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The Intersections of Race, Ethnicity, and Medicine

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FROM THE EDITOR

Hazardous Intersections: Race, Ethnicity, and Medicine

Race and ethnicity have always played a pivotal role in the shaping of society in the United States. From the birth of this nation, and for centuries to follow, race and ethnicity defined the bounds of citizenship [1-3]. With each consecutive wave of immigration, these bounds have been challenged, contested, and redefined, as the US has become an increasingly polychromatic mosaic of racial and ethnic categories; in fact, the very boundaries between these categories are progressively being blurred by cultural assimilation and intermarriage, calling into question the very meaning of race and ethnicity [4-5].

When Barack Obama was elected as the first United States president of African descent, much of the popular media hailed the advent of a “postracial” America [6-7]. But, as attested by the many controversies that have followed, from continuing debates over affirmative action to questions about the impact of race in high-profile criminal cases [8-12], one must wonder: what does it mean to be “postracial”? Is it achievable—or even desirable?

Far from being immune to the influence of societal mores on race and ethnicity, science and medicine have in fact been deeply shaped by prevailing racial attitudes—from the segregated patient wards of days past to current practices regarding the race-specific approval of certain drugs [13]. Conversely, biomedical advances have altered societal conceptions of race, not least of all with the advent of the human genome project and the debate over the biological significance (or absence thereof) of race [14-16]. Some of the most profound and enduring effects of society’s racial attitudes on medicine and public health are the health disparities between racial groups that, to this day, elude resolution. These health disparities, in turn, deprive underserved communities of the chance to achieve their full potential as members of our society [17, 18].

This issue of *Virtual Mentor* explores the many intersections of race, ethnicity, and medicine, touching upon both historical events and emerging dilemmas.

In the first case commentary, Tom E. Finucane, MD, questions the commonplace practice of citing patients’ race in clinical presentations on the ward—and students’ role in challenging practices that they find questionable. Ruth M. Farrell, MD, MA, Holly Pederson, MD, and Shilpa Padia, MD, explore emerging challenges caused by the widespread availability of direct-to-consumer genetic testing, a timely issue given the Food and Drug Administration’s recent warning to genetic testing provider 23andMe [19]. In a third case commentary, Brian W. Powers and Sachin H. Jain,

MD, MBA, address the tricky question of how to respond to patients' racial and ethnic biases. An opinion from the AMA's *Code of Medical Ethics* alerts physicians to the presence of race-related disparities in health care and provides guidelines for minimizing them.

Race and ethnicity also play a significant role in the research that informs clinical practice and policies. Raegan W. Durant, MD, MPH, describes evolving policies on the inclusion of minority populations in health research, and Abdul El-Sayed, MD, DPhil, presents innovative research methods to better dissect the complex, reciprocal effects between race/ethnicity and health. LaPrincess C. Brewer, MD, MPH, and Lisa A. Cooper, MD, MPH, review recent research findings that are transforming our understanding of how race and ethnicity impact health outcomes.

Any effort to change the ways in which race and ethnicity affect the practice of medicine must include the education of physicians in training. Katherine Bakke, Kartik Sidhar, and Arno Kumagai, MD, present an innovative approach to incorporating discussions of race, ethnicity, and privilege in medical education that goes well beyond the notion of "cultural competency." Constitutional challenges related to affirmative action policies in medical education are debated by Shanta Driver, JD, and Abigail Thernstrom, PhD.

Drawing from the lessons of the past, Robert Baker, PhD, recounts the struggle of African American physicians to be included in the American Medical Association, and Brooke Cunningham, MD, PhD, reviews the ever-evolving struggle to define race and ethnicity biologically, culturally, or perhaps as something that becomes embodied over time. Finally, Thomas P. Duffy, MD, shares his experience of learning medicine in a segregated hospital and his reflections on cultivating conscious and critical awareness of our own attitudes and practices, so that we may see and rectify our misdeeds.

