“Race,” it’s such a simple word but a term that carries so much power and emotion. We hear the word every day in so many contexts but what is its’ significance? How did it come about? Many scholars argue that "race" was an evolutionary invention, a folk idea, not a product of scientific research. It was created to justify the social and political realities of America’s history. Now it is embedded into our society. We use race to describe the demographic make-up. We hear it when someone is given a medical history of a patient. We see it when we walk down the street and as we look around the room in our workplace. Some of us “feel” it every day in our lives. So why is it so hard to have an honest dialogue on race? As we watch the news, the events over the last few years have brought the issue of race and racism to the forefront. For me, I see the faces of Treyvon Martin, Michael Brown, Eric Garner, Tamir Rice, Walter Scott, Freddie Gray, just to name a few. I see the 14 year old African American girl at the swim party in Texas being slammed to the ground. I see these images being played in my mind over and over again. But instead of the faces of the victims, the images are changed to the faces of my children and family members. I feel the terror, the frustration and yes, the anger that these images and events provoke. I ask, “How could this be happening? After all, I am told, we are supposed to be a post-racism society.” We have an African American President. This generation is one of the most diverse generations of all
time. Yet, we continue to have issues with race that are unfathomable. “The Emmanuel Nine,” the nine parishioners who were killed during a prayer service, once again was shocking but not unforeseeable. Fortunately, the conversation about race is beginning to have traction but why did it take such horrific events to bring about change.

Reflecting on this I realize that the culture we live in allows us to talk about race and racism but only in superficial ways. We need a real dialogue on race, not to be turned into a debate of its importance or not, instead we can use a dialogue on race as an opportunity to move forward. Our usual discussion allows us to voice our indignation of events without truly owning it. This politically correct approach permits us to feel good about ourselves and our thoughts but does not change the underlying problem of structural racism.

The Aspen Institute defines structural racism as “A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic and political systems in which we all exist.” In most cases it is not something that we currently set out to engage in but it lies beneath the surface of our society. As the Aspen Institute Roundtable stated, “It is a system for allocating social privilege.” We have to acknowledge its existence in order to mitigate its influence.

Think about how structural racism plays out in the healthcare environment. Despite extensive efforts, we have made little progress in addressing the issue of health disparities. Minority populations continue to have a disproportionate burden of preventable diseases, disabilities and early death compared with non-minorities. Why does this occur? What are some of the underlying factors that play a part in health disparities? Research in this area has been expanding and has some intriguing findings. An article by Brewer and Cooper looked at the interaction of race, discrimination and cardiovascular disease. They reviewed articles related to three themes: 1) race as a stressor; 2) race influence on access and quality of care; and 3) race, the patient-clinician relationship, and adherence to medical therapy. They concluded that more extensive education and research is needed to understand the effects of race/ethnicity-based discrimination as psychological stressors on the cardiovascular system and the care minority populations receive.

Dr. Monnica Williams, Associate Professor in the Department of Psychological and Brain Sciences at University of Louisville and the Director of the Center for Mental Health Disparities, is currently focusing her research on the link between racism and post-traumatic stress disorder (race-based traumatic stress injury) which may manifest as the emotional distress a person may feel after encountering racial harassment or hostility. As you read through the newsletter, you will find an article by Dr. Williams about her work.

When we consider race and provider/client interaction, take a look at the article in the May, 2015 edition of JAMA written by Katherine C. Brooks, a medical student from another medical school who happens to be white. She described her lessons learned during her years of training from observation of her peers, faculty and other health professionals, the so called “silent curriculum”. She presented examples of racism that occurred in patient interactions. It was not as if these occurrences where facilitated by people who were evil or poor clinicians but many of these interactions were performed by people she described as her mentors; people she respected. The results were that she subsequently carried out her own discriminatory remarks and interactions with persons of color and found that they would go unchallenged. Her final message was, “I’ve learned to minimize the pain, forgo the consent, blame the behaviors, and dismiss the concerns of my patients of color. I’ve witnessed missed opportunities for healing and the loss of patient trust. And I believe that if we refuse to deeply examine and challenge how racism and implicit
bias affect our clinical practice, we will continue to contribute to the health inequalities in a way that will remain unaddressed in our curriculum and unchallenged by future generations of physicians.” How many others have the same observation?

What role does structural racism play in some of the social conditions that we see in our community? How does our policies that we have or had in the past impact the ongoing issue of health disparities and the social determinants of health? Consider the concept of wealth accumulation (Aspen Institute). It’s been reported that blacks and whites who earn the same salaries today don’t have the same wealth levels when taking into account resources such as capital assets, investments and other belongs. When you look back across generations you come to realize that the opportunities in many cases were different. While the majority population had more opportunities for higher education many minority populations were segregated to “separate but equal educational institutions.” When majority populations had access to good jobs with descent pay, minority populations were confined to lower paying opportunities with little or no long term benefits. When the majority population profited from home ownership in desired neighborhoods, minority populations were subject to “redlining,” which is the discriminatory practice of lenders who refused to lend money or extend credit to borrowers in certain "struggling" areas of town. The accumulation of these practices and others has lent itself to some of the social conditions that we see today, particularly poverty.

When comparing life expectancy for someone in St. Mathews (83.6 years) with someone from the California-Parkland neighborhood (67.8), it is easy to see where you live matters.

