One race, one science

Henry Oluwasefunmi Savage

Author

Henry Oluwasefunmi Savage
Consultant Cardiologist and Honorary Senior Clinical Lecturer, Anglia Ruskin University

Essex Cardiothoracic Centre, Mid and South Essex NHS Foundation Trust, Nethermayne, Basildon, SS16 5NL

Correspondence to:
Dr H O Savage
(Henry.Savage@btuh.nhs.uk)

Key words

disparity, ethnicity, race, science

doi: 10.5837/bjc.2021.008

Br J Cardiol 2021;**28**:5–6

The world is changing or is it? Science is changing or is it?

The concept of race based on skin colour, is an entirely social construct and its harbinger, segregation and slavery, projects itself into our modern day as racism. Perhaps more recently, it is acknowledged that racism remains a clear and present danger in today's world. It is deeply rooted within the fabric of society and can only be tackled by active and persistent engagement.

In scientific circles, what is whispered but not openly spoken about is the cumulative acts of indifference that contribute to racial disparities in healthcare within our society. This comes in the form of implicit and subconscious biases that affect healthcare allocation and worse, delivery, in the form of differential treatment of patients.[1] This is as deadly as it is silent. As clinicians and academics who contribute to healthcare, we can either pretend this doesn't exist or we can educate ourselves, and others, to foster health equity for all.

Pseudoscience

There is no genetic basis for race, as there is for sex, for instance. There is no white, black or brown gene. It is, therefore, a completely pseudoscientific argument to suggest that the colour of one's skin alone, is directly responsible for the risk of, or susceptibility to, disease, or indeed the response to treatment. Race is, therefore, a crude marker of underlying genetic and biologic variations. Conclusive scientific data to the contrary simply do not exist.

Ethnicity, however, a far more complex description, encompasses, but is not limited to, a fusion of culture, language, nationality, customs and religion. Though largely without genetic basis, these contribute to health seeking or avoiding behaviour, which can increase the risk of disease. This may in part explain the observed higher prevalence of, in particular, cardiovascular disease, in people who are from, so-called Black Asian and Minority Ethnic (BAME) groups, in a western society.[2] This population may also be directly affected by healthcare policy driven by social ideologies, stereotypes and prejudices that may disadvantage them. The ongoing global public health crisis involving COVID-19, has shone an even brighter light on the magnitude of this problem.[3,4]

Reasons for disparities

The reasons for these disparities may be hidden in plain sight, lying directly in the socioeconomic environment. If, for instance, you group all approximately 200 million people in the largest black nation on earth, Nigeria, according to socioeconomic status, you may find that the prevalence of certain diseases may be skewed towards those at the lower end of the scale. These would be people who are likely to be income deficient, have limited or no education, poor nutrition, who live in crowded spaces and have limited access to healthcare. All of the aforementioned would likely be all black and, yet, these disparities would still be evident. A similar experiment performed in an entirely white population, in the UK or an entirely Asian population in India, would likely yield similar results.

It is our responsibility, therefore, as scientists, to separate the genetic basis for disease from the colour of one's skin and from direct contributors to these healthcare disparities. It is lazy and convenient not to do so. And it is this *laissez-faire* attitude that perpetuates the status quo and fuels the mistrust that people from these communities have, who are only too aware of past atrocities committed in the name of science, based on skin colour.

This, however, is a culture of stereotype and racial bias that has pervaded our healthcare environment for decades. And, while it is important to re-orientate those scientists who have already passed through the educational system, perhaps a more efficient and productive strategy may be targeting those at the start of their training, and who may be more receptive to positive education.

First, listen

We are taught to 'Look' 'Listen' and 'Feel', in that order. Maybe we need to Listen, first. Listening may mean correcting misconceptions in medical literature and actively encouraging policy that removes health attainment gaps within society.

This may mean actively championing health education and primary prevention in communities where residential health status is poor. Listening may mean being attentive to the facts of the patient in front of you first, before putting them in a box based on what they look like.

There is no easy solution. It would be utopic to suggest so. But, perhaps, we need to have more courage in bringing this conversation to the forefront of policy making, as this is where tangible change can occur. And at its heart, there needs to be inclusion and diversity that isn't token, that would be meaningful and that would be heard.

We need longer tables and not higher walls

Conflicts of interest

None.

Editors' note

This editorial is based on presentations from, 'Race, ethnicity and heart failure care', a webinar held on 23 July 2020 by the British Society for Heart Failure (BSH).

References

1. Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci USA* 2016;**113**:4296–301. https://doi.org/10.1073/pnas.1516047113

2. George J, Mathur R, Shah AD *et al*. Ethnicity and the first diagnosis of a wide range of cardiovascular diseases: associations in a linked electronic health record cohort of 1 million patients. *PLoS One* 2017;**12**:e0178945. https://doi.org/10.1371/journal.pone.0178945

3. Public Health England. Disparities in the risk and outcomes of COVID-19. London: PHE, 2020. Available from: https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes

4. Aldridge R, Lewer D, Katikireddi SV *et al*. Black, Asian and minority ethnic groups in England are at increased risk of death from COVID-19: indirect standardisation of NHS mortality data. *Wellcome Open Res* 2020;**5**:88. https://doi.org/10.12688/wellcomeopenres.15922.2