Now I would like to turn it over to our fabulous speaker, Dr. Kathleen McChesney.

Thank you for that lovely introduction. I am expecting a drumroll. I want to extend my gratitude toward everyone here who has taken time out of their schedule to dial-in for another annual workshop virtually. Again come -- am a licensed clinical psychologist and I've been working with veterans and active-duty military population for little over 18 years. When I was asked to do this talk, I was a bit surprised. It is by no means an area of my expertise however, upon reflection and given the recent events that have happened in this world with the pandemic and the black lives matter movement and the Me Too Movement, I recognize as a representative of the privileged groups that perhaps some of the best ways I can offer change and opportunity for improvement and her ability to work with our patients is to be a communicator to speak to members of my own community. That being said, I am stepping up. I welcome each and every one of you, particularly if you represent a number of the black, indigenous, Latin, or other indigenous communities and have important information to share with the group, I am more than welcome to receive questions, feedback, comments and queries as well as literature and feedback for future talks. I look forward for communicating with everyone.

I recognize this is a provocative talk a -- topic so I will be the first to tell you if I fumble language or misspeak, please take the time to not only inform me but by all means educate me on how I may improve my conversational style. I am humbled before you and appreciate I may be speaking to some incredibly well experienced folks.

Before I dive into the material, I would like to acknowledge I'm coming to you from San Diego, California which was originally occupied by the -- indigenous people and they have been occupying this particular area and territory for over 10,000 years. They were originally created by the Spanish lists around 1642 and although there are many names and tribes sprinkled throughout the Southern California and San Diego counties in particular, we do know the current occupants have currently grown to 70,000 acres where they still occupy and live today. Let's take a moment to honor and pay our respects to those indigenous persons that welcomed Europeans here in the first place and enable folks like me to inhabit and share the land. [Pause]

Another thing I will be doing throughout this talk in order to engage with everyone and keep this a dialogue, I recognize sitting in front of our computers for our signing can be tiresome if not boring so I would do my best to keep the conversation active and engaging. I may be asking at any point in time not just a polling question but by a show of hands or if anybody would like to offer feedback in the chat room. Don't necessarily wait for a pause or wait for me to ask. If something shows up and you would like to express yourself or put a comment down, please feel free to do so. If some of you out there are feeling a little hesitant to express yourself or maybe you are taking in all the information, when I ask folks to raise their hand that this would necessarily be shared on the public platform. It is more of an opportunity to help me guide my conversation in order to maybe go into greater detail or gloss over more

generalities based on your background or experience. That said, his show of hands, how many people in my audience offer direct physical medicine or medical care to our patients? You are physician, registered nurse, physical therapist, acupuncturist, you do hand work -- hands-on work with your patient. I see a large number. Fantastic.

Out of those of you who are engaged in hands-on care, I want to expand my questions to how many of you out there are responsible for the provision of pharmaceuticals, medications, imaging or making orders for those types of treatments. A large number. I am aware Linda you might be working on this, there is someone with the hot microphone and if we could just ask everyone to please mute their phones and that way we don't have a lot of conflict or feedback. I am seeing a lot of people raise hands. Not only are you physically putting hands on patients, you may be involved in direct medical care as well as is -- applying treatments, applying prescriptive medication. I'm glad to have you on board.

It’s important I have my disclosures here. This certifies that I have not nor have my special partner or family member expect they have any financial relationship in-kind with the industry relevant to the subject matter of the presentation. This certifies the views expressed in this presentation are those of the author and do not reflect any official policy of the Department of the Army, Navy, Air Force, Department of Defense or US government.

Today we will be discussing race, ethnicity and cultural aspects associated with chronic pain. As I dive into the material, I think it is important to make sure I reviewed the subject matter I hope to cover at least minimally if not touch upon to spark curiosity, spark motivation this and although the topics and subject matter that may be somewhat provocative or delicate, I recognize every person who has dialed in today is here because we all share one thing in common and that is we want to help other people. We are involved in providing healthcare, supports, therapies and treatment.

We all share this desire to improve our own capabilities and the impact we have to improve the longevity and quality of the lives of those we treat. I will be reviewing some important biopsychosocial context. Many of you who have -- are familiar with the series. This is so important for the subject matter today. We are aware there seems to be a sick advocate paradigm shift the more we are involved in the comprehensive assessment and treatment of persistent pain, the more we recognize this is a purely subjective and highly complex process that requires not only conceptualization from multiple disciplines, but an interaction between disciplines in order to provide appropriate quality care for our diverse patient population. I will also be going through a little bit of history regarding race, ethnicity and culture and how that has played out in our current North America trend of medicine.

For those of you unfamiliar with some terminology, I want to introduce the acronym BIPOC which stands for black, indigenous and people of color. I will reference this acronym throughout my talk today. I will be talking about correlations and associations between these individuals and mental illness. As we know there is a strong overlay between mental

illness and pain or pain and mental illness. Furthermore, I will discuss pain management among members of these communities and how there is an overlay between psychosocial distress and pain management within these communities. I'm then going to offer some recommendations that maybe we alone as individuals can do. I recognize many of us may be experiencing what can I do concept were systemic problems may seem overwhelming or complex and how I alone can make a difference. I hope after today you will have some idea how you me able to chip away at that and feel some sense of efficacy and contribution to these efforts.

One of the reasons why want to speak to the biopsychosocial context as well as definitions is certain concepts are essential for case conceptualization especially if we are communicating across disciplines. If I use some form of terminology my colleague is not familiar with, we are not going to reach the same playing field. We need to have that shared language within our treatment culture to make sure we have a shared understanding of the case we are conceptualizing, in order to understand that maybe we are reaching a similar diagnostic goal, planner theory then it can also inform shared understanding of the treatment and prognosis of our individual.

I’m going to be a little bit brief with this. Nevertheless, I always welcome questions. The biopsychosocial context is complex and highly subjective. Psychosocial factors influence susceptible inputs to modulate pain perception. That is a biological peace. If I stepped on a nail, neurons are traveling from my foot to my spinal cord to my brain or my brain has to make some very quick and sophisticated decisions. What just happened? Where did it happen? Why did it happen? What does this mean? How am I supposed to respond? After that registers biologically, that input combines with my brains perception and interpretation based on the environment I am in.

It is also influenced by emotional mindset at the time I experienced injury and I am also pulling from my personal history memories of previously threatening events. I am anticipating future events based on my life of experiences in this body.

Pain is a perceptual experience created by the brain to ward off threats. Unlike other senses, it is the only sense that is so swiftly driven to ensure survival and the ability to determine life versus death or safe versus unsafe. When it is perceived as threatening in an environment that is threatening, it can amplify the individual's perception of what may be happening. What is interesting is what we are aware of is the longer we experience a painful or sensation over time, the more likely areas of the brain that are normally aroused, like on the sensory cortex in terms of our sensory awareness of the body parts, the longer we live at that sensation, the less there is a direct association between the anatomical site of injury and one experience of distress, suffering and pain.