Although improved with the Affordable Care Act, we continue to talk about healthcare access and quality of care for some of our most economically challenged individuals. We continue to lament on the need for more diversity in our healthcare workforce yet when we look at the percentage of minorities in professional schools both locally and nationally we have fallen short. What can we do to change this rut we find ourselves in? This is a call to action. Let’s have a dialogue on this issue in order to change the trajectory that we are on. It will take the collective, intuitive minds of us all to make a difference.
The Invention of Race
by John Chenault, MA, MS
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Race is a concept, an idea with a discernable and definable genealogy. Contrary to popular belief it is not written in our DNA; it is written in our laws. Although some scholars have sought its origins in antiquity, evidence shows it developed during the modern era—the beginnings of which can be traced to the early sixteenth century—and that it performed a central role in the emergence of modernity and the construction of modern social identities. “Race” in reference to human beings does not appear in the English language until 1508 when the poet William Dunbar used it to refer to a “line of kings.” Prior to and during Dunbar’s time the word conveyed the ideas of running or rushing water, or leaping, jumping, storming, raging. It also denoted contests of speed like foot races and horse races. The modern meaning of “race”—a division of humankind classified according to apparent human physical differences—does not emerge until near the end of the eighteenth century. How then did we get from the idea of horse races to human races? Why did “race” become the key conceptual means to classify and explain “differences” in the physical appearances of human beings?

The idea of “human” races owes its birth to European colonialism and the transatlantic slave trade. It originated in the English colonies of North America as a means for the elite landowners in the Chesapeake regions of Virginia and Maryland to establish and justify the hereditary enslavement and exploitation of African peoples. Although less than four hundred thousand of the estimated twelve million enslaved Africans trafficked to the New World arrived in North America, wealthy English colonists led the way in inventing a racial colorline and a fictive category of “whiteness” designed to relegate Africans and their “mixed” descendants to a permanent racial caste and condition of servitude.

The origins of race, therefore, are no more mysterious than the purposes it was designed to serve. Yet social conditioning to race and racial thinking over several centuries blinds us to the existence and reality of a pre-racialized past, a past before the emergence of white identity and white supremacy. Unable to perceive the pre- and early colonial past in any other than racial terms, we accept “race” and racial categories as natural
and universal, and as permanent signifiers of human identities. This anachronistic and fallacious belief—the idea that race has always existed and defined and divided human populations—obstructs all efforts to achieve social equality because it forecloses any notion that race, and the racism it engenders, can be erased from our society.

The racialization of U.S. culture since the advent of slavery thus implanted the false belief of “race” as empirical—as an obvious and observable product of nature. This notion leads inevitably to the false idea race was discovered rather than invented, and that its discoverers simply lacked the theoretical framework of a scientific or biological paradigm until science eventually caught up. European explorers and colonists observed and noted distinct physical differences of skin color, hair texture, and facial features in many non-Europeans they encountered. But they initially ranked and classified those human populations based on European cultural values and beliefs, typically deeming non-Europeans inferior, savage, and pagan based on religion, whether they were literate, and their apparel or the lack thereof. The pseudo-scientific theories that ascribed those purported cultural differences to human biology did not appear until the eighteenth and nineteenth centuries. Therefore we can say race was socially invented or constructed before it was pseudo-scientifically discovered.

Economic and political considerations created the conditions for the invention and institutionalization of race. The desire for wealth drove European colonialism, and wealth creation and accumulation was seen as dependent on conquest, domination, slave trade, and slave labor. As Africans entered the transatlantic slave trade in increasing numbers, Europeans began attaching a host of negative characteristics to them—hypersexuality, sloth, criminality, lack of intelligence—to justify reducing and relegating them to a permanent condition of servitude. Africans thus were “blackened” figuratively to dehumanize and market them as fungible commodities in the colonial Atlantic economies. Had Native Americans not been decimated by diseases brought by Europeans for which they lacked immunity, had the surviving “natives”...
been able to endure the labor-intensive regimes imposed by the colonists to produce tobacco, indigo, and other commodities for international trade, and had Africans not been available and provisioned to meet the workforce needs of New World colonies, Europeans imported as indentured servants, mainly from England, Ireland, and Germany, would have had to bear the entire burden of colony-building and the pre-industrial modes of labor management and production it depended upon. To comprehend how segments of the North American workforce shifted from European to African and in that process became racialized as “white” and “black,” we turn to Virginia colony where the apparatus of race, racialized slavery, and the racial state itself emerged.

Virginia was the first English colony in the world and is considered by some historians as the place where the British Empire began. Virginia also is the birthplace of American slavery and freedom, and the state where the Confederate States established their capital after secession from the US in 1861. The Virginia Company, a commercial venture organized under the authority of the English Crown, founded Jamestown, the first successful overseas English settlement, in 1607. In 1619, the House of Burgesses was established in Jamestown as the first elected representative legislative assembly in the Americas. Its membership consisted of the wealthy land-owning elite. Its structure mirrored that of the English Parliament, and its legal system was based on English common law. That same year a Dutch ship arrived in Jamestown from the West Indies bringing with it “twenty odd Negroes” for sale. During the two centuries that followed, Virginia acquired and maintained the largest population of enslaved Africans throughout the entire history of US slavery. The twenty Negroes spoke Portuguese or Spanish and most likely were Christians. They entered a society in which the majority of the population consisted of settlers who were contracted and sold as indentured servants. The term “indentured servitude” identifies a form of “bound labor” that included Indians, apprentices, debtors, convicts, and foreigners entering the country as servants. It also describes the first form of unfree labor in the English colonies of North America, a category or class that included many of the first generation of African arrivals and their descendants until slavery-for-life was instituted in Virginia in the mid-1600s.

Although African arrivals did not have indentured contracts, some were treated in the same fashion as European contract labor. They served a specified period of time and were freed and given an allotment of land to develop. Some freed Africans purchased indentured servants, including Europeans, to work their land. Some married Europeans and started families. During this early colonial period no legal colorline, marriage laws, or other barriers restricted the social mobility of African settlers. Africans could be found in all three classes of the colony—landowners, merchants, laborers—and they could vote, attend church, testify in court cases, and associate with Europeans as social equals.

