Meet the Director:

Eliseo J. Pérez-Stable, M.D.

Eliseo J. Pérez-Stable, M.D., served in the medical and research communities for decades before becoming the second Director of the National Institute on Minority Health and Health Disparities (NIMHD) in 2015. His path to NIH was guided by his unique experiences and partnerships, which prepared him to lead NIMHD in its mission to reduce health disparities and improve the health of minority and disadvantaged populations.

He also oversees his lab at the National Heart, Lung, and Blood Institute (NHLBI), where his research explores health differences among racial and ethnic groups and how social factors such as migration and the environment affect health.

Dr. Pérez-Stable shared highlights from his career and discussed advancing the science of minority health and health disparities with NIH MedlinePlus Magazine. He talked about NIMHD's unique role within NIH, how the landscape for health disparities research changed with COVID-19, and what he's most excited about moving forward.

Can you tell us about your background and what brought you to this field?

I was born in Cuba, and I spent the first eight and a half years of my life there. After the Cuban Revolution, my parents decided that they didn't want to risk staying there, so in 1960, we immigrated to the United States. I guess my journey starts there because as a Cuban American, I'm an immigrant and I'm a minority individual. We moved to Pittsburgh, where I learned English.

The second big thing is that I became a physician. My father was a physician, but he never really pushed it on me. I think I opted for medicine because it was a noble profession and I would always have a job.

I was originally a history major in college, and I always had a strong interest in politics and current affairs, particularly around Latin America but in the United States as well. I quickly realized if I wanted to be a physician—and a good one—I wouldn't have time for much else. Medical residency brought me to the West Coast, and I went to the University of California, San Francisco (UCSF), for training in primary care general internal medicine. I fell in love with the area and lived in San Francisco for 37 years, where I built my career.

Can you describe your career progression from clinical practice to research?

I learned research methods during a two-year [clinical] fellowship, which turned me on to academic research. There were people around me who encouraged and supported me. Dr. Steve Schroeder [Director of the UCSF Division of General Internal Medicine] was a mentor and my first boss at UCSF. He was an influential leader in general internal medicine, which didn't really exist in many academic centers at the time.

I began to collaborate with behavioral and social scientists. I worked first on depression prevention in primary care and in tobacco use and smoking cessation among Latinos, and then moved more toward population science.

IMAGE CREDITS: NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES

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A lot of my clinical work had very little to do with my research. I got funding from NIH very early on, but I also really enjoyed my role as a leader in research and as a clinician, a generalist, and an educator at UCSF.

How did you first become interested in minority health and health disparities?

My interest in minority health began in my third year as a resident when all of the residents in my year were asked to do a talk [on a topic of our choice]. I did two: one on Cuba and one with another resident on cultural factors in communicating with patients who are American but not White. I focused on Latinos, and the other resident, who is Vietnamese American, focused on Southeast Asians.

That was the beginning of my thinking about, "What is it about me being Cuban and able to speak Spanish that made it different [for me] to take care of these patients who did *not* speak English?" An obvious thing was language, but I felt there was something else going on, and I wanted to study that. I called it "cultural factors" in communicating.

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How did that interest shape your career path?

Once I became an associate professor at UCSF, my role became more defined, and I started to connect with others and do more collaborative work. I went from mostly working only on my own projects to now having networks, both local and national, which created the platform to make progress in my research. I partnered with Dr. Eugene Washington, who worked in a similar role to mine in the UCSF obstetrics and gynecology department. Gene is African American and got grant funding to create what we named the Medical Effectiveness Research Center for Diverse Populations (now called the Multiethnic Health Equity Research Center). It was the first center for minority health research at UCSF. We had different clinical backgrounds and were connected to different people. Combining forces was a huge step in the right direction in terms of what we were able to accomplish at UCSF.