Those of you may be where the International Association for the study of pain defines pain as both a sensory and emotional experience based on actual or perceived damage to the tissues of the body. Two significant factors are at play that explain and help substantiate the value of the psychosocial aspects and medicine. Perceived threat, emotionally

provocative, not just physically. That explains the combination of the biological and the psychosocial altogether. We need the integration of all of these to have a conscious experience of pain. What do we know now? Across individuals, note two people with the same injury present in the same way. For those of us who have a very large caseload, you may have seen numbers of your patients arrive with migraine headaches for example and no two persons with migraine maybe tell you the same story and maybe present in the same way. We have come a long way with our diagnostic checklists to share some features in common but as we start to narrow down our assessment of the individual, we may find there are slight areas of gray that make this person different from another, whether that is appearances, phenotypes, culturally help this person represents where they are from through their behaviors and mannerisms and through their identified sex, gender or roles they play. It is complex. The individual socio-cultural history and perceptional meaning of pain between each other creates a context through which the pain experience manifests. It does not happen in isolation rather it is an output based on the environment one finds him or herself in. Anatomical sites and biological processes through which pain is experienced will differ individually and are influenced by other co-occurring processes in the brain. Have a been you before? Have I felt this way before? The last time I had this experience, what was I doing? Where was I? Who was I with? How did I get out of it? How did it heal? These are areas of our brain that are involved collaterally. This impacts the pain experience uniquely in the transition from acute to chronic pain. The development or exacerbation as well as whether or not chronic illness is existent or developed and that is how it impacts our treatment planning which may often feel like a moving target. I am curious how many people in my audience specifically work with pain management or with patients who have pain related issues? Bless all of you. This is a challenging group of patients. I have been working with the chronic pain population for at least 12 years. It is complicated and often times we may feel like we are tweaking this gear to get this gear out of whack. It is complicated. If you feel like you are often throwing a dart in the dark this, you're not alone.

Let's transition to describe some essential definitions. Before I dive into these concepts, there are some fundamental thoughts I would like to introduce to everyone. I'm going to quote some of the thoughts of Paula Rothenberg who was a front runner of literature in the efforts to help improve movements for social justice as well as equality based on what this country has experienced dynamically with racial conflict, social injustices, gender and sex issues, etc. This is in reference to a new term or perhaps a very old term that is rarely brought up in discussion amongst medical communities regarding white privilege. When we discuss race, sex, sexual orientation, each needs to be described as a power system that creates privileges in some people as well as disadvantages in others. Most literature is focused on disadvantages or discrimination while ignoring the element of privilege. What I hope to address today is a combination of the two and how history and the development of certain systems has continued the enabling of certain power structures to exist in spite of efforts on individual levels to create change. This in turn creates the complex we often have today in treating patients in particular.

Let's talk about culture. Culture according to the American DSM 5 is knowledge, concepts, rules and practices that are learned and transmitted across generations. This includes language, religion, spirituality, family structures, lifecycle stages, ceremonial rituals and custom as well as moral and legal systems. Given its definition by show of hands, true or false, or you can type this in the chat. Is the military a culture?

Thank you for that. It is absolutely a culture. Here is something those neglect or forget to recognize. Cultures are open systems meaning you can have a culture live in a culture. They are dynamic systems that undergo continuous change over time. True or false. Is it possible to have a subculture within the military? What are some examples? Can you think of an example within a subculture within the military culture and if so type them in the box.

Rangers, okay.
Officers versus enlisted, Rick, I love it because that is a significant cultural difference. As providers we may be very privy to the conflicts that happen between those two communities, yet they have to work together. Those are fantastic. You might notice, birds of a feather flock together we say. This might be general allergies pick we have to be somewhat careful when we apply this language. Teachers of culture make it crucial for us not to overgeneralize culture [Indiscernible] nor stereotype them in terms of a fix because cultural shifts are fluid, absolutely fluid. For me to say all Navy SEALs are A Holes, I don't know what that is appropriate. Maybe my experience has been different but that make and the generality across-the-board. What it is to be a Navy seal is unique and stands in the overall culture of the Navy. Again, most individuals are exposed to multiple cultures which they use to fashion their own identities and make sense of an experience. It's also very common if somebody is a member of more than one culture at any given point or any particular system, they may downplay one culture and up play another. We all do this. I may in one of my staff meetings downplay my cinnamon roll as a woman and up-tick my role as a member of the Medical Community when I go to a staff meeting. Similarly, I know there have been roles and regulations that the language one should speak when in military uniform is American English.

If you are a member of a particular culture that speaks a different language, you have been informed to not use that language when in an American military uniform and to only use American English. Certain cultures and how we represent the culture we are in we may titrate, we may shift. New definition here. Let's talk about race. According to the APA, race is a culturally constructed category of identity that divides humanity into groups based on a variety of superficial physical traits attributed to some hypothetical intrinsic, biological characteristics. In other words, phenotype based on appearances. Racial categories and constructs have very widely over history and across societies. These constructs have been somewhat fluid. The construct of race has no consistent biological definition across time and across history, yet it is important. I want to open up the chat room. Why is it important that we talk about the construct of race? Does anybody want to take that on? But your answers in the chat box.

With got some cool people out there.

Why is the construct important if it has no consistent biological definition?

Provides a framework to relate to the patient to talk about pain.

I like that, absolutely. Implicit biases. You are both correct. Any other thoughts and I will expand on that.

I think it will address both of your responses. Drew says how individuals organize themselves, or how they are treated/marginalized absolutely. Let's touch on all three of these answers and I do appreciate the forthcoming feedback. The construct of race is important because socially it supports racial ideology. It supports acts of discrimination in racism, and it can result in social exclusion based on different environmental systems of power and power structure. Ironically what we made be concerned with in terms of how one identifies may not necessarily be based on race but it's going to depend on the eye of the beholder on the subjective report of the person you work with. And I'm also what Jesse says have concepts of race are rarely changing of the discussions need to be frequent to stay up with the changes.

I absolutely agree. In fact, I was having a conversation about race with my father who is 77 years old, a Vietnam era vet. He brought attention to the fact that we now use the phrase, people of color very broadly. I don't know if he used to use it as broadly as we use to. And so, we have also heard different terms come in and out of fashion, what's appropriate, or what is now considered inappropriate, offensive. And so, part of what I am hoping when we are doing this right now is for all of us, no matter how we identify, it's so important to ask questions, to beg forgiveness, to acknowledge our limitations or our ignorance in order to feel that we are more informed. Because better information is going to help me be a better provider, end of story.

I love the commentary. Please keep it up, folks. I can see that some people are writing. We also know if we are able to keep this social construct in our dialogue, we can start to study it and we can start to have a better understanding and begin to examine the strong and negative effects it has on physical, as well as mental health. We know that growing research in these areas are showing that racism can exacerbate many psychiatric disorders, contributing to poor outcomes. Racial biases can affect our diagnostic assessments. There is some literature to suggest how it happens, when it happens, and maybe even why it happens. I Will address these later on. We may also engage in behaviors that not only impact long-term health effects of our patients, but we may also over pathology eyes and result in an appropriate care, inappropriate treatment, and further harm that was not necessary. Jesse says, 50 years ago you could say [Indiscernible] and that is changed.

Absolutely, absolutely. Here's an interesting term, ethnicity top which seems to be almost like the intersection of race and culture one might argue. The API defines ethnicity as a culturally constructed group

identity used to define people's and communities. Culturally constructed, not by phenotype, not by appearances. It is constructed to define peoples and communities rooted in a common history, geography of location, language, religion, or other shared characteristics, a group, distinguishing that group from others. It may be self-assigned. Or it can be attributed by outsiders. Here we go again. Once ethnicity can be a source of strength or conflict. I will open up the question again. Why might once ethnicity be a source of strength or conflict? Put your answers in the box if you can.

Put your ideas, love it, love it.

While they are typing I am going to see [Indiscernible]. The takeaway overall is that cultural, ethnic, and racial identity can be sources of strength and group support if we share that identity, and we are able to support one another. It can help unite and build resilience. Birds of a feather flock together. On the other hand, yes, and I like what you are saying, Ana. Can come from a sense of community or solidarity. Or shared experiences. Absolutely. And Jesse adds mixed ethnicity folks are perceived as one thing and often identity with another. It is good to have it turn that helps define that person's identity with what appears other than their phenotype. Absolutely. I agree. I want to bring this up while it’s on my mind. One of my dear friends who is in IT and does Biomedical Research was born in Israel. No, she was born in Iran. I am Corrective. She was born in Iran. She left Iran in the 80s and immigrated to Germany. She speaks Hebrew because she identifies as Jewish. She speaks [Indiscernible] because she is from that area of the Middle East. And she practices very westernized methods of socialization, yet she is a conservative and Jew only keeps kosher. At her wedding to a white Anglo-Saxon Navy sailor, we involve ourselves with a lot of [Indiscernible] and certain ceremonial rituals. I asked her the other day, because I was doing this talk, how do you identify yourself? Do you identify as Jewish American? Do you identify as Persian? Do you identify as a person of color? Do you identify as Iranian Jewish? How do you identify? Her answer was one word. She said, somatic. I was, wow. Because essentially what she was describing was more of a culture or ethnicity in my opinion. From history, geography, language, religion, shared characteristics with a group. Even she hesitated.