The increasingly profitable tobacco trade incentivized the land-owning elite to expand the colonial workforce. With bound laborers providing service for a limited term and then acquiring land and becoming competitors in tobacco production, the wealthy elite perceived a financial advantage in increasing the numbers of Africans in the workforce and in developing a system of laws that would keep them in permanent bondage. To accomplish this mission the major landowners needed to drive a wedge between European and African workers. European indentured servants in the Chesapeake in the 1600s comprised the majority of the colonists and initially outnumbered blacks five to one. Shared circumstances and lifestyles led European indentured and African indentured and enslaved workers to seek and find common cause in rebelling, resisting, and fleeing from bondage and their “masters.” This burgeoning labor solidarity across ethnic lines posed a direct threat to the wealthy elite’s economic and political power. The racialization of slavery provided the means to divide colonial residents and workers into distinctive categories of free and unfree, superior and inferior, “white” and “black”—social divisions that could be legislated, regulated, policed, and en-
forced. Driven solely by their economic interests, the landed elite began to enact the formal and explicit institutionalization of race in a series of colonial laws that were codified beginning in the mid- to late seventeenth century. By the end of the eighteenth century—after a series of legislative acts made “blacks” slaves for life, their children slaves from birth, and interracial marriages illegal—Europeans became “white” by law and Africans became “black” by law.

The first legislative effort to implement racialized slavery focused on sex, human reproduction, and motherhood. It resulted in the passage of an act in 1662 by the Virginia Colonial Council titled “Negro Women’s Children to Serve According to the Condition of the Mother.” It reads as follows:

“WHEREAS some doubts have arisen whether children got by any Englishman upon a negro woman should be slave or free, Be it therefore enacted and declared by this present grand assembly, that all children borne in this country shall be held bond or free only according to the condition of the mother. And that if any Christian shall commit fornication with a negro man or woman, he or she so offending shall pay double the fines imposed by the former act.”

The act was based on the notion of partus sequitur ventrum, an ancient Roman legal doctrine. Translated from Latin the phrase means: "that which is brought forth follows the womb." The Roman Empire, one of the largest slave societies in world history, held that the status of a child as slave or free was determined by the status of the mother. The Virginia colonists reversed the application of this doctrine and in doing so reversed centuries of English common law that held that a child’s status was determined by the father as the head of the family. English courts held fathers accountable so that “illegitimate” children would receive support and not burden the nation. They forced fathers to acknowledge their offspring, pay for their care, and arrange for apprenticeships so the children could learn skills or trades to support themselves. Court records show this practice was followed in Virginia colony until the 1662 act. The act not only let English fathers off the hook in terms of supporting their children by “negro women,” it also allowed the men to own, exploit, and sell those born to them out of wedlock.

Notice that the term “white” does not appear in the act. “Whites” did not exist at that time in American history. The Europeans in the colony described themselves as Englishmen (or by other nationalities) and Christians. The first sentence sets English in opposition to Negro, a term borrowed from the Portuguese that had not yet acquired the meaning it has today. The last sentence sets Christian opposite to Negro, showing the centrality of religion as a social distinction for Europeans. Europeans saw themselves as Christians and others as heathens and savages. Those initial distinctions were cultural rather than physical. It would take an additional three decades (the year 1690) before the English colonists began to refer to themselves as “white.”

So-called fornication between Christians and Negroes also is banned by the act. However, it did not forbid legal marriages between Europeans and Africans who were Christians. It wasn’t until 1691 that Virginia passed the first law in world history to ban free blacks and whites from marrying. After the American Revolution the newly constituted State of Virginia enacted new legislation against “interracial” marriage that remained in force until the US Supreme Court decision in the case of Loving v. State of Virginia in 1967 declared it, and similar laws in other states, unconstitutional.

The 1662 law reflects the ruling elite’s plan to shift plantation production to an African workforce by reducing the social status of Africans to a position below that of English and other European bound laborers. To do so they had to convince working class Europeans they were “superior” to Africans, convince Africans they were “inferior,” and implement and enforce this “racial” regime in all public and private spaces and institutions. As part of that campaign, the landed elite enlisted poor “whites” to police free and enslaved “blacks” based on the notion “blacks” posed a grave threat to the security of the colony. Their “divide and conquer” tactics worked and became a mainstay of the slavocracy for its duration.
The act also shows the social and marital alliances formed between European and Africans, free or bound, threatened the power of the wealthy elite. The true depths of this threat did not materialize, however, until an uprising in 1676 called Bacon’s Rebellion brought together hundreds of armed Virginians of all hues in an attempt to overthrow the colonial government. Confronted by an angry mob that burnt down the colonial capital Jamestown, the colonial elite went into overdrive to end the rebellion, punish the rebels, and establish laws, policies, and practices designed to divide Africans and Europeans and prevent further alliances.

Although a prior law in 1643 levied a special tax on “Negro women,” the 1662 colonial act pertaining to the status of their children constituted the first significant step in drawing a colorline designed to divide Europeans from Africans and enslave the latter on the basis of “race.” It set the stage for the various expressions of antiblack racism that followed, including the so-called “one drop rule” that mandated that a person with any known African ancestry was “black” and should be treated as such regardless of his or her physical appearance. Establishing racial slavery was one thing; maintaining the slaveocracy was yet another. The system of white supremacy could not endure without protecting the purity of the newly founded “white race.” Whiteness could not exist unless “white” women only bore “white” children—hence the laws against “interracial” marriage. Those legislative acts show that “race” was invented at the intersections of gender and class, and that gender was central its creation.

Protecting whiteness also required the constant surveillance and policing of the entire US population for traces of “invisible blackness.” “Blacks” had to be stopped from crossing the colorline and passing for “white.” As “mixed” persons of every hue became common in the US population, some of that drama played out in court cases where judges bore the impossible tasks of deciding who was and was not “white.” Racial policing reached its peak with the establishment of the American apartheid system in the late 1800s commonly known as Jim Crow. It continued in the new guise of racial profiling after the Civil Rights bills of the 1960s purportedly ended legal racial discrimination.