Because we were focused on minority health, we attracted people from different disciplines. A pediatrician who was interested in studying birth outcomes by race and ethnicity came to me and said, "I want you to be my mentor." I was an internist, and I didn't have any experience with kids at the time. I said, "Tell me how I can help you." It turned out that she trusted me, and I knew about Latino health, and she taught me about the issues she was interested in. I realized I could be a mentor for someone in a different discipline, and I never again accepted the excuse (that I still hear), "I'm not an expert in that area so I can't say anything about it."

An older adult receiving health care assistance.

IMAGE CREDITS: GETTY IMAGES

What brought you to NIH?

In the late 1990s, we got a grant from the National Institute on Aging (NIA) to create the Resource Centers for Minority Aging Research. I began coming to the NIH campus [in Bethesda, Maryland] regularly, and I got to meet many different people, including NIA leadership in behavioral and social science research.

Eventually, I was nominated to be a member of NIA's [Advisory] Council, and Dr. Richard Hodes called and asked me to join. Serving on the council was a great experience. I learned a ton, and it gave me a window into how NIH worked from the inside. I collaborated with NIA leadership in developing their framework for minority health research, which they still use today.

How did you become the Director of NIMHD?

In 2014, Dr. John Ruffin announced his retirement as NIMHD Director. I thought a lot about applying [for the position]. One of my colleagues on the council had been the Director of the NIH Office of Behavioral and Social Sciences Research. I asked him, "What do you think?" He looked at me and said, "To be the Director of an institute? Of course, you should apply!" By the time Dr. Francis Collins [former NIH Director] called me to offer me the job, I was ready to take it.

It was the first time someone like me—a generalist who didn't have a basic science background—came to NIH [as the Director of an institute]. I think that was a big change for NIH. It was a huge change for me and for my family, but I thought the opportunity was one I shouldn't pass up. And I have not regretted it. I gave up seeing patients, but I had very much been anchored in my clinical work with patients, which I hope has influenced my role here.

What is NIMHD's role within NIH, and how has it changed over time?

NIMHD began back in the 1990s as the Office of Minority Programs within the NIH Office of the Director. In 2000, legislation created the Center for Minority Health and Health Disparities, and one of its charges was to monitor minority health and health disparities research across all of NIH. We were created as an institute in 2010 as part of the Affordable Care Act.

NIMHD's role at NIH is to lead and coordinate new research programs in minority health and health disparities, provide feedback on what people are doing, and nudge my colleagues to do more.

The pandemic really changed everything. Budget increases for COVID-19 brought new money to NIMHD for disparities research, and Dr. Collins asked me to co-lead NIH-wide initiatives. Not only did COVID-19 reveal these incredible disparities, but George Floyd's murder—and the subsequent protests—showed a major gap in our understanding of structural factors that lead to adverse health outcomes.

In early 2021, we launched a research initiative on structural racism and discrimination, which we had been developing for some time. We ended up funding 38 research grants with $34 million, and almost every institute participated. We'll see where that leads—everything takes time at NIH.

Dr. Eliseo J. Pérez-Stable became the second Director of NIMHD in 2015.

IMAGE CREDITS: NATIONAL INSTITUTE ON MINORITY HEALTH AND HEALTH DISPARITIES

What are you most excited about currently?

People now at least acknowledge that structural factors influence individual health, and it's not just people's bad behavior. These things are very complex. When I entered this field 40 years ago, I remember thinking, "What about biology? What about interactions between behavior, communities, and the built environment?" All these things contribute, and it's rare to find a single gene that causes the disease or one behavior that exclusively leads to a negative outcome. In most cases, there are very complex interactions, which is very compelling from a scientific perspective. We don't fully understand how race, ethnicity, and socioeconomic status interact with other factors to affect behavior, but their influence on health outcomes is remarkable, often dramatic, so we always need to consider them and measure them in a standardized way.

With COVID-19, we were able to legitimize and promote a community-engaged research platform as a way to go about helping communities respond to the crisis. We got investigators who know how to work within these communities and who are asking questions in ways that consider their individual needs. Working with different populations and communities is really a challenge. Some communities are very distrustful of government, researchers, or doctors for many different reasons. We saw in the pandemic how the disproportionate burden carried by Latino, African American, and American Indian/Alaska Native communities really evolved over time. These disparities reduced dramatically, in part because of the way we addressed these issues around mistrust. The community-engaged research platform can be very powerful. It takes a lot of resources to implement, but we have those resources at NIH.