I appreciate your comment, Ben. She was like, okay, sure. If you want to give me a label, she says here is how I tend to identify myself. Ben says, conflict can come when we oversimplify and make assumptions based on assuming individuals will fit the perceived norms of their ethnicity. So true. Again, really does fall on the eye of the person. Case in point, for those documenting in medical records, what you see in their demographics may not be the reality of the patient. It is so important for us to, how do I say, implement this in our assessment. How do you identify? We are finding with transgender individuals that they may represent or be represented in their medical record in one way that the individual identifies as another. That's going to inform I practice, particularly as I address him/her, or they. Also, if I want to find out what their hormone levels are depending on their level of transition. It’s so informative and helpful.

The point here is culture, race, and ethnicity are related to economic inequality, racism, and discriminatory practices that have resulted in health disparities in this country, in particular. However, the identification of one of a number of a group can help [Indiscernible] social and emotional psychological support. It's a mixed bag. We need to be wary of these things as we formulate our diagnostics, as well as our treatment plans. I separated this particular because I'm going to be spending a few more moments a little more on this particular one. Racism, according to Paradies in the Journal of General Internal Medicine, defined racism as: Phenomena that maintain or exacerbate avoidable and unfair inequalities in power, resources, or opportunities across racial, ethnic, cultural, or religious groups. Phenomena that maintain or exacerbate avoidable and unfair inequalities. Now, in many of the articles that I have read, and amongst many of my [Indiscernible] it's my current experience that no one provider desires to cause harm. Not a one of us if we have taken our oath have ever needed a point or intended to cause an injury. Perhaps there is a lack of social awareness or a lack of being woke, per se. We have to think of that in particular. Nevertheless, the systems that have been in place, that have been put in place for hundreds, if not thousands of years. Racism is expressed through three different ways. It is expressed through our belief systems. We have negative inaccurate stereotypes. It can be expressed through emotions. Better generated on a physiological and biological level. Those emotions may be fear, hatred, or disgust. And racism may be expressed through behaviors through acts of discrimination for unfair treatment be it explicit, implicit, or systemic.

Moving along, racism occurs at three different levels. Racism that occurs on the internalized level is when an individual incorporates racist beliefs into their worldview. This may have occurred from the earliest times of childhood development. I am going to pause and answer a particular question. Jesse is asking, do I think ethnicity will eventually replace the concept of race?

I doubt it. That my answer, because the concept of race is still based on visual cues, whereas ethnicity is not. And as long as we are visual beings, the brain will desire to categorize based on what we see and how we parse the differences out in our mind. That is my opinion. But I am open to other thoughts from the group as well.

The first level, as I mentioned, was internalized, incorporation of waste is released in the one's worldview. Once again, my doesn't might have been developed from the time in the womb and pick up things based on my environment, the people I am raised with our people raised by. That I learned in school or the textbooks I have been given, or through morals and stories I have learned over the years. Interpersonally is another level. Racism occurs interpersonally through racist interactions between individuals. Again, whether it be explicit, implicit, systemic, or in isolation, it occurs. And thirdly, with systemic/structural, or institutional racism. This occurs through policy, practices are processes within organizations or institutions. I appreciate your feedback, Jesse. It's a very difficult word and I know not everybody, including myself, is comfortable putting it out there and trying to explore what it means.

Okay.

Why does structural racism exist? What a good question. It exists because discriminatory practices in one sector, likely reinforced parallel practices in other sectors creating interconnected systems that embed inequities in Laws and Policies. It is a very poignant outcome of this. It's what we saw over the past year with the clear effects of the pandemic on the ability for persons [Indiscernible] persons to have adequate access to medical care, treatment, policies and healing. These systems effect health through pathways including but not limited to, social deprivation from access to employment; reduced access to housing and education; home loans are banking institutions; increased environmental exposures and targeted marketing of unhealthy substances based on access or lack thereof in particular areas; inadequate access to healthcare; perhaps physical injury and psychological trauma resulting from State sanctioned violence such as brutality. Also, chronic exposure to discrimination and diminished participation in healthy behaviors. Such as healthier coping mechanisms. As a person who believes in basically humans being good and wanting for good, and this is my opinion, we do the best we can given the resources we have, and if the resource available are lacking, inadequate, or less than beneficial, it's better than nothing. People do the best they can given the cards they have been dealt. Carrying on over some additional things I would like to talk about but want to check the room regarding ready for a break? Linda, any thoughts on that?

How about ten-minute break and resume at the top of the hour?

Okay, sounds good. We will see you in a few, everybody.

Okay, welcome back everybody. We are about to get started. I just want to quickly do a test. Hopefully everybody can still hear and see me. Let me know if you are able to hear me okay, see me okay. Thanks, everybody. Appreciate it.

I really would like to emphasize a point made by Ms. Oh bar. It's a big transition into the next section that I will be discussing and introducing for everyone's thoughts today. When we tried to remove an actual word there may be an unfortunate loss of something that would be very valuable to capture. I am also kind of a behavioral psychologist, if you will, and I come from a [Indiscernible] that we can only add-on to our experience. We cannot remove anything from our repertoire. As long as it is my lifetime got once the word has been planted it will be in my brain. Try, try as I might to suppress, alter, shift or substitute, it is in my brain. So, to the extent to which we can permanently remove that, I'm hesitant to say that it will happen in my lifetime. The point that would make what you said in the chat room extremely valuable is when we are talking about appearances. In twins study it's fascinating work that although twins share the same DNA, if one twin has a phenotype and presents as traditional Black compared to the other twin who presents as traditionally White, we're now to predict there may be poor health outcome for the twin that is seen through his or her appearance of being a person of color more so as the person of the dominant White traditional appearance. We need to be mindful of that as providers based on the

research and data findings we continue to observe today. With that being said I'm going to share with everybody some general historical patterns and themes. Before doing so I am going to give a couple of other announcements.

How do we understand some of these thoughts to be true? There was in September of 2020, a meta-analysis conducted of 293 randomized clinical studies that reveal that racism is significantly associated with poorer mental and physical health outcomes. As I transition into some of these statistics, I do want to highlight this concept of privilege and how many folks who represent the dominant race, or the dominant population are also finding it uncomfortable subject matter to speak of. Nevertheless, each of us as I mentioned have the best of intentions but some of the aspects, nevertheless, that are upheld by our system continue to enable discriminatory practices. Ironically, the term privilege was defined as far back as 1988, which I found less surprising, but an individual named Peggy McIntosh. She was known as a feminist an antiracism activist and has been the Associate Director of the Wellesley College Center of research on women studies works is also the Founder of the national [Indiscernible] project on inclusive curriculum. That said, she is also done interesting work on white privilege. Generally speaking, white privilege is defined as power structures inherent in American society based on the appearance of race that disproportionately benefits White persons while putting people of color at a disadvantage. I can give an example as a member of the privileged folk that through no intention of my own benefited from the system that discriminate others. I was relocating, I had just done some work as an exchange student overseas. I was still in college and the year I was overseas my father lent my car to a buddy of his. During the year that I was gone this buddy neglected to pay the annual, basically, the DMV for my registration and license renewal. My tags had expired, and I did not know this. I was driving through downtown Los Angeles, near where I grew up with expired tags. I was pulled over somewhere near Wilshire Boulevard, West Los Angeles. I was told by the officer that I was cited, and he wrote me a ticket. I had to go to court to pay the difference. I went to court and, actually, as long as I paid for the registration I was cleared, no problem. The officer did not even appear in court. That was 1995. It just so happens that one of my patients who has now medically separated due to symptoms of PTSD had not just this one experience, but a handful of other experiences where he was actually pulled over while he was driving home near Atlanta, Georgia, in 2018. When this officer pulled him over asked my patient to step outside of his vehicle, patted him down but not before placing his firearm against the back of the head of my patient. And upon reviewing my patients driving license and registration, informed my patient that is registration tags were about to expire. They were still legal. Thankfully, my patient was let go and put back in his car, but it, nevertheless, had a lasting impact on his sense of safety and trust of people in uniform. Not to mention people in the State of Georgia or near Atlanta at that time. This was almost 15 years, maybe even longer, yeah, almost 20 years after my incident happened.