Virginia’s role in setting this nation on its torturous course of institutionalized antiblack racism is undeniable. Soon after the American Revolution Virginians wrote the Constitution, which authorized and sanctioned slavery in the newly formed United States without ever mentioning the word. Through its three-fifths compromise, the Constitution established a policy and system of determining Congressional representation that effectively gave political and electoral control over the nascent American democracy to the slaveholding states. Southern domination of the government lasted until the Civil War, and resulted in part from the efforts of Virginia’s slaveholders to make their interests and the interests of the fledgling nation one and the same. In the sixty-two years following George Washington’s election in 1789 and the Compromise of 1850, which attempted to avert a growing crisis over the expansion of slavery in the West, southern slaveholders controlled the Presidency for fifty of those years. Washington, Jefferson, Madison, Monroe and Jackson, all slaveholders, were the only men to be reelected president and serve two terms before 1837. Andrew Jackson was the only one of the five who was not a Virginian. Virginians thus occupied the White House for thirty-two of the first thirty-six years of the nation’s history. Under their leadership slavery expanded exponentially, and Virginia emerged as a key player in the internal slave trade in the United States. The internal slave trade, which involved more than one million enslaved African Americans being “sold down the river” to the deep South, spread slavery into the lands of decimated and displaced Native Americans. The invention of race in Virginia thus defined the fundamental principles of American slavery and freedom, and set the political and socio-economic course for the entire nation. The actions of Virginia’s wealthy elite—the 1% of the 1600s—continue to haunt us to this day.

For additional readings on the invention of race, click here.
PTSD in Minorities

Allen was a young African American man working at a retail store. Although he enjoyed and valued his job, he struggled with the way he was treated by his employer. He was frequently demeaned, given menial tasks, and even required to track African American customers in the store to make sure they weren’t stealing. He began to suffer from symptoms of depression, generalized anxiety, low self-esteem, and feelings of humiliation. After filing a complaint, he was threatened by his boss and then fired. Allen’s symptoms worsened. He had intrusive thoughts, flashbacks, difficulty concentrating, irritability, and jumpiness—all hallmarks of posttraumatic stress disorder (PTSD). Allen later sued his employer for job-related discrimination, and five employees supported his allegations. Allen was found to be suffering from race-based trauma (from Carter & Forsyth, 2009).

PTSD is a severe and chronic condition that may occur in response to any traumatic event. The National Survey of American Life (NSAL) found that African Americans show a prevalence rate of 9.1% for PTSD versus 6.8% in non-Hispanic Whites, indicating a notable mental health disparity (Himle et al., 2009). Increased rates of PTSD have been found in other groups as well, including Hispanic Americans, Native Americans, Pacific Islander Americans, and Southeast Asian refugees (Pole et al., 2008). Furthermore, PTSD may be more disabling for minorities; for example, African Americans with PTSD experience significantly more impairment at work and carrying out everyday activities (Himle, et al. 2009).

Changes in the DSM-5

Changes to PTSD criteria in the DSM-5 have been made to improve diagnostic accuracy in light of current research (American Psychiatric Association, 2013; Friedman et al., 2011). Previously, a person was required to have directly experienced a discrete traumatic event for a diagnosis. But under the new criteria, if a person has learned about a traumatic event involving a close friend or family member, or if a person is repeatedly exposed to details about trauma, they may now be eligible for a PTSD diagnosis. These changes were made to include those exposed in their occupational fields, such as police officers or emergency medical technicians. However, this could be applicable to those suffering from the cumulative effects of racism as well.

The requirement of responding to the event with intense fear, helplessness, or horror has been removed. It was found that in many cases, such as soldiers trained in combat, emotional responses are only felt afterward, once removed from the traumatic setting. The most notable change to the criterion is from a three to a four-factor model. The proposed factors are intrusion symptoms, persistent avoidance, alterations in cognition and mood, and hyperarousal/reactivity symptoms. Three new symptoms have been added—persistent distorted blame of self or others, persistent negative emotional state, and reckless or self-destructive behavior. These symptoms may be also seen in those victimized by race-based trauma.

Racism and PTSD

One key factor in understanding PTSD in ethnoracial minorities is the impact of racism on psychological well-being. Racism continues to be a daily part of American culture, and racial barriers have an overwhelming impact on the oppressed. Research has documented that implicit and explicit racism create barriers to health care
hyper vigilance, and other symptoms associated with PTSD may develop or worsen (Bryant-Davis & Ocampo, 2005). Many clinicians only recognize racism as trauma when an individual experiences a discrete racist event, such as a violent hate crime. This is limiting given that many minorities experience cumulative experiences of racism as traumatic, with perhaps a minor event acting as “the last straw” in triggering trauma reactions (Carter, 2007). Thus, the conceptualization of trauma as a discrete event may be inadequate for diverse populations. Moreover, existing PTSD measures aimed at identifying an index trauma typically fail to include racism among listed choice response options, leaving such events to be reported as “other” or squeezed into an existing category that may not fully capture the nature of the trauma (Malcoun, Williams, & Bahojb-Nouri, 2015).

This can be especially problematic as minorities may be reluctant to volunteer experiences of racism to White clinicians, who comprise the majority of mental health care providers (US Department of Labor, 2013). Patients may worry that the clinician will not understand, become defensive, or express disbelief. Additionally, minority patients may not link current PTSD symptoms to cumulative experiences of discrimination if queried about a single event.