As our society's understanding of race and ethnicity evolves, we must learn from the sins of the past and remain vigilant about the ways in which we may be harming or failing our patients today. At stake lies the medical profession's ability to uphold the promise of "complete physical, mental and social well-being" for all [20]. It is my sincere hope that this issue will be informative to readers and that it will trigger both reflection and action so that we may contribute to greater justice and equality.

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ETHICS CASE

Mention of a Patient's "Race" in Clinical Presentations

Commentary by Thomas E. Finucane, MD

It is a big day for Michaela. A fourth-year medical student, she is just beginning a sub-internship in internal medicine at City Hospital, her top choice for residency. She took her first call yesterday and is about to present on rounds for the first time the patients she admitted. Knowing how important a letter of recommendation from her attending Dr. Ross will be for her residency application, she is eager to make a good impression. Although she is a bit nervous, she is well prepared and confident.

When it comes her turn to present her first patient, Michaela takes a deep breath and begins, "Ms. Adler is a 76-year-old woman, with a history—"

Before she can finish her sentence, Dr. Ross interrupts her: "76-year-old black woman, right?"

"Uh, yes," Michaela answers, after a brief hesitation. "As I was saying, she has a history of coronary artery disease and presented to the ED after a fall and a brief loss of consciousness."

Although she is a bit unsettled by the interruption, the remainder of the presentation goes well and she gets positive feedback from Dr. Ross on her management plan for Ms. Adler. With this confidence boost, Michaela begins presenting her next patient. "Mr. Rocha is a 26-year-old man with recently diagnosed Crohn's disease presenting—"

To her surprise, Dr. Ross interrupts her again. "White?"

"Well, I... I didn't ask..." Michaela stutters, as she sees Dr. Ross raise an eyebrow briefly.

"OK," he responds with a wave of his hand, "Go on." Although she is worried that she is not making the impression she was aiming for, Michaela gets through the rest of her presentation uneventfully.

Later that day, as Dr. Ross is about to leave, Michaela approaches him to get some feedback on her presentations. "I'm sorry I didn't ask the patient's ethnicity. It's just that it wasn't relevant to the case."

“Well, I can’t decide what’s relevant if you don’t tell me, can I?” Dr. Ross responds. “Listen, you’re doing a great job for a beginner in managing these patients, but you have to make sure that your presentations are complete: name, age, race, chief complaint, same old script every time. I’ll give you a pass for today but just don’t forget next time, OK? See you tomorrow, bright and early!”

Commentary

On my way to a Fulbright at the Hospital Civil de Guadalajara, I asked my Virtuous Mentor, Dr. William Greenough, what might be helpful during ward rounds. He replied that knowledge at the hospital would be as good as mine and clinical skills perhaps a bit better. What we have to offer, he said, is the tradition of asking questions. In many places, attending physicians proclaim and learners record the proclamations. What we’re looking for, instead, is a creative, mutual search for the best way to take care of our individual patients. He was pointing out that knowledge is incomplete and that teaching more closely resembles learning than it does downloading.

Ward teams are complex, stylized social groups, with aspects of family, classroom, guild, and municipality. Case presentations are a focal point on rounds, and several important agendas are in play. In Michaela’s case, the attending physician asserts that the presentation must include early mention of the patient’s race. This demand makes Michaela uneasy. I agree with her. It is problematic both clinically and as a matter of social justice. What should she do?

Does the requirement lead to better patient care? The number of situations in which diagnosis or management is, or should be, affected by patient race is small. To apply evidence from randomized trials, for example, the patient at hand should be as similar as possible to subjects in the relevant clinical trials. In trials that have found significant differences associated with patients’ races [1], race was generally assigned based on patient self-identification. If we assert that race is relevant, we should use the same criteria as in the trials, the patient’s self-identified race. This is not usually done and is rarely as simple as it sounds. A medical records study found

that many respondents had trouble identifying with the concepts of race and ethnicity as understood by health researchers, many respondents described themselves in ways that were inconsistent with the categories included in the registration database, and many respondents were assigned categorizations in the database that were inconsistent with their self-reported identities [2].