This being said, I would like to draw some attention to certain historical facts we know to be t rue, that racism in medicine, in particular, goes back as far as the antiquity era. With ancient Greeks

called their view of the enslaved and enslaved persons we're all seen as inferior and less than intelligent. There has also been noted observations of Aristotle displayed prejudice towards Black and Asian individuals. And then there is a literature that we have picked up their documents by the Romans [Indiscernible] in the second century AD that whites are superior and non-whites are not only inferior but subhuman. Much of this philosophy was generalized and shared amongst those who our literate, and those who our literate was most likely educated or already socioeconomically in a privilege state, able to travel, able to be mobile, able to read and write. So, the writings of philosophers, academics and scientists perpetuated this worldview, historically. This persisted throughout the development of history in Western Europe and also moved to the Americas when the age of exploration, imperialism and colonialism boomed. During that time imperialism and colonialism was building, many colonialists operated under this paradigm of thought that concepts regarding manifest destiny. If I see it and I want it, I can have it. If I can conquer it, it is mine. Survival of the fittest. The writings of Darwin and his contemporaries we're really starting to look at Fino typical features in trying to correlate intelligence and capability to physical attributes. These new writings and developments in science justified the exploitation of the enslaved, disadvantaged, or indigenous folks for profit and gain. And as we know, slavery has produced a legacy of racism, injustice and violence in this country dating as far back, if not earlier to 6019. As I mentioned in the beginning of my talk, colonialists, the Spaniards, came to the coast of California in 1542, I believe, on this 100 years earlier before the conquistador and the missions we're built and many of the natives were enslaved to build the churches and cathedrals we now call missions in California. So, slaves divided economic security for physicians and clinical material that permitted the expansion of medical research. Of the improvement of medical care and enhancement of medical training. Ironically in the 19th century, white American physicians began to note that Blacks inherently experienced poorer health. And yet at this time we were operating under a very biomedical, evolutionary paradigm way of thought. Individual [Indiscernible] we're based on individual biological entities and inherited traits. There was very little perspective of recognizing the impact of systemic learned environmental difficulties on the individual. This was perpetuated by stereotyping, by stigmatizing, and through biases all the way through the 20th century. To this day when we think of privacy and our ethics regarding informed consent, when we have procedures done or if we undergo surgical procedures, who has the right to our body parts? And if our body parts are used for research, or for financial gain, who stands to gain from this? If we offer ourselves up for research and clinical trials, who will benefit? The pharmaceutical companies? The researchers got the position to apply the care. The systems themselves have become very complicated. Clearly, for those of you privy to the information regarding what happened with the Opioid Crisis and certain pharmaceutical companies and families, this continues to be a difficult issue that has so many layers to it. I, in particular, would like to draw everyone's attention to the Tuskegee trial where there were over 500 Blacks, 500 Black men who were allowed to let their disease process worsen and debilitate them while they were studied to look at for long-standing impact of disease over time that was untreated. How many people out here by show of hands our familiar with [Indiscernible]?

Raise your hand? Anyone familiar with [Indiscernible] cells? Anyone? I see a few people typing.

Anybody who has ever been very interested in cancer research, [Indiscernible] are the cells that were originally derived from one Black American woman whose name was, Henrietta lacks. Because of the development of centrifuge and freezing systems, refrigeration, essentially, and centrifuge, at the time she was alive, she had an incredibly deathly type of cancer. Her cells were harvested by a number of positions. At the time they were able to preserve her cancer cells and given these advantages and findings in technology they were able to store them and save them and disseminate them to other medical institutions and share them with other researchers who wanted to know about cancer growth and treatment. Because of her body, too this day we have figured out not only how to treat but how to better understand incredible forms of cancer. Amongst all of the research conducted on cancer was the development of [Indiscernible] cells. Get what we never learned at this time, the time of her life was did she consent to the harvesting of her cells? I believe not. Who profited from the proliferation of her cancer? Once things were harvested, did her family ever gain right to choose who else gets to learn from her remains? This did not happen. Only after the development and the realization of this did issues in our current practices emphasize the need for us to take on greater medical [Indiscernible]. Things like consent, things like understanding what happens to human remains once they are removed from the original source. What happens to the descendants of certain individuals? [Indiscernible] the Dell about the Holocaust, however we know there has been talk about reparations for those who have been wrongfully discriminated against, taken advantage of, or to their own detriment, enable profiteering from those of the superior population, so to speak, if you know what I mean, the one in power. I stand corrected.

Thinking of this, in general, in 1965 we finally have the Civil Rights Act and the creation of Medicare and Medicaid. But even though this resulted in improved access to care for many of our type of individuals, it limited efforts to improve access to medical education, and those who could access medical education would still set aside for those in the more powerful majority echelon that benefited. It did not benefit underrepresented groups. The medical practices that we engage in today have [Indiscernible] from the exploitation of Black men and women, of minority groups such as Gypsies and members of the Jewish systems, indigenous persons, and so forth. If we can even go into persons that we're studied for the HIV and AIDS epidemic, we also know that underprivileged groups were studied because of the fact that it was originally named or coined as a disease that we know no better than that. Ironically is much as we would like to think society has improved its ways, we still know in the past year when we were trying to better understand the symptom presentation of those who had COVID, and we were looking at dermatological changes, [Indiscernible] or discoloration of the skin, all of those trials we're still conducted on white skin. As a result of this historical trend in America, what do we see now?

Systemic racism, unfortunately, continues and persists in our healthcare systems today. We still see disparities in access to care, inferior

treatment, and poorer health outcomes. There are systemic barriers because of systemic or institutionalized racism. These include economic barriers where we still understand that banking institutions and lending institutions are less likely to create home loans for people of color than they are for whites. [Indiscernible] we know exists. There was a study in 2017 and found that areas with more like indigenous and people of color residents per capita had significantly fewer access to pharmacies. Or pharmacies that had benefits and sliding scales to serve them. We know that there is often less access due to insurance or inability to afford co-pays and other out-of-pocket expenses due to economic hardships. We are aware that through the CDC and the prevention of COVID 19 data reveals from LA rates of hospitalization and death and Black patients were twice as high as what's expected on the basis of demographic representation. Upon reflection there is some speculation that maybe those [Indiscernible] were unique and attributable to the fact that higher numbers of BIPOC individuals work in the service industry, and therefore, more likely to reside in densely populated areas. In 2008 the American Medical Association issued a formal apology for racism in America. March 5, 2021, NIH Director apologizes for structural racism in biomedical research. Long overdue, in my opinion. April 9, 2021, Centers for Disease Control stated that racism has become a public health threat. And most likely because of what we were observing with COVID. We have now seen the discrepancies and disproportionate effects of this virus by noting that mortality risks our highest amongst Black and Brown persons.