I'm also excited to see a greater interest in diversifying the biomedical research workforce and leveraging minority-serving institutions to speed up the process. It's a long path to get there and has been a priority for me since I started in academia as an assistant professor.

What are determinants of health?

Determinants of health are the various factors that influence a person's overall health and well-being and include social, structural, biological, behavioral, and health care system influences. Recent findings from research supported and conducted by NIMHD highlight the importance of these determinants. Examples include:

Geographic location. Residents of rural counties in the United States are more likely to die from diabetes than those living in urban areas. This shows that health disparities are not limited to race or ethnicity but also extend to geographic location and access to health care.

Systemic racism. A study conducted by NIMHD researchers found that Black college students reported better mental health outcomes when their school's administration acknowledged institutional racism on campus and took steps to address it.

Access to health care. A study supported by NIMHD found that pregnant women were more likely to receive treatment for gestational diabetes if they were enrolled in Medicaid.

Lastly, I'm energized by the challenge of addressing issues of racism without placing blame or making anyone feel defensive. These are all normal reactions, and they're intimately linked to power. So how do we evaluate or cope with that as it affects health? We are working on research models to look at differences in mortality and morbidity

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by race and ethnicity, socioeconomic status, and geography. The economic cost of tolerating these disparities is close to $1 trillion a year. Reducing that number by even a modest percentage would be a huge savings and can be achieved by investing in certain areas. I'm hopeful that this will have an impact.

What are some of your favorite things to do when you are not working?

My wife Claudia Husni is also a physician. She is from Argentina. Our two sons are both young adults now and we always enjoy time with them, but we live with two cats who keep us company. We like to cook and sample the varied cuisines in DC. We also love movies and hiking in nature. I like to listen to jazz, and we go to the theater sometimes.

I really enjoy mindless tasks. It used to be washing the dishes until we got a dishwasher. I learned as a medical resident that I needed to not bring the work and emotional toll of taking care of sick patients back home. You can't always do it, but it's important to unplug for a bit and then to be able to go and do what you need to do. ■

This interview has been edited slightly for length and clarity.

Other NIMHD initiatives and resources

NIMHD focuses on research, training, and collaborations to improve minority health and reduce health disparities by focusing on the determinants of health and working to increase the diversity of the biomedical workforce. Through their community-engaged research program, NIMHD develops partnerships between academic researchers and community organizations to address health disparities at the local level.

NIMHD also created an endowment program for low-resource institutions (now named in honor of the late U.S. Representative John Lewis) and leads a popular and successful loan repayment program for minority health and health disparities. Here are a few more examples:

- The Research Centers in Minority Institutions Program supports institutions to conduct research and promote diversity in the biomedical workforce.
- The Centers of Excellence Program supports centers to conduct research on minority health and health disparities and to train the next generation of researchers and health care professionals.
- The Immigrant Health Initiative addresses the health needs of immigrants, including those who may not have access to health care.
- The Health Disparities Research Institute provides training to promising early-career research scientists in minority health and health disparities to encourage more research in these areas.

NIMHD also offers tools and resources to help advance the science of minority health and health disparities. They include:

- HD*Pulse*, an online resource that provides information on minority health and health disparities using descriptive statistics, interactive graphics, and maps that cover national, state, and county levels.
- The PhenX Social Determinants of Health (SDOH) Toolkit, a set of standardized measures for collecting data on the social determinants of health.
- *The Science of Health Disparities Research*, a textbook that explains how an interdisciplinary approach can help researchers understand and address health disparities. It focuses on reducing inequalities in population health, involving communities in the research process, and promoting social justice.
- New Perspectives to Advance Minority Health and Health Disparities Research, an NIMHD publication in the *American Journal of Public Health* with research and perspectives for improving minority health and reducing health disparities.