One respondent identified her race/ethnicity as “Beautiful.” The idea that each person can be assigned to one of a few objective racial categories by someone else is demonstrably false; race is far more complex and subtle than that. When Michaela is accosted the second time, then, her reply is brilliant: she doesn’t know the patient’s race because she “didn’t ask.” Dr. Ross is not appeased.

The disparity seen here is part of a bigger problem with case presentations. In the sentence “This is our delightful, 86-year-old, black female,” a boilerplate formulation for some housestaff, every single word is wrong and fraught with meaning except “86 year-old.” “This” is not “ours.” She is not “black.” Unless you have the karyotype, she is not “female.” And if a 20-something calls me “delightful” when I am hospitalized, we may not get along. I am guessing that President Obama’s ward team would not, as a matter of respect, use this construction. For every patient, in my opinion, this is a matter of respect.

That initial sentence serves to establish dominance and demonstrate sophistication. How much more useful to say “Ms. J. is a 53-year-old auto mechanic and flea market enthusiast who recently lost her job,” or “Mr. O. is a 53-year-old reader, athlete, and President of the United States.” Labeling Mr. Obama as black precisely illustrates the social power and scientific incoherence of specifying race.

On the merits, then, race as a one-word identifier has a paltry scientific underpinning and is usually irrelevant to providing the best medical care. It’s hard to imagine that this vague descriptor is generally central to patient care. Featuring it prominently in a presentation is at best a distraction.

In a small 1999 study where housestaff presentations at morning report and chief’s rounds were tabulated, “Race was specified more often...(and) more often specified prominently and repeatedly during presentations of black patients. Among patients to whom ‘possibly unflattering’ characteristics were attributed, race was more likely to be specified for blacks (10 of 10) than for whites (4 of 9)” [3]. I feel sure that these housestaff would honestly deny bias, but there it is. Implicit bias is well recognized, and unfavorable characteristics are often ascribed to members of racial and ethnic minorities. No one benefits.

Within the uneven power dynamic of a ward team, what is Michaela to do? Is Dr. Ross’s requirement so wrong that she should take the risk and speak up anyway? There are certainly such times; bigotry is not extinguished by appointment to faculty. Regardless of risk, students should speak up if they believe something wrong is being done. (In speaking up we must of course always listen up.)

If the attending physician were to insist on using the “n” word, the answer would be yes, Michaela should speak; we all should. If he calls the station clerks “girls,” however, whether or not to speak up becomes a judgment call—it’s certainly evidence of prejudice, but merely condescending, rather than a hostile slur. Dr. Ross’s belief that race is clinically relevant may be evidence of a certain bias but I don’t think that is harmful or unprofessional. In my opinion, it does not rise to a level that requires Michaela to challenge her attending physician.

Harm occurs when race is used as a proxy for characteristics stereotypically ascribed to members of a group, much as the obligatory mention of age is intended to provide an indication of the patient’s place on the vitality-to-decrepitude continuum. The

ability of race and age to stand in as proxies for information that medicine needs is being questioned—often by younger members of the profession like Michaela. Michaela will make the call for herself. Other means are available to raise the issue, although they are regrettably few.

If she believes that Dr. Ross is open to discussion of the idea that race is an outdated proxy for relevant information, she could ask to meet and present her views. This should be done with an inquisitive spirit and the respect due to someone with far more experience on the subject. Exceptional clinical intuition develops with scrupulous attention to detail and conscientious follow-up over time. Dr. Ross may believe that early focus on patient race during presentations leads to better patient care. He may have confirmatory anecdotes. (As an incidental matter, Dr. Ross's manner, which appears to do violence to a great tradition of mutual respect and openness to ideas, could instead be a pedagogical device.) Michaela would be suggesting that the risks of using race in this manner—from scientific imprecision and from unconscious bias—exceed those benefits. Michaela could submit that, in the *New England Journal of Medicine*'s weekly "Case Records of the Massachusetts General Hospital," a generally reputable source, race is not given in the first sentence and often is not mentioned at all.