How does racism affect the individual? One can honestly recognize, especially, among intergenerational storytelling that distrust of the medical community is profound and continues to exist. [Indiscernible] our more likely to trust and seek the advice of a physician or provider who was also Black. They are less likely to trust a provider who is not Black. Randomized nuckle trials found that Black men signed 28 racially [Indiscernible] Dr. [Indiscernible] preventative care than those assigned to [Indiscernible] and that study was done in 2019. This said, probably, I did mention this earlier called the Meta-analysis of [Indiscernible - muffled] studies noticed significantly [Indiscernible - muffled] physical health. Moreover, Black, Indigenous, and People of Color have less access to quality pain care than whites to do their insurance or ability to afford co-pays. Expenses or disadvantages based on the types of work and access to benefits that a lot of service jobs can provide.

Moreover, one of the things that has been studied is implicit bias between patients and providers in healthcare. I like to talk a little bit about that. There is ample evidence to demonstrate that disparities in the assessment and treatment of pain exists when the provider is treating a BIPOC individual versus a White individual. It stems from personal/subjective nature of pain, provider-related racial biases regarding pain in these individuals which can lead to the under treatment of pain. A study that was conducted in 2015 revealed that 50% of white medical students and residents hold false beliefs about biologic differences between Black and white people. For example, there was a believe that Black people skin is thicker and that Black people's blood coagulates more quickly. This is false. BIPOC patients have historically been less likely to receive opioid analgesia than their White counterparts across [Indiscernible] and regardless of painful conditions.

Black patients in primary care settings are significantly less likely to be screened for pain then White patients. Black patients of chronic pain our more likely to have long-term opioid therapy discontinued following detection of illicit drug use, more so than their White counterpoints with illicit use. Wow! Given the breath of literature noting difficulty accessing opioid analgesics, studies have suggested that Black patients to be generally subjected to even more aggressive risk mitigation procedures by providers then White patients. What does that mean? Black patients have been observed, Black patients on opioid treatment have been observed to be more likely subjected to you in blood test and restructured refills than White counterparts. This was actually repeated in a similar study at a VA hospital in 2013. In spite of a study that suggests prescription pain medication use was less common in Black patients than any other racial and ethnic group, that is when prescription opioids our more common amongst white users then BIPOC users.
Let's talk a little bit about what may also be happening between patients and providers. Bias affect patient and provider communication. It can affect treatment related decisions and, ultimately, contribute to poor health outcomes and health disparities. Racism and discrimination can inflict continued trauma which may potentially increase hypervigilance, stress in Black, Latinx or indigenous patients. And has greater impact on the physical and mental health outcomes. I want to pause for a second and ask the group out here in my audience, by a show of hands, how many of you have experienced either ambivalence, trepidation, perhaps, suspiciousness or guardedness amongst your patients who identify as Black, indigenous, people of color? I know I have.

And we must be careful when we are working with these individuals that we do not attribute global assumption or jump to conclusions about pathology. One of the things I have learned through my practice over the years that I would like to impart if you do not already know this is, a generalized sense of guardedness, distrust, or suspiciousness in certain members of the BIPOC community is considered adaptive, resilient, and healthy. We must not necessarily jump to the conclusion that this person is struggling with anger, paranoia top or wrongfully diagnosed them because this very behavior may have actually protected them from violence or injustices in their earlier years of life. So, the difficult thing about communication and about what is happening between the patient and us, the provider, is that are relationship with our patient doesn't happen in a vacuum. We are two intersubjective brains with histories coming together here. I come into the room with my history, my knowledge, my background, which is not visible, and I also come into the room with my race and my phenotype and the impression one gets when they see this.

The patient walks into the room already within a culture and a system, particularly, in military medicine, a system that has a very strict power hierarchy. This patient comes in with a history, experiences, education, knowledge, but I do not know, and I cannot see unless I am reviewing the chart or even have time to review the chart that I see this individual’s phenotype and I see this individual's race. When both of us are in the room together are two psychologies interface and we have to find a way to connect. That ability to connect involves very sophisticated higher order cognitive processes inherent in the firing and wiring of our brain. I

will return to this in a moment. Nevertheless, there have been studies looking at what may be facilitating implicit bias that is subconscious to the provider. What is it that may be happening in the room that is outside of your awareness of those in the privileged class? A particular study looking at implicit bias defined implicit bias as the fact that it impacts clinical judgment. It is associated with a failure to make eye contact with the patient. There may be an inadvertent use of condescending tone of voice or pitch that has been observed. Discordant word use has been observed and talk down directed communication seems to be more prevalent when BIPOC patients are the patients being treated and the provider is not a BIPOC person. As a result, based on these two psychologies interacting there is absolutely ambivalence, and ability to determine trust, sometimes in our patient's population there may be an increase in anxiety. Of course, poorer outcomes. What else may be happening here? There have been some theories about in group versus out group cognitive processing.
There was a very fascinating study that took place. It's one of my references that I'm teaching everybody about today. This is collected by researchers in the University of Milan, Italy. Racism on the empathy for pain on our skin. We recognize that empathy for pain as a source of deep emotional feelings and a strong trigger a prosocial behavior. In this particular study these researchers investigated the existence of racial bias in the emotional reaction to other people's pain. In terms of what was happening implicitly. And by measuring the participants physiological arousal of the study, the researchers found that Caucasian observers reacted to pain suffered by African people significantly less than pain suffered by Caucasian people. The reduced reaction to the pain of African individuals is also correlated that the observers' individuals implicitly biased. The role of others race in moderating [Indiscernible] reaction is a crucial clue here, and there are some hypotheses about what might be happening as it registers. One of those hypotheses is in group, our group awareness. Keeping in mind, [Indiscernible] in group, our group awareness is not necessarily based on, I want to say environmental learning, per se what is fascinating about this study is what they were able to notice theologically based what they believed might be happening in the brain. What may be happening in the brain. If we think about the need to communicate and they need to identify with our patient's eye contact is huge. I also, again, this is somewhat of a working thought that I have and I am very open to dialogue here. If any of you are aware of brain biology, I am very curious how much people recognize and understand the parts of the brain that are more responsible for our mirrored neurons. I'm going to throw that out there. How many of my folks in the audience know the parts of the brain that are helpful for our activation of nearer neurons? Anyone?

Close. That is the emotional center. It's very important. We know that the amygdala loves poignant and powerful emotional memory, but it's not quite were [Indiscernible] takes place. Any other guesses or thoughts?

I am speaking in terms of generalities. This I came from a fascinating urological conference myself where I was trying to connect the dots limbic systems involved want to step away and talk a little bit about anatomy of the brain, generalities. We have the upper echelons of the brain, the cortex. We had, that's the thinking part where we are trying

not to cuss in front of grandma or make executive decisions that we are to follow instructions and maybe we know the consequences of our behavior, so we are really careful about the higher order decision-making that we do. That is the higher cortex. We had the emotional part of the brain. That is the deeper limbic system. You get special credit for that. The emotional part of the brain is processing connections. May be experiencing powerful or poignant memories and experiences. Within have the survival brain which are the deeper, older parts of the brain that we would call the more primitive parts of the brain. In dealing with general allergies, researcher indicated we have our two hemispheres. We have a left and a right hemisphere. The left hemisphere, in general, tends to be responsible for developing narrative, being very logical and sequential. It focuses more on accomplishing tasks than connecting with people. It also is involved in more positive experiences and approached behaviors. Language, interpreting meaning, and detailed monitoring our all involved in the left hemisphere. If we think about their general responsibilities that we have been able to understand about the right hemisphere, the right hemisphere tends to harbor and focus more on the negative emotional outcome, with draw behaviors. However, it is very responsible for attunement, dialing in with the person and socializing them. It is very much connected with this concept called, attachment, connecting with people, feeling like we have something in common, self-awareness of my body, of where my body is. It is also responsible for aspects of empathy, seeing that someone is suffering, and I can identify with that. That is where our mirror neurons are most likely to be located. And, in general, the right hemisphere is more preoccupied with connecting and relating to people and relationships than with tasks.

Now that I have given that general information, I am hoping I can offer some guidance into what we believe may be happening based on some of this early thinking within in group, are group, was the neurology of what might be happening in our brain. If we use the biopsychosocial model across each individual, we are more likely going to be able to better understand what is in the room with us, and what I bring to the room as a provider.

