



SPOTLIGHT ON HEALTH EQUITY RACISM AND MEDICINE

Problem Statement:

More than century ago, Dr. W.E.B. DuBois advanced a thesis that race is not a scientific or biological category and that racial differences in health outcomes are due to social conditions (e.g., disadvantaged socioeconomic position and social capital) rather than biological differences between races. Analyses of the human genome show that there are more differences within racial groups than there are among racial groups. Despite these clear findings, racial essentialism – the belief that health outcomes are predetermined by race and are immutable – persists, only exacerbating existing health inequities.

Why is this important?

Before the advent of modern medicine, science was used as a means of perpetuating racial biases within society. From “medical” experimentation on Black slaves to the well-known 20th century Tuskegee syphilis study, scientific racism was a hallmark of early American medicine. While such practices have long been considered inhumane, differences in health outcomes by race persist, prominently exemplified by the U.S.’s high maternal mortality rate – with Black and Indigenous pregnant women dying at three times the rate of White women.

KEY DEFINITIONS

Race – a socially and politically constructed way of grouping people, implying common ancestry based on physical characteristics alone.

Racism – a system of structuring opportunity and assigning value based on how one looks, which unfairly advantages some and disadvantages others.

Ethnicity – a variety of sociocultural relationships and practices that can be fluid and change over time.

Inequity – unfair or unjust distributions of resources across social, economic, environmental, and health care systems.

Clinical decision support tools – the integration of data and research to help clinicians assess patients’ health, predict diagnoses or outcomes, and determine options for diagnostic tests and treatment.

INEQUITIES IN ACTION: A CASE STUDY OF THE INTERSECTION BETWEEN RACISM AND MEDICINE

Long heralded as the “father of gynecology,” Dr. J. Mario Sims received his acclaim for the surgical experimentation he conducted to repair vesicovaginal fistulas, complications stemming from childbirth. From 1845-1849, Dr. Sims conducted experimental surgeries on Black female slaves – without their consent or the use of anesthesia. After five years of surgery (30 on one woman alone), Sims published his findings in the American Journal of Medical Science in 1852. While Sims ultimately discovered an approach to address these painful medical conditions, his findings were based on medical abuse and forced experimentation on enslaved women.

A statue celebrating Sims’ medical achievements stood in New York City’s Central Park until activists successfully campaigned to have it removed in April 2018.

“the desire to be trusted and the best of intentions to practice cultural competency – among African Americans in particular – is simply not enough to allay their fears of being used as experiments or overlooked and mistreated as unworthy of the best care. Their history of abuse at the hands of America’s medical establishment ... is too long and fraught with missteps.”

- James E.K. Hildreth, PhD, MD, President of Meharry Medical College in Ways and Means Testimony, May 27, 2020



How the misuse of race in clinical decision tools exacerbates inequities

Today, clinical decision support tools are pervasive in clinical settings but vary widely in their scope, use, utility, effectiveness, and evidence base. Many of these tools include a factor to account for race and ethnicity in ways that research has shown exacerbate racial disparities, compromising momentum to address social determinants of health and often yielding fewer treatment options for people of color. A study published in *The New England Journal of Medicine* in June 2020 showed that racial correction in clinical decision tools and algorithms is harmful for conditions ranging from childbirth to cancer care – further exacerbating racial health inequities. Examples of how the misuse of race in medicine negatively affect patient outcomes and exacerbate existing disparities include:

- Cystic fibrosis is underdiagnosed in populations of African ancestry, because it is thought of as a “White” disease.
- Because of a race modifier in calculation of kidney function, Black patients are systematically classified as having a healthier kidney function, which leads to delays in referral to specialists and for kidney transplant evaluation.
- Black and Latina women are systematically stratified as high risk for vaginal birth, which leads to increased rates of cesarean section.
- Rheumatologic conditions are underdiagnosed in non-White and non-Asian populations

Should data on race and ethnicity be collected at all?

Although using a biological definition of race in medicine is harmful and inaccurate, using race as a political or social category to study the impact of structural racism and its physiological effects is extremely relevant.

Scholars have shown how important it is to collect data on health indicators and outcomes by race and ethnicity to quantify the impact of oppression on health. Researchers have found that racism is negatively associated with physical health and every dimension of psychological well-being. A 2016 study assessing beliefs on race found that half of medical trainees surveyed held incorrect beliefs about biologic differences between Black people and White people, and that those who held the incorrect beliefs were more likely to treat Black patients inappropriately.

The COVID-19 pandemic has demonstrated both gaps in demographic data collection as well as the importance of collecting these data to target interventions and resources.

According to written testimony provided to the Committee from Joia Crear-Perry, MD, and Daniel E. Dawes, JD: *“What we choose to measure is a values statement. When we fail to comprehensively capture and report information about the impacts of COVID-19 and other morbidities on communities of color, these communities are erased...With smart policies created with cultural humility and sustained federal investments – modest by comparison to overall COVID-19 related appropriations – Congress and the states can rebuild our data to be prepared for future COVID-19 waves and address other racial and ethnic health inequities around the country.”*

Today’s racial health inequities represent the lasting legacy of our country’s history of racism. To lead our country into a more honest, equitable, and just future, we must acknowledge this history and its impact on science, medicine, and trust in the U.S. health care system.

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