To address this need, Carter and colleagues (2013) developed a new measure called the Race-Based Traumatic Stress Symptom Scale (RBTSSS), designed to assess racist experiences and the associated psychological and emotional reactions. RBTSSS contains 52 items that comprise seven scales, descriptive of symptoms of depression, intrusive thoughts, anger, hypervigilance, physical reactions, low self-esteem, and avoidance. Although more study is needed, this measure may be one good way to evaluate the impact of racism in ethnic and racial minority patients. **Implications for Treatment**

Racism is not typically considered traumatic by mental health care providers. Psychological difficulties attributed to racist incidents are often questioned or minimized, a response that only perpetuates the victim’s anxieties (Carter, 2007). Thus, patients who seek out mental healthcare to address race-based trauma may be further traumatized by microaggressions — subtle racist slights — from their own clinicians when they encounter disbelief or avoidance of racially charged material (Sue et al., 2007)

Mental health professionals must be willing and able to assess race-based trauma in their minority patients. Clinicians assessing ethnoracial minorities are encouraged to directly inquire about the patient’s experiences of racism when determining trauma history. Some forms of race-based trauma may include racial harassment, discrimination, witnessing ethnoviolence or discrimination of another person, historical or personal memory of racism, institutional racism, microaggressions, and the constant threat of racial discrimi-
nation (Helms et al., 2012). The more subtle forms of racism may be commonplace, leading to constant vigilance, or “cultural paranoia,” which may be a protective mechanism against racist incidents. However subtle, the culmination of different forms of racism may nonetheless result in victimization of an individual parallel to that induced by physical or life-threatening traumatic experience.

Unfortunately, many clinicians are unprepared to address cultural issues due to social taboos surrounding racism, discrimination, and White privilege. This will in turn prevent open dialogue with patients about potentially relevant experiences. Thus it is important that all clinicians are well-trained in the delivery of culturally competent care to enable them to properly serve diverse patients (see Miller et al., 2015 for a discussion).

Summary

Although changes to the DSM increase the potential for better recognition of race-based trauma, more awareness is needed among clinicians to properly identify it. Additionally, current instruments for screening and assessing trauma are generally inadequate for race-based trauma. More research is needed to develop validated tools and a culturally competent model of PTSD to address how culture may differentially influence race-based trauma. In the meantime, clinicians must be educated about the impact of racism in lives of their ethnic minority patients, specifically the connection between racist experiences and trauma (Williams et al., 2014). To that end, interventions to increase awareness and improve clinical dialogue should have the same value as other aspects of medical training (Penner, Blair, Albrecht, & Dovido, 2014). Article references are accessible here.

School of Medicine
Dean’s Perspective on Race

by Toni Ganzel, MD, MBA, FACS
Dean, School of Medicine

The theme topic for this month’s Diversity Newsletter is race, and I was asked to contribute my perspective. I view race as one of the factors at the heart of diversity, but certainly not the only factor. Diversity represents a rich constellation of elements such as age, gender identity, religion, national origin, sexual orientation, etc. and adds dimensional depth to our culture and climate.

As Dean, my goal for promoting diversity and a climate of inclusion at the School of Medicine is two-fold. First, being an academic community that reflects different perspectives and experiences makes us a more highly performing institution; it enhances the educational experiences of our learners, broadens our leadership pipelines and advances our mission of improving the health of our patients and our communities. In 2014, the American Psychiatry published an article entitled The Critical Need to Diversify the Clinical and Academic Workforce in which it was noted that diversifying the academic community enables institutions to “enable the next generation of leaders to incorporate new ways of thinking in discovery application, integration and teaching, as well as to better serve the needs of an increasingly diverse society.” Our organizational pillars of education, research, patient care, and community engagement are directly impacted by the degree to which we are successful in weaving diversity and inclusion into the core values of our school. Second, a diverse current and future workforce of physicians and scientists can better meet the medical needs of the underserved and contribute to addressing health disparities. According to the Association of American Medical Colleges (AAMC), “diversity in the physician workforce impacts the quality of care received by patients. For example, race concordance between patient and physician results in longer visits and increased patient satisfaction, and language concordance has been positively associated with adherence to treatment among certain racial or ethnic groups.” The AAMC goes on to suggest that, based on tracking data, physicians from underrepresented racial and ethnic backgrounds are more likely to practice in low socioeconomic and federally designated medically underserved areas.

A particularly troubling statistic related to racial diversity in medicine is the tragic paucity of black
males applying to and entering the field of medicine. The AAMC recently published *Altering the Course: Black Males in Medicine*. While we have made progress in some areas of diversity, this demographic group has in fact reversed its progress for entering medicine. The data on African American male medical school applicants shows a decline in applications, falling from 1,410 in 1978 to 1,337 in 2014. Additionally, enrollment of African American males declined from 543 in 1978 to 515 in 2014. When one considers the overall increases in medical school admissions in this 35 year period, this comparative declining trend is especially unsettling. We have to look at the factors that influence the decline. The literature on this topic cites inadequate K-12 academic preparation, the percentage of African American males who grow up in underserved communities, the overall lack of positive role models and even fewer role models in the medical profession, lack of exposure to medical careers and an understanding of the aspects of the profession that make it an attractive profession, the overall negative public perception of black men, and the absence of financial resources to obtain an undergraduate degree and, moreover, a degree in medical education. This will take a comprehensive effort and commitment of leadership from many different levels to effect sustainable change.

At the School of Medicine, we take our role as a premier metropolitan research university very seriously and consider ourselves “of,” not just “located in,” an urban environment. It is our legislative mandate and moral imperative to move the needle towards reducing health disparities, which are very real in our community and in our Commonwealth. The socio-economic implications that result when barriers such as race impedes the full participation of individuals and communities is a reminder of how powerful social constructs can be in providing varying levels of access to opportunities and resources.