If Michaela feels that a collegial interaction with this faculty member is unlikely, her course evaluation might be a useful tool. The same high level of care should be used in writing this as in a personal interaction. The goal is to invite reflection about how a patient's race functions in case presentations, not to accuse and seek punishment. If even this seems too risky, a trusted adviser might have perspective and ideas. And finally, a thoughtful letter after graduation might nudge the situation in a good direction; these small acts, gently done, are sometimes unexpectedly consequential.

In summary, at our current level of knowledge, patient race is in general not clinically useful in knowing a patient, understanding a patient's disease, or creating a treatment plan. For a case in which it is relevant, I favor reporting race during the physical exam or, as Michaela has taught me, as part of the social history. The harm from presenting it by rote in the first sentence surely exceeds the benefit. Michaela has a difficult decision in front of her. She can confront Dr. Ross, more or less gently, or she can address him, more or less directly, through other channels. Michaela's task now is to be involved in learning and teaching. The sociology and politics of doing this are, as always, highly local.

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Related in VM

[Race: A Starting Place](#), June 2014

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[Pain and Ethnicity](#), May 2013

[“Vulnerable” Populations—Medicine, Race, and Presumptions of Identity](#), February 2011

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

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ETHICS CASE

Incorporating Genetic Testing Ancestry Results into Medical Decisions

Commentary by Ruth M. Farrell, MD, MA, Holly Pederson, MD, and Shilpa Padia, MD

Ms. Stewart was eagerly awaiting her upcoming trip to Boston to celebrate her parents' fiftieth wedding anniversary. She had grown up in a large Irish family, with two brothers and two sisters, but she rarely got to see them since moving to Oregon for her job. She was especially looking forward to seeing her sister Anna, who was recovering from a mastectomy after receiving a diagnosis of breast cancer several months earlier.

As a gift to her parents, Ms. Stewart had decided to create a book tracing the family's genealogy. Growing up, her mother told her stories about how her great-grandfather had arrived at Ellis Island with hardly anything besides the clothes on his back, and she had always been curious about the family's roots in Ireland. As she was searching the Internet for genealogy records websites, an advertisement on the side of her screen caught her eye. "Find out where your genes come from!" Her curiosity piqued, Ms. Stewart clicked on the link to geneheritage.com, an online service for genetic testing of ancestry and ethnicity. She had heard of these online genetic testing services before and even read in a magazine that one of her favorite actresses had gotten one, but she had never before thought of doing it herself. "I could put it in the book," she thought, as she perused the website. She decided to order a kit and, a few days later, she sent off a cheek swab for the DNA tests.

Two weeks later, Ms. Stewart got her eagerly awaited results. To her surprise, the results indicated that she carried several polymorphisms that are known to be more common among Ashkenazi Jews than in the general population. According to the test, she had 23 percent Ashkenazi Jewish ancestry in her genetic panel.

Later that week, Ms. Stewart went to see her primary care physician, Dr. Lowe, for her annual physical. During the review of systems when Dr. Lowe asked her whether she had had any lumps or pain in her breasts, Ms. Stewart hesitated a bit. "Well I haven't had any problems, but I was thinking...I want to get tested for the breast cancer gene."

Somewhat surprised, Dr. Lowe explained that the BRCA is not a routine test and is recommended for women who are at increased risk of breast cancer due to their family history and ancestry.

“Well that’s just it,” Ms. Stewart responded. “You know my sister had breast cancer recently, and now I just took this test and it turns out that I’m part Jewish. I think I need the test.”

