CONSTRAINTS ON THE VALIDITY OF BLACK/WHITE DIFFERENCES IN EPIDEMIOLOGIC MEASUREMENTS

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Present reports of racial and ethnic differences in epidemiologic data, though far from ideal, must be acknowledged as being a major improvement on the past, when social class factors were assigned minor roles in attempts to interpret disparities in health status[1,2,3]

In Ethnicity/Race, Ethics, and Epidemiology, Whaley discusses the poorly explained differences that remain after controlling for socioeconomic status, arguing that genetic factors may not be the sole explanation for residual disparities, and that researchers need to be aware of cultural and other factors, which they often overlook.

Table 1 lists various factors[4,5,6] that may contribute to spurious or distorted disparities. Researchers, journal editors, administrators, and health policymakers need to be familiar with these sources of differences. If left unaddressed, such differences will perpetrate the frustrations so ably highlighted in this paper and mislead serious decision-makers.

Evidence-based rather than sentiment-based challenges to this 2003 diagnosis of the state of compassionate coexistence would advance the debate, and are therefore welcome.

Whaley's discussion is a good illustration of the Yoruba saying: "The deceived, though puzzled, knows there's something missing."

The time may be ripe to collate fragments of information for new standards of research design, data collection, and data analysis, to discover what is missing. Researchers will thus be able to go beyond making a point about racism, to discover and measure the contribution of various other factors to the epidemiologic outcomes under study, the prioritization of planned interventions, and the measurement of progress towards society's egalitarian aspirations.

The black/white comparison he discusses in terms of socioeconomic, genetic, cultural, and ethical factors is a special case of the multiple regression equation: $Y=k+A\pm B\pm C \pm D$, where Y is a medical or sociological dependent variable (morbidity, mortality, economic participation, political participation, quality of life, quality of existence);[7] k is a statistical constant; A is a measure of demographic variables (age, sex, socioeconomic status)[8]; B is a measure of biologic factors (genetic, medical);[9] C is a measure of positive cultural variables (religion, resilience);[10] and D is a measure of transitional cultural variables (persistent disparities in income, education, administration of justice).[11,12]

Similar categories can be derived for other American minority groups and for minorities in Great Britain, Europe, Canada, and elsewhere.[13,14,15] Caveat statements should alert readers whenever data in these categories is missing, causing artifactual "disparities" in research publications.

"Today's Tuskegees" are measurable, trackable, actionable, and targetable with policy modifications. They merit focused analysis by epidemiologic methods in order to effectively intervene in the life experiences of minority racial and ethnic groups that have no equivalents among whites.[16] Progress is not auditable where data collection by racial categories is forbidden by law.[12]

Since recent research suggests that both blacks

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Table 1. Minimum Data Categories for Valid Racial/Ethnic Epidemiologic Comparisons

FACTORS:			
Demographic	**Genetic & Medical**	**Positive Cultural**	**Transitional Cultural (Today's Tuskegees)**
1. Age	1. Sickle Cell Disease	1. Religious Values	1. Generic Disrespect Sentiment-based Epidemiology
2. Sex	2. Diabetes	2. Resilience	2. Disparities in Administration of Justice a. Driving While Black b. Police Brutality Beyond the Call of Duty c. Prison Population Disparities d. Death Row Disparities e. Ethnically Incongruent Juries f. Legal Prohibition of Research
3. Socioeconomic Status a. Health Insurance Status	3. Hypertension	3. Creative family structures	3. Education Disparities g. Cyclical ambivalence about Affirmative Action
4. Marital Status	4. Prostate cancer	4. Intuitive and adaptive avoidance of sly systems	4. Economic Disparities h. Aristocentric econometrics i. Income disparities j. Unequal employment practices
5. Distinctive Demographic Groups e.g. Young Black Males Elderly Black Immigrant Females	5. Breast cancer	5. Judicious pluralistic use of Alternative Medicine	5. Progress Milestones k. 1943–1963 Pre Civil Rights l. 1963–2003 Post Civil Rights m. 2003–2050 Human Rights for mature Diversity in the Global Village
	6. Cardiovascular procedures		
	7. Asthma		
	8. Diagnosis of Schizophrenia		

and whites appear to suffer in a social climate of unintended and unexpected inequalities,[17] voluntary retrospective analyses of the computerized data collected in the past 25 years[18] should provide indispensable baselines for guiding future research[19,20,21]. They may also discover best practices and state-by-state variations, ranging from those whose policies are relatively exemplary, to those that tolerate obsolete practices.

Departments of Epidemiology in the traditionally black medical schools might take the cue to stimulate the curiosity of their students, who will have a less optional existential relationship to the subject matter, than others. The newly created Office of Minority Health and the National Center for Primary Care may have an important role in such efforts. Readers of this journal can also help jump-start the stalled initiative.[22]

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