So, what can we do? Again, we need to be able to engage with the patient, engage with our students, trainees, colleagues, residents, and follows with more education than what I have been able to do today. We may need to have greater dialogue on diversity and helping people practice getting uncomfortable in order to become more comfortable. Depending on the generation of providers that are in my audience and that you all work amongst and with, I am very aware that was a paradigm and may continue to be a paradigm where many providers at one point were taught that we needed to be colorblind, that we need to apply the instant work to the greater population and do not discriminate. In that way everybody should be equal. We need to be careful about using the term, colorblind, and be comfortable enough to acknowledge the differences in appearances because of the history of what that may suggest, in terms of the experience of the person in front of us. We need to continue to do our best work connecting with our patients to build trust one individual at a time.

Again, I will be coming back to the topic of your own talk -- [Indiscernible] and our brain but I do want to ask another question of

the group here. I want to expand this. Why is it important and put your chat typing fingers ready if you can? Why is it important that we discard the, I don't see color approach? Why is it important that we discard the, let's treat everybody all the same approach? Please put your thoughts in the box.

Especially when we're thinking about medical healthcare.

I agree, Jesse. Any other thoughts? I see all typing.

Equality does not mean equity.

I like that too. That is like a bumper sticker.

I see Anna writing.

I have been told if you are colorblind means you cannot see the pattern, i.e., systemic racism. Interesting thought. The subtle differences that actually result in practices that are limiting or discriminatory are overlooked.

Robert says, if you discard color, you discard their experiences. That is well said.

I'm going to offer some interesting commentary here. Again, this is from, so misquoting from the literature on white privilege that I think is helpful. If we avoid or neglect the opportunity by adopting a worldview associated with seeing no color, being colorblind, or seeing biological sex as the same as gender, we may be missing out on crucial, valuable medical information. This can not only in for clinical practice if we do pay attention, but it can also improve our practice. So, by a show of hands, how many people out there are aware that pain complaints, confusion and fatigue amongst primarily Black patients could also be an indicator of sickle cell anemia? And how much information do you have to that medical knowledge?

Many of our patients in military medicine identify as BIPOC, and yet, are we looking at that differential when our patients come into the room? How are we clear on that differential? We also know, believe it or not, based on the lineage of certain Jewish communities you may or may not have a greater risk for certain types of cancer. We are getting so interesting, I'm kind of double speaking but interesting information on genomic medicine. It's kind of scary cool.

In my particular position, how much do we want to know? How much is Big Brother understanding? Again, erases these ethical questions. Do we want to have this knowledge for greater good? Or do we want to have this knowledge for power and control? These are really important difficult conversations that in academia, like we had today, it's important for us to discuss. It's important for us to make sure that we are aware of some of the situations, whether they be physical, biological or psychosocial acknowledged when we are working with patients to identify a BIPOC. One of the things that I did this morning, or this afternoon with you is I am modeling for you what I often do with my BIPOC patients is, I realize my

stimulus value. One of the most important things I was taught by one of my mentors was, know your stimulus value. What do I mean by that? When I walk into a room, what are people going to think that the minute they see me, and they know nothing? What are the assumptions they are going to jump to because our brains do it. No brain is immune from trying to categorize, label, understand and move on. It is what the brain does. It is our higher parts of our brain that may be responsible for suppressing and appropriate response, discarding responses that are inaccurate, and going for the behaviors that may be more appropriate. So, I realize that when I walk into a room, I am White, I am fair gain, I have blonde hair, I am female. When I walk into a room what might these people, my audience, my colleagues think upon first impression? Attractive, not attractive? Smart/dumb? Fun/boring? Nerdy? These characteristics are going to be shifted to our brains very quickly. This is why Phenotype is so valid. If I walk into my patient's relationship and I am able to say right up front, clearly, you are a person of color. You see that I am not. What is your experience been? Or you comfortable working with someone like me? If not, let's talk about what has happened to you, or would you be more comfortable with someone else? Is it okay if I ask you some questions about your background? Help me understand. I know a lot. I have the plaque on the wall. That doesn't mean that I have walked in your shoes. I tried very hard to say, look, I may fumble. Please correct me.

That is part of establishing trust, why is establishing trust so important? It has to do with neuroplasticity. If our BIPOC patients, and we know military service members, in particular, our more likely to have an early history of adverse childhood ADVENT exposure, we know the trauma may have been a part of their early life. I think it is fair to investigate and perhaps approach our patients with an understanding that they may have come from hardship. We need to clarify, nevertheless, building a therapeutical alliance is important regardless of race or ethnicity or culture. The therapeutic alliance accounts for between 15% and 50% of any outcome variants and treatment for psychotherapy. The therapeutic alliance accounts for more of outcome variants than any other mechanism of psychotherapy in care. Whether you decide to do hypnotherapy, CDT, meditation, psychoanalysis, exposure, insomnia care, it is significant.

How do we develop the therapeutic alliance? We recognize that our brain can influence other brains through something as simple as eye contact and certain forms of touch. Which, again, ethical issues in our line of work, how we make eye contact, how long we engage with eye contact, body posture, tone of voice, these things are incredibly valuable. If we recognize the fact that we may want to highlight and activate more of the right hemisphere, let us keep in mind what tends to happen. Am I making powerful assumptions here, but I want to ask everybody out there by a show of hands how many out there are [Indiscernible] or Physical Therapists? Anybody? I have nothing but respect for the fact that you've got 15 minutes to 15 -- 20-minute stop. I ordered are you supposed to collect vitals, to overall assessment, tech history, check refills, side effects, ask them if they are smoking, asked them how their sleeping. It's insane. I do not know how you guys do this and I applaud you for it. Nevertheless, because of the nature of the system that has been set up to

be efficient in some ways, I would argue the quality [Indiscernible] may be diminished. Neurologically that expectation of priming the left hemisphere to be task oriented, go down the list, analytical, knock it out, get it done, language, language, document, document, tech what is next on the list. Have a great day. It might not be maximizing the capability of the right hemisphere. With that shortened amount of time and the pressure of having to evaluate you may be missing out on an opportunity to tap into both hemispheres, eye contact. If we want to tap into those mirror neurons and really increase our ability to help are patient be understood and feel validated and be seen, those mirror neurons are activated when we activate the right hemisphere and engage in greater eye contact, body posturing, using a tone that suits their tone, using language, using reflective language that actually repeats some of the words we hear them say and they know they are heard. In other words, mirror neurons are the neuro mechanism of the therapeutic alliance.
For those patients of ours who may have had their trust broken, who may have been traumatized, may have greater activation like the fight or flight in the most primitive parts of the brain. The Colm or parts of their day can be regrown and developed through simple supported interactions with you. How do we get that going on more so that ourselves, believe it or not? Exercise activated the right hemisphere may be needing to do more mindfulness and meditative practices. There is some literature to support that. [Indiscernible] the more primitive fight or flight areas of the brain limbic system by doing things like [Indiscernible], yoga, certain forms of meditation. Ironically, and this is a topic I have instructed in the past, if we want to build our own sense of empathy and maybe improve our own sense of compassion for patients, we me see as not a member of our group, we may wish to sharpen the tool by making sure we still have empathy and can attune with our patience. Any questions on that?

Pretty cool stuff. I am kind of mind blown with some of this stuff.

A PA is introduced in this book another alternative way to help providers be more sensitive toward individual differences and apply the biopsychosocial model when we are assessing the person who walks into the room. I am going to break down some of the features pick if you are curious and wanting to locate where this conceptualization is, it's located [Indiscernible] in terms of how you may want to conceptualize with your patience. First of all, the identity of the individual. I implied this earlier, but I will say it one more time. It is not based on what showed up on the medical record. I repeat, the identity of the individual is not confirmed by what is on the medical record. It is so important that you ask the patient and confirm their identity. You may be surprised at what additional information you receive.