Commentary

In the case of breast cancer risk, genetic testing can provide important information to help guide the patient through a number of personal and medical choices about her health [1]. Genetic testing is most informative when performed first on the family member at the highest risk of having a mutation. In this case, it would be Ms. Stewart’s sister [2], and her breast cancer is sufficient indication for genetic counseling and possible testing even in absence of ancestry information [3]. Ancestry information can assist in identifying people who may be at increased risk for heritable disease. Most commonly, this information is obtained from discussions with family members, discussions that can be key in identifying and contextualizing an individual’s heritable health risk. While reported family history provides insight into possible risk status, it may be limited since some families are not fully aware of or forthcoming about their family history. Increasingly, patients are turning to ancestry testing to gain this information, using direct-to-consumer (DTC) kits sold by independent manufacturers. These tests use either a single genetic and genomic analytic approach or a combination of methods to analyze an individual’s DNA and draw inferences about ancestry [4].

In the hypothetical case of Ms. Stewart, information from the ancestry test may not significantly alter the course of action regarding referral for genetic counseling and possible testing. However, it is important to recognize the ethical issues associated with DTC genetic testing [5]. One of most relevant issues for this case is the fact that the results may not accurately reflect Ms. Stewart’s ancestral background. This could be due to the genetic markers the test manufacturer elects to use, how it defines reference populations, and the statistical methods and interpretations used to analyze the genetic data, all these in addition to baseline variability in human genetic diversity [6, 7]. The information gained from DTC ancestry testing may not correctly categorize an individual into one of the recognized ancestral groups, a concept about which there is already a lack of scientific and sociological consensus [6]. The test may either misattribute someone to an ancestral group or, equally problematically, fail to identify another ancestral link associated with increased risk. This could lead to either false reassurance or unwarranted concern in response to news about the presence or absence of risk based on ancestry. Questions remain not only about how users should interpret these data but also if and how clinicians can use this information in a meaningful way.

If the DTC ancestry test correctly identified Ashkenazi Jewish ancestry in Ms. Stewart’s case, that information could be of value in determining whether further testing is recommended [8]. Ashkenazi Jewish ancestry is a well-known ancestral lineage linked to a three specific recurring mutations. [9] This ancestry confers a 1 in 40 chance of carrying a BRCA gene mutation, in comparison to the 1 in 300 chance in the general population [2, 10]. Other ancestries also come with an increased risk

of developing breast cancer, including those from the Netherlands, Iceland, Norway, and Sweden [9, 11-14]. In Ms. Stewart's case, the information obtained from the ancestry test did not speak to other possible ancestral associations that may have also shed light on her situation. Furthermore, BRCA gene mutations are not the only cause of hereditary breast cancer. Cowden syndrome, Li-Fraumeni syndrome, hereditary diffuse gastric cancer, and Peutz-Jegher's syndrome all increase breast cancer risk [15, 16].

People with a high risk for carrying genetic mutations, such as women of Ashkenazi Jewish descent, are advised to seek genetic counseling and consider genetic testing at any age if they have breast or ovarian or pancreatic cancer [2]. One of the leading concerns regarding DTC genetic testing is that it does not involve the guidance of a medical professional, either a genetic counselor or a physician trained in clinical genetics. Professional society guidelines recommend that genetic testing be done only in association with genetic counseling [2, 17] This is critical; before being tested, DTC test users should understand the limitations, risks, and consequences of acquiring genetic information about themselves (whether in the clinical or direct-to-consumer arena) and the possibility of finding gene variants of uncertain significance.

