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# Dismantling Structural Racism, Supporting Black Lives and Achieving Health Equity: Our Role

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On July 7, 2016, in our community, Philando Castile was shot and killed by a police officer in the presence of his girlfriend and her 4-year-old daughter. Acknowledging the role of racism in Mr. Castile's death, Minnesota's Governor Mark Dayton answered his own question “Would this have happened if those passengers [and] the driver were white? I don't think it would have.” Such incidents are tragic and disturbingly common. Indeed, in the past two weeks, the nation has witnessed the deaths of two more black men at the hands of police —Terence Crutcher and Keith Scott.

Disproportionate use of lethal force by law enforcement against communities of color is not new, but video evidence now lays bare the traumatizing and violent experiences of black Americans. Structural racism—a confluence of institutions, culture, history, ideology, and codified practices that generate and perpetuate inequity among racial and ethnic groups[1]–is the common denominator of the violence that is cutting lives short in our midst.

The term racism is rarely used in medical literature. Over the past 11 years, only 14 *NEJM* articles contained the word “racism.”[2] Most physicians are not explicitly racist, and are committed to treating all patients equally. However, they operate in an inherently racist system. Indeed, structural racism is insidious, and a large and growing body of literature documents disparate racial outcomes despite the best efforts of individuals.[4] To curtail systematic violence and premature death, clinicians and researchers must take an active role in addressing the root cause.

Structural racism, the systems-level factors related to – yet distinct from – interpersonal racism, increases mortality and reduces overall health and well-being.[3] It is an epidemic, causing widespread suffering, not only for black people and all communities of color but for our society writ large.[3] Structural racism is a threat to the physical, emotional and social well-being of every individual in a society that allocates privilege based on race.[4] As clinicians and researchers, we wield power, privilege, and responsibility for dismantling

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structural racism, piece by piece. Below we share five recommendations for clinicians and researchers who wish to do so. .

## Learn, understand and accept America's racist roots

Structural racism is born of a doctrine of white supremacy created to justify mass oppression for economic and political exploitation.[4] In the US, this was carried out through centuries of slavery premised on the social construct of race. [5] In a very literal sense, this country codified the value of black lives as 3/5 that of whites in the Constitution. Historical notions about race have shaped our scientific research and clinical practice.[5] For example, experimentation on black communities and the segregation of care based on race are deeply embedded in the US healthcare system.[5] Disparate health outcomes and systematic decrements in the well-being and livelihoods of black Americans in the United States must be seen as an extension of a historical context where non-white – and specifically black - lives have been devalued. It is both a collective and individual responsibility for health care professionals to understand the historical roots of contemporary health disparities.

## Understand how racism has shaped the disparities narrative

Researchers and clinicians have long employed rhetoric implying that differences between races are intrinsic, inherited or biological. For example, dating as far back as the antebellum period, physicians attributed poor health among slaves to their biological inferiority, rather than to their conditions of servitude.[5] Such beliefs persist today. In April 2016, a study found that 50% of white medical students and residents hold false beliefs about biological differences between black and white people (e.g., black people's skin is thicker; black people's blood coagulates more quickly).[6] Implicit bias and false beliefs are common; we all hold them, and it's incumbent upon us to challenge these beliefs when we see how they contribute to health inequities.

## Define and name racism

In health care and health services research, consistent definitions and accurate vocabulary for measuring, studying, and discussing race, racism and health are necessary. Armed with historical knowledge, we must recognize that race is the “social classification of people based on phenotype. [1]” Camara Jones explains that, “…race is the societal box into which others put you based on your physical features.” Racism, however, “…is a system of structuring opportunity and assigning value based on phenotype (race) that: unfairly disadvantages some individuals and communities; unfairly advantages other individuals and communities; undermines realization of the full potential of the whole society through the waste of human resources.[1]” Recognizing and naming racism, in our work, our writing, our research, and in our interactions with patients and colleagues will advance understanding of the distinction between race and racism, and allow for efforts to combat racism when it is recognized and clearly defined.

## Recognize racism, not just race

We frequently measure and assess difference based on race. Patients check boxes on forms; clinicians and health systems may assess racial differences in care; and researchers include race as a variable in regression models. When an individual's race is ascertained and measured, is it an indicator for race, or for racism?

For example, race is often used as an input in diagnostic algorithms, (e.g., hypertension, diabetes), deflecting attention from underlying etiologies – beyond biology - that are contributing to the actual infirmity. Black Americans on average have more poorly controlled diabetes and a higher rate of diabetes complications.[7] Successful treatment of chronic conditions like diabetes requires attention to structural factors and social determinants of health, but anti-racism strategies are rarely recommended for improving diabetes control. A shift from individual responsibility to collective action may ensue when the clinical and research focus moves from race to racism.

## Center at the margins

To provide clinical care and conduct research that contributes to equity, it is crucial to "center at the margins," which describes a shift in viewpoint from a majority group's perspective to that of the marginalized group or groups.[9] Historical and contemporary views, informed by centuries of explicit and implicit racial bias, normalize the white experience. Indeed, in describing Philando Castile's death, Minnesota's Governor noted that the tragedy was "not the norm;" in our state, revealing a deep difference between the Governor's perception of "normal" and the experiences of black Minnesotans.

Centering at the margins in health care and research requires anchoring and engaging within the experience of disenfranchised groups, to yield a shift in the discourse that typically subordinates them to the dominant race or culture.[8] Centering at the margins in clinical care and research necessitates redefining "normal." To do so, we must employ critical self-consciousness—the ability to understand how society and history have influenced and determined the opportunities that define our lives. For clinicians, this means reflecting on how they arrived at their understanding of a diagnosis or clinical encounter, and the willingness to understand how their patients arrived at theirs. The ability to center at the margins represents not only an important opportunity to practice an elevated level of patient-centered care but also reveals new findings and clinical insights about the experiences of those often overlooked or harmed by our institutions.

In Minnesota and across the nation, health care professionals have an obligation and opportunity to contribute to health equity in concrete ways. Addressing violence against black communities starts with anti-racist practices in clinical care and research. We have shared five recommendations for doing so: 1) Learn, understand and accept America's racist roots; 2) Understand how racism has shaped the disparities narrative; 3) Define and name racism; 4) Recognize racism, not just race; and 5) Center at the margins, using critical self-consciousness to give voice and power to those who are voiceless or disempowered.

Lives are at stake, do we have the courage and conviction to fight for the clarion call that Black Lives do indeed matter?

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