We do ourselves a disservice when we fail to recognize the uniqueness that each individual represents. Recognition of the value that is embedded in our individual differences, is the evolutionary force that propels human beings to be collaborative, competitive, innovative, and ever dynamic. Our challenge is not to ignore the variations between individuals but to enhance and capitalize on the advantages that these differences present.

Creating a diverse academic community and physician and scientific workforce is challenging and complex. The School of Medicine has a strong history of a commitment to diversity, including racial diversity. We recognize the need to foster a culture that feels genuinely welcoming to all and that allows for individual experiences, perspectives, and preferences to coexist in a thriving intellectually stimulating environment. To assure that our school has a continual opportunity to foster this type of climate, we sponsor and coordinate several pipeline programs to cultivate and attract students from underrepresented populations. Our premedical pipelines are some of the strongest in the country. The Professional Education Preparation Program (PEPP) equips young scholars to transition into college and prepares them to be more competitive for medical or dental school application. PEPP targets students from medically underserved areas in Kentucky. The Summer Medical and Dental Education Program (SMDEP) annually provides an introduction to medical and dental careers in Kentucky. The Professional Education Preparation Program (PEPP) equips young scholars to transition into college and prepares them to be more competitive for medical or dental school application. PEPP targets students from medically underserved areas in Kentucky. The Pre-matriculation Program helps better prepare our rural and underrepresented students for the rigors of medical school classes.
Once students matriculate, it is important to provide a supportive environment and an inclusive climate. While I am proud of the progressive impact these pipeline programs have had on our student enrollment, I am acutely aware that we must intensify our efforts to create pipelines to increase diversity among our faculty. Faculty pipelines should include residents and graduate students which will be an area of emphasis this coming year.

A recent article published by the American Association of Colleges and Universities entitled *Diversifying the Faculty* notes that “all students are better educated and better prepared for leadership, citizenship and professional competitiveness in multi-cultural America and the global community when they are exposed to diverse perspectives in their classroom.” My personal experiences confirm that teams with diverse perspectives, experiences, thoughts, and ideas working in agreement on common goals are advantaged for successful outcomes. The degree to which we will be successful in meeting the medical challenges of the 21st century will be significantly impacted by our ability to integrate diversity, equity and inclusion. Diversity is everyone’s business and we all reap the rewards of investing in it.

I’d like to thank Dwayne Compton for the identification of resources used in this article. Article references are accessible here.

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**Do YOU Really Care if Black Lives Matter?**

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ATTENTION AMERICA! There are some concepts that have permeated our society in both, historical AND contemporary times: prejudice and racism. Prejudice opinions are rooted in negativity and hostility, and are facilitated by socially learned dislike and intolerance towards different groups. In the United States, one of the most notorious forms of prejudice has been within the racial context. Race is a social construct developed by whites to designate privilege to their racial group while undermining humanity and privilege of other groups. While unfair treatment of darker-skinned people did not begin in, nor is it exclusive to the U.S., it is often the narrowly-framed paradigm from which our society conceptualizes racial prejudice; contrastingly, some faith-based perspectives argue that the current treatment of “Blacks” or “Moors” in the world is biblical. While this article in no way intends to give a comprehensive history lesson on prejudice and racism, it will briefly discuss just some of the related concepts and legacies that have, consequently, shaped this place that we call, “...the land of the free and the home of the brave.”

Currently, narrative around racism attempts to distinguish different forms of it by examining outcomes. While many people understand racism as the dislike and maltreatment of a group based on skin color, some argue that racism cannot exist without power. In this instance, people do not necessarily have the capacity to act as individual racists, but would be deemed racially prejudice. The alternative perspective posits that racism is facilitated through institutions and structures that regulate political, social, and economic conditions in ways that exclude, and further, marginalize certain racial groups. Regardless of perspective, racial dislike and exclusion are ignorant, indoctrinated practices of human beings, and the U.S. has informally and formally enabled these explicit practices since Europeans stole this land from natives in the 1500s.

The examination of “White” versus “Black,” and its respective alignment with dichotomies such as good versus evil, pure versus contaminated, light versus dark, and others is deep and convoluted, especially when applied to humans. 1619 marked the first year that Whites began selling Africans into the U.S. slavery system after being transported across the Atlantic Ocean stripped of power, pride, and humanity. These Africans were considered less than human, and treated as creatures used to generate and sustain economic vitality for Whites. It was not until 1787 that “Black lives mattered” (pun definitely intended) outside of the slave classification. The socio-political context of enslaved Africans garnered interest from northern and southern stakeholders,
though at opposite ends; northerners objected the counting of slaves as persons since they represented property, while southerners insisted that slaves were counted as people. Ultimately, each slave was acknowledged as 3/5 of a person in the Three-fifths Compromise, albeit the reasons were pragmatic and beneficial for slave owners, since they were using slaves to gain political representation in the House of Representatives. Moreover, increased political representation meant more power to enact laws, policies, and systems that sustained White supremacy, a notion that southern U.S. Whites heavily supported since they possessed a higher number of slaves.

In 1862, President Abraham Lincoln signed the Emancipation Proclamation, mandating that slaves be freed the following year; however, interestingly enough (or is it?), slavery continued illegally until at least 1865. Coincidentally, the Ku Klux Klan was formed that same year, and has since, been widely known for ideology rooted in white supremacy, as well as historical hate crimes and terrorism against Blacks, and Whites who were supportive of Black liberation and justice.