Genetic counseling is paramount. This includes appropriate pre- and post-test counseling to prepare the patient for personal and medical consequences that can come from learning such information. Genetic counseling can often be reassuring in situations in which a likelihood of heritable cancer risk is low. Genetic counseling may empower both Ms. Stewart and her sister to make educated and informed decisions about genetic testing, cancer screening, and prevention. In absence of pre- and post-test counseling, users may not be ready to confront personal risk information that can alter perspectives and choices about their life and health care or to frame future reproductive decisions based on knowledge of a heritable risk [5]. For example, Ms. Stewart's sister, who already has the diagnosis of breast cancer, has a 1 in 10 chance of being a BRCA gene mutation carrier if, in fact, the ancestry information is accurate [10]. Furthermore, users may learn information about their families that may be unexpected or even considered undesirable, something that could result in profound personal conflict [6]. This raises larger questions about when and how to disclose what has been learned.

Finally, ambiguity surrounds how individual DTC test manufacturers subsequently store and use the genetic sample, so consumers must also be aware of issues related to privacy and confidentiality of their information after the testing process is completed.

It is imperative that a patient be referred for genetic counseling if there is concern about a genetic predisposition for disease. When evaluating an individual with breast cancer or who is at high risk for developing breast cancer, it is important to obtain a detailed medical and family history. Information gathering includes ancestry as certain ethnic groups, such as those listed here, are a few of the better known groups

with documented genetic mutations. Until further data can be obtained about the accuracy and precision of DTC ancestry tests and their clinical utility, family history remains a primary way of acquiring this information. However, given the growing presence of genetics and genomics, clinicians must educate themselves about the medical and ethical implications of such tests, whether offered in the clinical or DTC context. Without such knowledge, clinicians will be limited in how they guide their patients through the often difficult decisions that must be made in light of this information.

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genetic testing without ancestry as a consideration, genetic panel testing may be offered. If Ms. Stewart's sister demonstrated a genetic mutation, our patient would have informative single-site testing for the mutation. If it were indeed a Jewish founder mutation, the ancestry would be confirmed, and the multi-site 3 panel would be offered to Ms. Stewart.

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ETHICS CASE

The Prejudiced Patient

Commentary by Brian W. Powers and Sachin H. Jain, MD, MBA

Dr. Simms is a new physician at Harbor Clinic, a primary care practice in a small town. He does not yet have a full panel of patients so he has agreed to fill in for his colleague Dr. Chen while he is on vacation. Things are finally starting to wind down after a busy day, when he welcomes his next patient. Ms. Smith, a 53-year-old woman, has been a patient of Dr. Chen's for the past five years. She is here because of her diabetes, which she has been controlling with diet and metformin. As he steps into the room, Ms. Smith exclaims "Oh, are you the new doctor? It's so nice to see a black doctor here! When did you start?" Dr. Simms hesitates for a second before responding, "Uh, yes, I just started a month ago and I'm filling in for Dr. Chen today. So I see you are coming in for your regular diabetes check-up?" Dr. Simms introduces himself to Ms. Smith and explains that he is replacing Dr. Chen for the week.

Ms. Smith seems to be doing well with her diabetes control. Her A1c is well within her goal range, and she has been able to keep to her diet and exercise regimen on most days. As the visit is about to end, Dr. Simms asks whether there is anything he can do for Ms. Smith. "Well, actually, I have this mole, I don't know I'm a bit worried about it."

"OK, let's take a look," Dr. Smith responds. After asking a few questions and examining the mole Dr. Simms reassures Ms. Smith that it is actually a benign skin tag.

Ms. Smith smiles, relieved. "Thank you so much! I was so worried about that!"

As she is walking towards the door, she turns back towards Dr. Smith: "You know, I really like you. I mean, Dr. Chen is good, but sometimes I can barely even understand what he's saying. You know? The accent? I mean, everywhere you go now, it's immigrants. Sometimes you just want someone who looks like you, you know?" Dr. Simms is slightly taken aback and does not know how to respond. Before he can say anything, Ms. Smith adds: "Can you be my doctor from now on?"

Commentary

The intersection between race and interpersonal comfort is complex, and often problematic. What does it mean that someone is more comfortable with someone who shares aspects of his or her identity? Does it mean that they carry biases toward people from different backgrounds or groups? Or is there some real and potentially

valuable connection that we feel with those with whom we share these commonalities?

