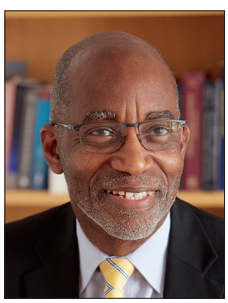
Profile

David Williams: finding solutions for racial inequities in health



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David Williams was born "in the Dutch Caribbean island of Aruba", and "raised in, at the time, the British colony of St Lucia". His parents had not attended high school but they were, he recalls, "avid readers who had a lot of books at home" and his mother, who became a nurse aged 62 years, was a powerful source of inspiration for him. Over his influential career, Williams, who is the Norman Professor of Public Health and Chair of the Department of Social and Behavioral Sciences at the Harvard T H Chan School of Public Health and Professor of African and African American Studies and of Sociology at Harvard University, Boston, MA, USA, has elucidated the ways in which racism, socioeconomic status, stress, and health behaviours impact physical and mental health.

Williams followed an unusual but serendipitous route that eventually led him to his present roles at Harvard. After a bachelor's degree in theology at the University of the Southern Caribbean in Trinidad and Tobago, he did a master's in public health in the USA at the Loma Linda University School of Public Health. "It was my studies in divinity that led me to public health", he says. "I'm a child of the 60s. Growing up, one of the people who was a hero to me was Martin Luther King. I admired him for his commitment to equality and justice." After studying and working in public health, he was motivated to study sociology "to get a better sense of how we can be more effective in helping disadvantaged populations deal with the challenges they face", and followed that with a PhD at the University of Michigan, with a doctoral thesis that focused on socioeconomic inequalities in health. Despite having done his doctoral research "in a community that actually was predominantly white…and was well resourced", he still found socioeconomic gradients in illness and mortality. In other research, early in his career, he "found that socioeconomic status mattered for both Black people and white people…but at the same time, at the same level of socioeconomic status, Black people tended to do more poorly. And so it raised the question, because income and education were not completely explained in the racial differences—what else is it about race?"

At the time, in the early 1990s, he recalls that "there was little attention in health research to describing the mechanisms and pathways by which racism could affect health. There was very little attention to laying out the research agenda to document the role of racism in health inequities. And I thought this is not good enough…If racism is a factor, we need to measure it…and we need to empirically document that it mattered. And that was a source of motivation." Williams recalls he "started to read qualitative research descriptions of experiences of racism in Black Americans and Black immigrants in the Netherlands, and tried to think, how do I turn these descriptions that people are giving of the experiences into actual measures that we could use in a survey? And out of that with the help of one of my colleagues, James Jackson, I developed scales to measure interpersonal experiences of discrimination—one aspect of racism—and we piloted them in a study in Detroit. And that's the birth of the Everyday Discrimination Scale, which is now the most widely used scale to assess discrimination globally." What surprised Williams was "the power of those little day to day indignities. And there are studies that show people who score high on everyday discrimination, followed over time, are more likely to develop breast cancer, type two diabetes, hypertension, or subclinical indicators of heart disease. You know, it's just the pervasive adverse impact across a broad range of outcomes, suggesting that discrimination is one type of stressful life experience that has striking pathogenic effects, but has been historically neglected in the assessment of stress." The work of Williams and others since then does give him optimism and he welcomes the "groundswell of research" on racism, increased funding, and recognition that racism is a public health problem. But he also cautions that "because of political polarisation, it's difficult to have a rational conversation in some circles about what the evidence tells us, and what are the steps we need to take to address the problem".

Williams was involved in the 2003 US Institute of Medicine's report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* that showed how "across virtually every therapeutic intervention…Black people and other minorities in the USA receive poorer quality care than whites". But nearly 20 years on, he says: "the evidence is that that continues… Now, importantly, there are some structural determinants of it. But it also reflects the behaviour of individual providers. I do not believe that most those inequities are driven by conscious deliberate discrimination. It is driven, I think, by implicit bias. Research finds that implicit bias is more likely to occur when individuals work under time pressure, need to make quick judgements…and have to manage complex cognitive tasks. Thus, the very conditions under which many physicians' practice are likely to heighten the chances of implicit bias. So, there is enormous work to be done in raising awareness levels of the potential of implicit bias among health-care workers."

Structural change and multisectoral actions are also needed to address racial health disparities. Progress must build on how the field has developed since the days when "the whole conversation was about health care". Now, Williams says, we are "talking about the factors outside the health-care system, where you live, learn, work, and play, and the opportunities to be healthy in our homes, our neighbourhoods or workplaces, our schools. These are the drivers of health."

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