In the contemporary U.S. South, places wherein a stronger historical connection to slavery exists, so do greater disadvantages for Blacks when compared to Whites. Specifically, Black poverty rates are positively and significantly related to 1860 slave concentrations, as illustrated by higher Black/White poverty inequalities in counties that contained larger slave concentrations during that time, illustrating that contemporary racialized poverty is related to structural legacies of slavery. Additionally, practices such as inequitable sharecropping, Jim Crow laws, and explicit economic discrimination aimed at Blacks upheld and reinforced racism across many institutions, leaving many of them with a fight to lead productive lives in the midst of battling a society created for Black destruction and White supremacy. Complementing this concept is the 2014 Health Equity Report released by Louisville Metro Public Health and Wellness. It highlights desolate social, environmental, and health conditions that pervade a particular section of the city mostly inhabited by Blacks. Unfortunately, similar conditions can be observed in many impoverished urban areas across the coun-

Trinidad Jackson captured this picture at a Mike Brown protest in Ferguson, Missouri in November, 2014.
try heavily populated with Blacks.

As demonstrated, generations of Blacks across the U.S. have fought to restore positive racial identities, all while dealing with consequences rooted in the violent ascendancy of racism. In August 2014, Mike Brown’s murder was the catalyst for many things old and new: protests, heightened personal surveillance of police interactions with the public, and the Black Lives Matter movement. While not an exhaustive list, these actions have garnered national attention and have helped shape priorities for some neighborhoods, health departments, police departments, and other entities interested in solving social ills.

Public and police surveillance devices have captured the slaughtering of many Black lives, events that have occurred without warrant. While people from many different ethnic backgrounds have been killed by the police while unarmed, the rate at which Blacks are killed supersedes all other groups. On January 22, 2015, the Black Lives Matter movement released a State of the Black Union, and affirmed that, “Our schools are designed to funnel our children into prisons. Our police departments have declared war against our community. Black people are exploited, caged, and killed to profit both the state and big business. This is a true State of Emergency. There is no place for apathy in this crisis. The US government has consistently violated the inalienable rights our humanity affords.” These statements are supported by facts that Black Lives Matter has delineated; for example, remember the aforementioned text about power associated with political representation in 1787? Black Lives Matter has highlighted the fact that 22 states have passed new voter restrictions since 2010, disenfranchising as many as 34 million Americans, most of them Black. Additionally, 1 in 3 black men will be incarcerated in his lifetime, and Black women are the fastest growing prison population. Adding insult to injury, children are being funneled into the “school to prison” pipeline—a phenomenon that engages youth in the juvenile and criminal justice systems at alarming, and disproportionate rates. Specifically, Black youth are suspended and expelled at the highest rates—3.5 times more than Whites—although they are engaged in a comparable number of offenses as their White peers.

Souls are being attacked. Spirits are heavy. People are angry. Freedom, economic stability, education achievement, and political rights are still being infringed upon. Genocide is occurring in the U.S., and we still have confederate flags, statues of slave owners, and other symbols of Black oppression that are elevated and celebrated in this country. This definitely sounds like a country wherein social justice is a priority for everybody, right? How can we explore and facilitate TRUE and actionable history initiatives in our society that foster racial uplift, positive identity development, and unity across “racial” spectrums? Is that something that our America wants? As Black church after Black church has burned in the summer of 2015, people are still on the front lines attempting to actualize, “...liberty and justice for all.” In 2015, “all” should include Black people, too.

As we observe the cumulative disadvantage that impacts Black lives, we have to be intentional and strategic about addressing roots of these issues. We all inherit a legacy that was facilitated by opportunity structures created before us. A pertinent question, though, is “Are YOU satisfied with your opportunity structure, and the manner in which it is impacting the world?”

Google is a friend of those who seek information, and there are many entities that you can contact to contribute your energy to knowledge attainment, research, and action related to racial and social justice. Listed below are just a few...good luck!

Anne Braden Institute for Social Justice Research
Black Lives Matter Movement
Showing Up for Racial Justice
Action Research Center at University of Cincinnati
“I am not an American; I just live here” sums up my feeling of belonging in this country these days. The almost weekly occurrences of reported shootings of black males and females have gotten to me over the years so much that I feel like a fish out of water. I recall when Louisville was in the midst of a series of police shootings involving black males in the late 1990s. I felt like my parents had done all they could to protect me, but I was still vulnerable.

As a child, my dad always commented how he hated driving from our home in Middletown to visit friends in Berrytown because it required cutting through Anchorage. He was overly cautious when passing through Anchorage and one time, I naively stated “well you won’t get pulled over unless you are doing something wrong” only to receive my dad’s side-eye along with a “you’ll learn, Brian” comment. I had no idea what he meant at the time, but as I have aged, my parental warnings have made sense.

One of my most memorable parental interventions centered around my ability to learn to whistle at the age of eight. I was with my mother and sister in Bigg’s one day and decided to whistle at every female in the store. I wasn’t doing this to flatter anyone, but rather because I learned how to do something so seemingly innocent as whistle. Soon after returning home, my 14-year-old sister told my dad what I had been doing while we were in Bigg’s, after which he instilled in me that I was to never do that again. I had no idea what prompted my dad to react with so much anger towards me; I was only refining my newfound skill. I later learned I was not disciplined solely for displaying chauvinistic qualities, but, most importantly from my parents’ perspective, because Emmett Till, a 14 year-old black teen, was beaten, shot, and tossed in a river for allegedly having done so to a white female in 1955. This had happened in both of my parents’ lifetimes and the murderers were acquitted, which set the tone of race relations in this country at the time.

I tell my parents I most certainly would not have lived through the Civil Rights Movement of the 1960’s when they endured racial slurs, being stolen from and left too afraid to report the crime, and living separate, but “equal” to their white counterparts. I have too much of a fighter / confrontational...
streak in me to have endured all of that and not taken one for the team for the sake of the greater good. Fast forward 50 or so years and, although the date has changed, the landscape looks all too familiar in this country.