The case example powerfully raises these questions—by turning on its head the more commonly raised scenario of a white patient requesting a white physician or expressing negative thoughts about a physician who is not white [1]. In the prompt, an African American patient, Ms. Smith, expresses greater comfort with an African American physician, Dr. Simms, than with Dr. Chen, her longstanding Asian primary care doctor.

Race and Patient Preferences: Plenty of Evidence, Fewer Answers

Soliciting and honoring patient preferences has become an increasing focus of our health care system—a core tenet of patient-centered care [2]. Ms. Smith states clearly her preference to be seen by an African American. She is not alone. When allowed to choose their physicians, patients, especially African Americans, tend to choose those of the same race or ethnicity [3-5].

This choice has an important impact on the health care experience and the delivery of care. Visits between race-concordant doctors and patients have been found to be longer and to correlate with greater patient satisfaction and physician engagement [3, 4, 6]. Many African American and Hispanic patients feel that race concordance positively influences a physician's empathy [7]. Furthermore, patients with race-concordant physicians, especially African Americans, are more likely to use needed services, including preventive care, and less likely to delay seeking care [8, 9].

This empirical evidence is bolstered by legal and ethical principles. The *AMA Code of Medical Ethics* [10] makes clear that patients have the right to choose their clinicians. An analysis in the *UCLA Law Review* that explored this issue came to a similar conclusion. The author argued that accommodating a patient's preference for a physician of a particular race or ethnicity is consistent with most prevailing medical ethical principles, including informed consent and respect for autonomy, and that no existing civil rights legislation could be used to bar this practice [11].

So why does selecting a physician based on race still make us uncomfortable? It's a matter of context. Our country's sordid history of race relations heightens our awareness when race enters into ethical decisions and the practice of medicine.

Were the patient in the scenario white, some of us would instinctively declare her racist. Is Ms. Smith any different? Had she merely said, "You know, I really like you. I mean, Dr. Chen is good, but sometimes I can barely even understand what he's saying"—we might be more inclined to acquiesce, believing the problem to be one of communication style and interpersonal relations. After all, poor communication can negatively affect the therapeutic relationship, and race concordance could lead to better outcomes and a better experience of care. But things change drastically when she continues, "You know? The accent? I mean, everywhere you go now it's immigrants." Here, Ms. Smith betrays her xenophobia.

This exchange highlights the importance, and subjective challenge, of perception. Our perceptions of a patient's beliefs impact our gauge of the validity, and the ethical ramifications, of acquiescing to his or her request. It is not Ms. Smith's request that bothers us, but rather our inference of the opinions that underlie this request. When we feel she is bigoted, our belief in the validity of her request instinctively decreases.

Where does this leave us with Ms. Smith? Evidence [3, 4, 6] shows us that if she is cared for by Dr. Simms, the quality of the care she receives, and her experience of care, will most likely improve. Could this added comfort be the reason she discussed her new mole with Dr. Simms during their first visit? Furthermore, her right to choose a race-concordant physician is consistent with several fundamental principles of medical ethics as well as existing legislation. Despite all of this, her comments have made Dr. Simms, and us, a little wary of her opinions.

Dr. Simms's Dilemma

At the center of this case is how we navigate our personal discomfort and negotiate a solution that is consistent with our values and Ms. Smith's expressed preference that she be cared for by a different physician. We believe Dr. Simms has two simultaneous imperatives that apply to any physician navigating this situation, regardless of physician or patient race.

The first is to respect the patient's articulated preferences. For the reasons outlined above, it is critical that Ms. Smith be able to select a physician of her choosing. The case brings to mind an encounter early in one of the author's (SJ's) internship in which a 76-year-old African American patient said, "it sure is nice to see a young Negro doctor." SJ is not African American and told the patient as much, but grasped that the patient might feel some added comfort being cared for by an African American physician. Patients are not required to feel equally comfortable with all clinicians, and we must try to understand the factors that contribute to this comfort and help patients find their way to clinicians with whom they are the most comfortable.

