ethics at UT Health San Antonio. Founded in 2002 by the Texas Medical Foundation and supported by others in the Medical Humanity and Ethics Center of UT Health San Antonio, Dr. Bryant is remembered as "a man that cared and showed that he cared. He is remembered as a man who overcame adversity yet would never accused anyone else of being unfair. Dr. Bryant graduated from UTMB in one of the first classes to admit black students; He went on to become a respected physician, a loving family man and an advocate for the medically underserved in East San Antonio. Dr. Bryant was the cofounder and first medical director of the Ella Austin Health Clinic and co-developer of the East San Antonio Medical enter. He served as the first African-American President of the Bexar County Medical Society and the first President of the C.A. Whittier Medical Society."

Dr. Bryant's connection to Southeast Texas is through his wife, Mrs. Gloria Bryant, who is a native of Beaumont along with her brothers Dr. Richard Price, a mathematics Professor at Lamar, and Mr. Al Price, the first African American State legislator from SE Texas. Two of Dr. Bryant's daughters live in Beaumont, Dr. Janice Murphy, wife of SETMA partner Dr. Vincent Murphy, and Mrs. Kellie Fowler, wife of Beaumont physician Dr. John Fowler.

The 2018 Frank Bryant memorial Lecture was presented on April 3, 2018 by Harvard University Professor, Dr. David Williams. In a lecture supported by extensive research, Dr. Williams demonstrated the continued presence of racism, bigotry and prejudice in the United States. As compelling and even convicting as Dr. Williams' lecture was, his presentation was devoid of anger and condemnation. On the contrary, Dr. Williams' manner and spirit was winsome and engaging.

Personally, I was struck by Dr. Williams' concept that mental constructs, which perpetuate racism and bigotry, are often so subtle and intrinsic to our worldview as to make their presence unapparent and unconscious to us. This fact makes those prejudices to appear almost intuitively true. I found his research and conclusions to be intriguing and compelling.

In a note to Dr. Williams, I addressed our work at SETMA in which our use of data analytics to evaluate provider and patient behavior and the determinants of that behavior, allowed us to learn that the discovery of a "potential cause" of a problem always leads to additional questions. For instance, when we discovered that out patients with diabetes who are over 70 years of age have better control than younger patients, we did not celebrate our care as excellent. We asked other questions such as could this be the result of a common comorbidity of malnutrition which could make it appear that our care of diabetes in this age group?

We examined this age-specific cohort to see if the appearance of excellent control of diabetes was because of malnourishment. Using patient interviews, blood chemistries and physical examinations, we proved that these patients were not malnourished. Due to the patients' efforts and ours, the care of diabetes in this age group is excellent.

Dr. Williams demonstrates this when he applies statistical controls on multiple variables to his research. I commented to Dr. Williams that his research is amazing. As he explained his study of the disparity in the prescribing of pain medicine in the face of long-bone fractures in emergency department care of Hispanics and non-Hispanic Caucasian, I thought of the above concept. Certainly, I was disappointed to know that Hispanic patients did not receive pain medicines three times more often than non-Hispanic Caucasians. I suspect that there is an ethnic bias at the root of this fact, but in order to deploy a remedy, I would like to know:

1. Were pain medications not offered to the Hispanic patients?
2. Did the Hispanic patients ask for pain meds and were refused?
3. Is there a health literacy foundation to one groups not knowing how to access needed care?
4. Is there a real or imagined issue related to costs of pain medications?
5. Pain is real but is a perception which can be considered subjective though there are physical signs of some kinds of pain. Are there culturally discernible distinctions in the sensing of pain or in the willingness to report pain?

The identification of the specific social determinants of disparities is critical. If it is overt bigotry and racism due to prejudice against Hispanics, it would be an egregious breach of medical ethics. It would be a grave and reprehensible problem and the solution would be complex and difficult. If it is an educational deficiency, i.e., a problem of health literacy or if it were due to economic distress, it would be a different kind of problem and the solution would be different. We do know there are gender disparities in the treatment of heart disease. We know there are ethnic disparities in the outcomes of many kinds of care. To solve these problems, we must know that the reasons are complex, and the solution depends first upon recognizing and acknowledging the presence of the disparity and then finding the cause and designing a solution.

It is probable that the solutions to ethnic disparities in health care are going required the uncovering of and the solving of one specific disparity after another until at last we reach a threshold and we experience a sea change in the universal quality of health care.

After listening to Dr. Williams, I am intrigued as to whether it would be possible to design a "racism, inclusion, diversity questionnaire," like we have "stress," "wellness," and "depression" measures? Would such a questionnaire for health care providers and others be evidence-based and could it contain questions like:

1. Do you have a multiracial and/or multiethnic social circle?
2. Do you have and segregated organizational associations?
3. If you named the ten people you admire the most are any of them of a race or ethnicity other than your own?
4. Do you have any important close friendships or relationships with a person on another race or ethnicity which is over ten years in length?
5. When you read a publication, are you more or less inclined to read an article about a person of another race or ethnicity?
6. As a health provider are you inclined to apply screening and preventive health standards to all races and ethnicities?

In reality, such tools already exist but need boarder deployment in healthcare and in our society at large. I am grateful for The Frank Bryant Memorial Lecture and for the Medical Humanities and Ethics Center at UT Health San Antonio. They are both helping us take steps to improve the quality of life and health for all. I am grateful for meeting and knowing Dr. Williams, he has set a new and higher bar for presentations in this lecture series.