We live in a time when people rationalize the outcomes of shootings without considering the symptom. It is very uncomfortable to consider that Trayvon Martin should not have been harassed while walking home in his own neighborhood in 2012. It’s much easier to rationalize George Zimmerman’s perceived threat after he followed and started a fight with a 17 year-old, only to kill him with a gun after he was losing the fist fight he instigated, contrary to the advice of a 911 operator. It is also uncomfortable to consider what Walter Scott was really stopped for instead of having a taillight out in April 2015, since the officer who killed him lied in his report about all other material aspects of the “routine” traffic stop. It’s easier to consider his struggle with the officer who subsequently shot him in the back as he was running away. It has become acceptable to say “that girl should not have mouthed-off to that officer in Texas” instead of, “he should have been the adult, managed his emotions better, and not waved his gun at those teenagers.” And most recently, perhaps had Sam Dubose exited his car, he would be alive, although his reason for remaining in his car is because history has proven that, as a black man, stepping-out of your vehicle tends not to end well.

Racism thrives in America because it is all we know. From the time North America was “founded” in the 15th century, there has been someone rationalizing why one group of people is lesser than another in this country: why Native Americans should be relegated to live on reservations or why blacks should work for free and be beaten, raped, and killed at someone else’s discretion.

I try my best to hide my feelings as I walk the halls and sidewalks of the HSC, but deep down feel like I, as a black male, do not belong in the U.S.; I am a man in a foreign land. As a result, I feel out-of-place standing for the national anthem at sporting events or graduations because I just don’t feel that the America referenced in that song is MY story; I feel the land of the free is some far away land because it seems to be socially acceptable for people who look like me to be subservient in this America. Again, I am not an American, I just live here.

I make no apologies for how I feel. I live a life with a unique perspective; a perspective that has been in the car with parents who were pulled over for "looking lost" (read: driving while black) in Louisville’s east end suburbs on multiple occasions, despite receiving no warnings or violations from the patrolling officers after “standing our ground” that the officers were blatantly harassing us for being black in our own neighborhood. My perspective is one that is extremely hesitant to let my 12 and 13 year-old nephews out of my sight because of what has happened to Trayvon Martin and Tamir Rice, both whom were killed while committing no crimes.

The problem is racism often times occurs subtly before it is blatant. We often make the mistake of thinking racism manifests itself when people use a racial slur or some other derogatory term. On the other hand, racism likely begins the first time we say "they" and generalize a population or group of people based on the actions of a few. It happens when we call people “thugs" because of where they wear their pants, how they wear their hats, and/or how they speak. Racism was borne out of the idea that one group of people is superior to the rest based on someone’s skin color or cultural identity. It occurs when I’m at my grandfather’s house in Austin, TX and the conversation turns from typical Davis family conversations to talk about “they” or “them” (Hispanics) being everywhere. I know it wasn’t too long ago that my family was “them.”

If you think that all guys who wear backwards or sideways baseball caps, listen to rap music, and wear chains are thugs, then, well, if you catch me on the wrong day, you may consider me a thug. And let’s be honest, “thug” is a code word for a much more offensive word. In light of my aforementioned experiences and revelations, I will say for a third time: I am not an American, I just live here. I guess it’s best that I am just passing through.
Upcoming Diversity Events

- **“Introduction to LGBT Health and Wellness”**
  *LGBT Health and Wellness Competency Certificate Series*
  Tuesday, August 25 from 12:00—1:00 pm
  Location: Medical School Instructional Building, Room B215

- **Women’s Equality Day**
  Wednesday, August 26 from 11:00 am—1:00 pm
  Location: Humanities Quad, Belknap Campus
  Contact: Phyllis Webb

- **“Unconscious Bias: Exploring Self Awareness”**
  *School of Medicine SMART Staff Program*
  Wednesday, August 26 from 12:00—1:00 pm
  Location: Kornhauser Auditorium
  Register: here

- **Community Discussion on Minority Health in Kentucky**
  Tuesday, September 1 at 6:00 pm
  Location: Kentucky Center for African American Heritage, 1701 W Muhammad Ali Blvd.

- **“Evidence-Based Transgender Medicine”**
  *LGBT Health and Wellness Competency Certificate Series*
  Friday, September 11 from 12:00—1:00 pm
  Location: Kornhauser Auditorium

- **National Association of Minority Medical Educators (NAMME) Annual Conference**
  September 16—20
  Location: Hyatt Regency Louisville
  Register: here

- **4th Annual Symposium on Pediatric Behavioral and Mental Health**
  Friday, September 25 from 8:15 am—4:30 pm
  Location: Home of the Innocents, 1100 E. Market St.
  Register: here

- **6th Annual Kentucky Health Literacy Summit**
  Wednesday, October 7
  Location: University of Louisville Shelby Campus

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**RACIAL CONFLICTS AND THE IMPACTS ON OUR HEALTH:**

**HSC Office of Diversity and Inclusion Lunch and Learn**

Thursday, August 20 from 12:00-1:00, Kornhauser Auditorium: Register here

Police shootings of unarmed black and Latino men by white officers, deaths of men and women of color while in jail for minor offenses, removal of the confederate flag from state capitals and subsequent protests held by the KKK and other white supremacy groups are just a few of the weekly and sometimes daily news reports regarding racial conflicts in the U.S. Are these conflicts increasing and what are the impacts on our society and our health? Join us and our panelists as we explore these critical issues impacting our society today.

**Featuring panelists:**
- Dr. Latrica Best - Assistant Professor of Pan-African Studies and Sociology
- John Chenault - Associate Professor and Medical Librarian in the Kornhauser Health Sciences Library
- Felix Garza - Library Associate / Public Service Associate in the Kornhauser Health Sciences Library
- Trinidad Jackson – Program Coordinator, Sr., Office of Public Health Practice in the School of Public Health and Information Sciences
- Dr. David Owen - Associate Professor of Philosophy and Chair of the Philosophy Department