The cultural conceptualizations of distress. This is a construct that influences how the individuals experiences, understands and communicates his or her symptoms to others. Are you working with a patient who was raised to be stoic, that boys don't cry, that you rub a little dirt in it, and it will be fine? That may be the person sitting across from you. The extent to which this person is really tapping into their limbic system and having a clear awareness of where their body part is in space,

how to set the body and understand the sensations of the body may be an area that needs to be addressed. Helping the patient create language and a vocabulary to describe their experience is part of the conceptualization of their distress.

You may also want to find out their coping and health seeking patterns in the past and in the present, as well as what is currently available. Just because resources our available doesn't mean our patients want to use them or have opted to use them. We may want to ask, how did their family members cope with pain or distress or injury? What about older or elders in the family, those who have progressed diseases or illnesses, how are they treated by other family members? This may give us some really great collateral information on what we can expect our patients to be surrounded with in their environment of home.

We now have and see the psychosocial structures and cultural features of vulnerability and resilience this is what I alluded to before when we were thinking about the role that appearance and race can have in how they may actually be more vulnerable to systemic discriminatory practices that have already been put in place.

Have you and the patient identified key stressors and supports of their social environment? What is the community that they grew up in? How our adverse events managed? Handle? What resources were available to them?

Born and raised outside of the Detroit area, had a lot of pelvic and abdominal pain and is associated with her sexual and reproductive health. In spite of her excruciating symptoms, she was terrified to have any exploratory procedural work done. Come to learn, her family history and stories about what happened with the physicians and also American history regarding how people in the stories she heard among family members really reinforced that desire to take care of herself on her own into not take professional medical care. Case in point to summarize, although I was able to work with you individually for short time, she did eventually withdraw from care and I'm not sure how she is to this day. If we look at these key stressors and look at a better way to connect, we may be able to look at the individuals' insights, have a better understanding of why they behave the way they behave. May be a greater appreciation for the decisions they have made based on their experiences. This can also inform our lens not based on disability but rather on resilience and helping steer the patient to either continue certain helpful behaviors or pared down others that are not so helpful. Overlooking how advocating for the right individual to obtain care can stigmatize and cause more harm than good. We need to be mindful of that based on their community and whether that community supports it or against it.

Cultural features of the relationship between the individual and the clinician is important. Acknowledge your differences and as I mentioned before, I am clearly quiet, are you okay with that? I don't know if they are going to be comfortable lying or being honest. For the most part when I have done my assessments, many of them shrug. Many said I didn't tell you everything at first because I just didn't know I could trust you. I'm okay with that. If there is some little bit, they are able to gather and garner and overtime that development in using consistent presentation and

consistent efforts to reach out and check in, it may be above and beyond, nevertheless, you will have a greater connection and maybe learn more about this patient situation then you would have before. To assume is to err and aim for asking open-ended questions. Give room for the patient to clarify, to validates or challenge your thoughts.

I will often say to my patients and feel free to steal this phrase, I will say to my patients I would like to plant the seed and you tell me if you think it will grow. Let me just put this out there. Another phrase I like to say is I have an imaginary coffee table and we look at them and put them up and pick them back down. Let's put this idea on my coffee table and see if it stays there. We don't have to answer to it right away and we can come back to it, there is no rush. That eases the burden and the anxiety on the patients to have to formulate a direction when it may be the hardest thing to show up and disclose what is going on with them. Overall cultural assessment. Summarize your collected information. I will often wrap up my up the patient to try to say if I can summarize the main points of what we did today, what were some of the big takeaways? If I don't have time, I will start the next appointment with that question. What were the takeaways from our last appointment? And no, it is not because I forgot to look your chart, I want to know if you remembered what we are working on. The patient is their own best expert on their experience, not me. I hope that kind of humility can be utilized to your advantage. Our patients have a wealth of knowledge, and our role is to try to collect the knowledge to apply the best care we know how to give. If you can, summarize what your impressions are. I tend to be more transparent than one of my colleagues if a patient is unhappy with my impressions, I would say let's put that on the table and this is a work in progress. It would be foolhardy for me to know everything about you in these 60 minutes we have been talking. We will call it my working idea.

I do see it is 12:00. How are we doing in terms of breaking or resting? What is the temperature out there? Do people want to five-minute break or keep going? We can keep going or walk away. You could use a walk around. I don't mind a stretch. It is starting to get hot here. I may need to air out my wings. Let's take a break. I was see you guys in 10 minutes.

All right everybody. Welcome back and we will get started. Let's do another quick sound check. Can everybody hear me and see me? It's time for haircut, I think. Thank you for coming back. The good news is we are rounding third base heading towards home. I have a few final thoughts and comments to add to my talk, but it should give us time for some last-minute Q&A opportunities from the group or any additional thoughts I might have inspired in anybody out there. So here we go.

The philosophy from the biomedical model, that is the presentation of pain in patients is to be assessed and treated -- uniformly and with objectivity is not yielding equitable care across different patient populations.

I extend my props to the individual who typed that almost verbatim in the chat box. Treating everybody equally does not provide equitable access to

care. An individual's biology, psychology and socio-cultural worldview must be considered in order to achieve a comprehensive and holistic understanding to drive more equitable care. Current coronavirus pandemic information plus ongoing protests and political aim for social justice highlights the persistent detrimental effects of systemic racism. Now more than ever it is an opportune time to take actions toward creating long-standing change toward delivering more equitable pain care.

Again, in terms of recommendations, be willing to step outside of your comfort zone and take action. What might that look like? Things you may not have seen yourself doing you can do depending on how open you community is right now in terms of restaurants and venues. CV if you would like to maybe eat food in a neighborhood or area in a particular community that maybe you have never tried before. See if you want to sign up for diversity groups and social justice organizations that may be available for you to participates in your particular environment, whether you are part of faculty or staff, the events that have taken place over the past year have motivated certain groups to meet regularly in order to make sure folks are up to par with language, communication in certain ways of describing events in a political correct manner without causing unnecessary insult or offense. Be aware of your own bias as I mentioned before. Know thyself. Understand thyself as best to your ability.

One of the things I try to impart not only myself when I am undergoing struggles or suffering is I try to practice the concept we often use in acceptance and therapy which is the definition of acceptance. Those of you have access to your smart devices, Google the word acceptance and what you may find is it is a particular state of being or awareness that something is believable and true. That is it. Is it believable that this country continues to utilize and establish and maintain institutions and systems that engender continued bright -- bias, discrimination and racism? Is it believable? The question is if we can knowledge that these things do exist and we can acknowledge these things are true, we cannot choose to do something about it, whether it is on the smallest level individually or systemically.

Hopefully this talk has engendered in many of you a greater chance to look inward and maybe pay attention to some of the areas in your own line of work interpersonally and neurologically that may help you regulate that right brain and engender greater compassion, reduce your risk for apathy and burnout and increase your opportunity to connect and attune more with your diverse patient population.

Understand the cultural context of pain. Pain does not happen in a vacuum. The environment of injury is so important. The environment of repeat injury or flareups, even more important. What is happening in their home environment? What social support networks are available? Do they have others they are responsible for or can they just take care of themselves? Are they geographically separated, or do they have a system in place to care for them? Practice compassionate communication, I think I made that pretty clear in the last hour. Support, recruit and advocate for the incorporation of BIPOC patients into policy and decision-making. How on earth do we try to do that? One of the things I am pleased to know

within the VA medical system, maybe some of you are employed through the VA system right now. I am aware of peer counseling programs for veterans.

