Equity360: Gender, Race, and Ethnicity: Heroes, Rep. John R. Lewis, and Orthopaedics

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When I think of how one defines “heroism,” I fall back on this quote from Arthur Ashe, the first and only Black man to win the Wimbledon Men’s Singles title: “True heroism is remarkably sober, very undramatic. It is not the urge to surpass all others at whatever cost, but the urge to serve others at whatever cost” [10].

I have been thinking a lot about heroes since the onset of coronavirus 2019 (COVID-19) and the death of Representative (Rep.) John R. Lewis on July 17, 2020. As Chair of Movement is Life, I had been engaged with Rep. Lewis and his staff on legislation to address healthcare disparities. This column was to be an interview with Rep. Lewis, but his illness kept delaying our session until it was too late.

The questions that I had prepared for Rep. Lewis focused on health equity, racism, and the pandemic. What can policymakers do to address social determinants of health as well as promote and support individuals adopting healthier behaviors? How can Congress become educated on the unintended consequences of advanced payment models disadvantaging patients with multiple comorbidities and fewer socioeconomic resources? How can bipartisan support be generated for health equity?

Rep. Lewis was a national icon who dedicated his life to protecting human rights and civil liberties; he advocated nonviolent protest, and participated in many of them. For these reasons, I was interested in what Rep. Lewis had to say about my topics of interest, and also on what he would ask of us as orthopaedic surgeons to help our nation in these challenging times.

There wouldn’t have been a better person to ask. Born in 1940 to sharecropper parents in segregated rural Alabama (the library in his hometown of Troy was “whites only”), Rep. Lewis grew up on a 110-acre farm, the third of 10 children. On the farm, Rep. Lewis was tasked with taking care of the chickens. Called “Preacher” by family members, he was known to baptize the chickens soon after hatching and put together funerals when they died [8]. The “Preacher” found inspiration from listening to Dr. Martin Luther King Jr. on the radio, and eventually met Dr. King at the age of 18. Rep. Lewis ran nonviolent demonstrations against segregation and voting inequality, where he was often beaten or harassed [8].

On March 7, 1965, during the height of the Civil Rights movement, Rep. Lewis led a group of activists on a march from Selma, Alabama to Montgomery, the state capital, demanding voting rights for all Americans, in what is now one of the most famous marches in American history [9]. Rep. Lewis, along with several hundred nonviolent protestors, suffered severe injuries at the hands of the police during the march. Rep. Lewis was arrested that day in Selma, one of more than 40 arrests he endured while

A note from the Editor-in-Chief: I am pleased to present the next installment of “Equity360: Gender, Race, and Ethnicity” written by Mary I. O’Connor MD, FAOA, FAAHKS, FAaos. Dr. O’Connor is Chair of Movement is Life, a multistakeholder coalition committed to health equity, Professor of Orthopaedics and Rehabilitation at Yale School of Medicine and Emerita Professor of Orthopaedics at Mayo Clinic. She has written extensively on increasing the number of women and underrepresented minorities in orthopaedics and other social issues. Her column will unravel the complex and controversial motives behind disparities in musculoskeletal medicine across sex, gender, race, and ethnicity. The author (MIO) certifies that she receives payment in the amount of USD 10,000 to USD 100,000 as a consultant for Zimmer Biomet (Warsaw, IN, USA) on musculoskeletal healthcare disparities. All ICMJE Conflict of Interest Forms for authors and Clinical Orthopaedics and Related Research® editors and board members are on file with the publication and can be viewed on request.

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protesting nonviolently, which he would later call getting in “good trouble.” Despite his “record,” Rep. Lewis was elected to Congress in 1986 and served for 17 terms in the US House of Representatives.

Psychology professor Frank Farley has defined different types of heroism, broadly categorized as “big H Heroism” and “small h heroism.” [3]. Big H Heroism involves significant risk to oneself and could be situational (risking one’s life to save another), life-long (people like Martin Luther King Jr. or Mahatma Ghandi), or professional (for example, firefighters and police). Small h heroism is “everyday heroism, helping others, doing good deeds, or showing kindness, where serious harm or major consequences are not usually a result” [1].

Rep. Lewis was both a big H and small h hero. Throughout his life, he understood that good health is more than just good healthcare. While access to high-quality healthcare is critical, 89% of health occurs outside the clinical space, reflecting the impact of genetics, social circumstances, environment, and individual behaviors [5]. Health is related to poverty, with projected poverty rates in 2020 of 6.6% for whites, 13.8% for Hispanics, and 15.2% for Blacks [4]. In response to these statistics, Rep. Lewis wrote legislation [2] to require that social determinants of health be considered in the context of new healthcare payment policies.

As physicians, are we doing enough to make it clear that good health is more than just good healthcare? Yes, orthopaedic surgeons generally perform small h hero actions, providing the best and most compassionate care to each patient and help our patients improve their health. But the question in my mind is whether our small h actions are becoming less frequent as we practice in the increasingly complex world of health systems and new payment models. Do we avoid recommending surgical treatment to patients whom we think will consume more healthcare resources (so-called “bundle busters”)? Or, do we require hard cut-offs for preoperative risk factors such as BMI and smoking [7, 11]? Are we committed to helping our patients achieve our preoperative recommendations (weight loss, smoking cessation) by ensuring that they are accepted into appropriate programs, or do we defer this to the primary care provider? Do we perform small h actions and stay engaged with the patient to support and encourage them as they embark on this journey toward improved health (and inevitably stumble along the way)? Or, do we essentially wish them the best, tell them to return after the goals are achieved, and avoid them taking up a patient appointment slot because they are not yet surgical candidates [6, 11]?

We know the challenges of our healthcare system better than our administrative colleagues, insurance executives, benefit managers, and politicians. Yet, generally, physicians are not the decision makers in the healthcare system. Our voices, as advocates for our patients, have become muted and marginalized. We must change this in order to continue to serve our patients.

How can one’s voice be elevated? Nearly all of us work in a healthcare system, large or small. Can we advocate for training on health disparities, social determinants of health, and unconscious bias training? Do we volunteer to serve on health system committees that review patient access, experience, or clinical outcomes? Do these groups analyze data based on race, ethnicity, and gender? Do we push for access to programs for our underserved patients, for example, weight loss and smoking cessation? We can bring the voice of the patient to our hospital administrative colleagues.

We need to continue to advocate for access to high-quality medical care for all patients. The Movement is Life coalition shared with Rep. Lewis concerns regarding Centers for Medicare & Medicaid Services (CMS) payment policies decreasing access to care; Rep. Lewis introduced the “Equality in Medicare and Medicaid Treatment Act of 2019” (H.R. 3910), which would require the Center for Medicare and Medicaid Innovation, which is a part of CMS, to “ensure that [payment] models under consideration address health disparities and social determinants of health as appropriate for populations to be cared for under the model” [2]. Mr. Lewis died before this bill could be voted on, but after talking with colleagues, I believe that other lawmakers may adopt it for introduction in the next legislative cycle. Orthopaedic surgeons can then influence the passage of this important legislation by contacting their Congressional representatives and asking them to support this bill.

We also need to recognize that fighting poverty, promoting economic growth, and addressing neighborhood violence will improve our patients’ health in ways that direct medical care could never achieve. I am not naive to think that we can solve these national issues as orthopaedic surgeons. But our awareness of the impact of these conditions on health is important. We can support or engage in programs in our communities to address these issues. For example, are you or your practice small h heroes in supporting your local food pantries? I borrow from the old adage, “All politics is local,” to say, “All health is local.”

As Mr. Lewis has said, “We are one people with one family” [12]. Let’s be larger heroes for each other.
References