I will throw that out there is a question. For those of you who may be affiliated with the VA, peer counseling can go a long way. Many patients undergoing that transition or having a difficult time adapting to the medical reasons for separation may be a mentor in may be able to maintain the mentorship role they had when they were in uniform and as a civilian, transitioning servicemembers and to acclimate and adapt to their new status. That is one avenue that is showed up for me. In terms of other recommendations from articles I have read, some recommendations call for cultural sensitivity training. I think this would probably account for some of that. We are also thinking about increasing the number of BIPOC professionals in leadership. The interesting thing about military life as you know is it strongly emphasizes institutionalized meritocracy. Easier said than done. We also recognize there may be idiosyncratic flaws in the blueprints that present that type of advancement. Nevertheless, the one thing based on this meritocracy is we may have a lot of representatives from the BIPOC community in positions of leadership where certain military policies can in fact be done and taken care of.

Utilizing the individual approach is helpful. If we are thinking about the economic flaws and inequities that exist in certain communities, we may want to consider offering some forms of incentivizing undergraduate medical students or offering residency fellowship training programs that can increase the ranks of some of the underprivileged persons. Of course, we know a precedent was set before and there is some literature that seems to show in 2000 and for example systemic review intern -- have resulted in greater numbers of healthcare providers choosing to work in underserved areas. Types of incentives include but are not limited to direct financial incentives, service requiring scholarships, educational loans with service requirements. Loan repayment programs and service option educational loans. Incentivizing positions where the practice has proven easier then regarding what to practice.

I do have a wonderful example of another colleague of mine, Native American by her own identity who was a member of the Air Force. Finished her time in service and that paid for her graduate education and as a result she has been employed through the IHS and served the largest urban patient population of Native American persons in the San Diego area. It is always nice to hear about how an incentive decision program has helped people return to offer care and services to those within their community, and I applaud that.

I have some reading recommendations. I did not have any handouts for this talk, I recognize our time is precious, so these are some of the references I think have incredible value if you want to circulate amongst your staff or if you are starting to start a diversity group to make sure you are engaging the best practices. These would be a great beginning place. I have referenced the -- the author, a Jewish journalist wrote this historical and medical and ethical biography. I strongly recommend it. It hits many interesting provocative points on what we have been talking about today and very informative for your own medical practice. I know they made a movie about it with Oprah, I didn’t watch it. I stick

with the literature. It speaks wonders. Robin D'Angelo became a well-known name this past year because of her book entitled white fragility, why it is so hard for white people to talk about racism. I am acknowledging that here today. It is difficult. Just because we look alike does that mean we think on the same plane. This particular discussion I have raised today I recognize is a sensitive topic. Many people of the white groups would argue all lives matter so why are we emphasizing Black Lives Matter? This is addressed in Robin D'Angelo's book. She is an academic by her education and training, so she takes a very technical and linear and pragmatic approach. If you want to practice getting comfortable being uncomfortable, I encourage you to read it. It may spark or challenge some provocative thinking on your part and give you some unique perspective.

One of the articles I referenced here a lot was by -- chronic noncancer pain management. If you are a prescribing provider and want to look at some of the interesting data is summarized, it is in this article. I have not read this I confess but I look to it is almost like a textbook on the chronological history of medical practices on underprivileged black Americans to help inform your practice with your population. Uncomfortable conversations with a black man -- a great YouTube series. Any other suggestions? I appreciate the recommendations. There are so many historical and pop-culture references I don't have time to mention and yet I do want to give a shout out, for those of you who were in my class earlier on sex and gender, again cultures overlap.

It is not just a matter of whether my person this black, indigenous or whether or not they are or straight or identify as transgender or not, these things overlap. These cultures overlap. In terms of entertainment that might be outside a regular prime time television, I do believe there is a new miniseries called The Chair where she represents a faculty member of a prestigious university newly assigned as the department chair for English and she is kind of in this paradigm shift in how we help educate and inform and change the approach toward educating our student body given the diversity. There are other movies and cinema representations of cultural shifts. The Danish girl was an independent film, not for child audiences, about the very first known documented case of a male to female person in transition in Europe and it was beautifully performed. If this is another community or cultural area you would like to have experience and grow some compassion towards, I would recommend that.

Any other thoughts? Any other offers? I'm always up for some great recommendations. -- Is that a book or a movie? Thank you, Robert.

I'm going to go ahead and open up the forum for any commentary, questions or dialogue. Don't be shy. I love it when people show face. Again, I know Linda has enabled webcams if you would like to show face and offer any particular concerns or questions regarding the subject matter. I am more than welcome to any feedback, particularly if you are a member of the BIPOC community. I definitely appreciate feedback, criticism and support.

Fantastic, Ben. A contribution of black Americans, contribution to psychology. Even the rat was white, I will remember that. Jesse, thank you for your transparency.

I will ask a question for those of you still online and listening. This has to do with this year survey, although for me it is coming from a teaching perspective. Were there any particular topics you would like to have learned more about that maybe I touched upon or didn't. Maybe it didn't even show up on the radar. Any particular topics? Should this subject matter come up again, what more information would you like to experience or learn if possible?

I see that recommendation, Anna. The clinical handbook that some symptoms might appear differently on darker skin tone -- very helpful information. For those of us who do more direct patient care and physical assessment, fantastic. Amy says I love we are addressing this topic as a whole. I have a couple BIPOC patients and wondering if they are getting adequate care based on how they look. What a powerful question. I am not familiar with your area of expertise, but if you would be willing to share, how have you talked to the patient about that? How did that go?

Jesse wanted to know about neural plasticity and pain. From maybe even of racial or kind of what I was touching upon at the end, if we are noticing some differences neurologically, what might we do to alter the plasticity and change the neurology and wiring in our brains, is that what I'm hearing? Okay. Another resource -- disparities in healthcare deliveries. Fantastic. Thank you for the link.

Just to answer quickly, Anna, it has been my experience mixed gender is not recommended if you're doing MST group therapy. I have also had -- the only time I have seen mixed gender be successful is if the indicia index trauma was in fact the same thing. If you do have mixed gender, make sure it is MST the patients are struggling with. I have also seen it the other way around where there was mixed gender because the men and women are living with combat related PTSD. When you can clarify that, group processing can be fascinating. Not easy but fascinating. Again, part of the development may be engaging your patience literally in some basic bottom-up mindfulness and relaxation practices. If we are trying to down regulate the fight or flight sympathetic nervous system and down regulate the HP access which tends to be overactive, teaching them practices to down regulate that and up regulate the relaxation response can be helpful.

I can make a note for future reference that maybe we can practice some of those skills, whether we are dealing with pain or trauma, you are right, there is an overlap. Trauma is not always and only psychologically based. We know there is a mind-body connection. It can alter our immunosuppressive responses and alter all of these areas we experience in medicine that are pain related. Absolutely.

I appreciate the feedback, Amy. I do believe so much has to do with the climate of the command as well as the rate or the job. I do find it interesting, and I went to open to this who were familiar with special forces and operational forces, it is an observation. I don't understand

why although I have thoughts. Why is its many of our higher more specialized forces seem to have a lower representation of BIPOC individuals? Is it due to systemic racism or discriminatory practices? What is it we are looking at that makes this unique? If you have any thoughts, I'm interested in learning about that as well.

When it comes to the processing of the community, as I said, going back to the command climate, kind of the demographics of the command would be fascinating to maybe process with members of your group. There could be as we know -- that is creating conflict and impressions and the efforts one may have to go through. I would even argue outside of appearances, there is definitely a sex and gender bias stereotype that is perpetuated amongst men and women who serve. The rumor and ally and the misconception is women you able to promote and advance are either lesbians or loose for example, that they didn't necessarily obtain it meritoriously. I see this more with my female Marines, when they have a pain complaint that the only way they are getting things taken care of is because they have been basically taking advantage of their bodies in a way to help them get what they need, and that is not the truth.

Great dialogue. Any other questions, comments or thoughts? Observations or curiosities? Going once, going twice.

Fantastic. May be some neural plastic exercises to help us, that is great feedback. Thank you everybody for being so present and willing to discuss such a rich and complex subject matter. It is timely to where we are right now.

Thank you, Nicole. Good luck to everybody out there, stay safe and stay healthy.

>> [Event Concluded] >>