The nature of the primary care patient-physician relationship is such that if the patient enters into it half-willingly she may not have the trust in her physician that is necessary for a productive relationship. Ms. Smith expresses frustration with inability to understand Dr. Chen, something that can directly detract from their therapeutic alliance.

Dr. Simms's second imperative is to be consistent with his own values and feelings. He must address whether the patient's prejudiced views will impact his and his partners' relationship with the patient and impair their ability to provide high-quality, patient-centered care. Dr. Simms does not need to turn his relationship with Ms. Smith into a lecture on the importance of tolerance, but he should be free to express his discomfort if it could directly impact her care. Ideally, by discussing their

concerns with candor, Dr. Simms and Ms. Smith can understand each other's views and make a decision regarding her care that is consistent with both of their values.

Medicine's Dilemma

Above we offered our thoughts on how to manage a patient's preference for a race-concordant physician within the patient-physician dyad. It is equally important to consider how to manage these requests at the system level. Should hospitals and health systems institute policies for honoring or denying requests for race-concordant physicians?

As we discuss earlier, the personal and ethical challenges of these scenarios stem from our belief of the opinions that underlie a patient's request. Our health care system has neither the ability nor the resources to systematically assess these opinions. Any blanket policy, recommendation, or ethical guidance could hardly anticipate every situation. Furthermore, despite how uncomfortable it makes us, patients have the ethical and legal right to choose their physicians. Physicians, in turn, should be free to react to these preferences if they find them uncomfortable or objectionable, because they should be present in the encounter not merely as professionals but as people.

There are important exceptions and limitations. For example, we are told that the scenario takes place in a small town where concordance may not be possible. In settings where physicians are abundant, we believe that physicians and patients have more flexibility to choose one another. In smaller communities, where there are fewer choices, the obligation is greater to make the relationship work because patients do not have alternative sources of care.

If medicine is to truly embrace patient-centered care, we must try to match patients with the physicians with whom they will forge the strongest relationships and attain the best health outcomes. Race is just one dimension of the complex interplay behind the patient-physician relationship, but a meaningful one for many patients [12]. While we hope that society eventually arrives at a place where race is not part of this equation, for the time being, it is.

Conclusion

Acknowledging patient autonomy and the primacy of patient choice does not absolve us, as individual physicians or as a profession, of taking an active role in trying to alter the roots of Ms. Smith's preferences, and those of other patients for whom bigotry, racism, and xenophobia impact the choice of physician. The discomfort that comes from hearing Ms. Smith's request should not be met by passive acquiescence. Rather, it should serve as a reminder of the responsibility to use the position of medicine to expand cultural awareness, and continue to train all of our clinicians to provide culturally sensitive care. The fact that race concordance leads to better care is not a universal truth, but a modifiable outcome.

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THE CODE SAYS

AMA Code of Medical Ethics' Opinion on Disparities in Health Care

Opinion 9.121 - Racial and Ethnic Health Care Disparities

Differences in treatment that are not directly attributable to variances in clinical needs or patient preferences constitute disparities in health care. Among racial and ethnic minority populations, such disparities may contribute to health outcomes that are considerably worse than those of majority populations. This represents a significant challenge for physicians who ethically are called upon to serve patients without regard to medically irrelevant personal characteristics. The following guidelines are intended to help reduce racial and ethnic disparities in health care.

- (1) Physicians must strive to offer the same quality of care to all their patients irrespective of personal characteristics such as race or ethnicity. The provision of care should be customized to meet patient needs and preferences.
- (2) Physicians must learn to recognize racial and ethnic health care disparities and should examine their own practices to ensure that inappropriate considerations do not affect clinical judgment.
- (3) Physicians should work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients. Inappropriate discrimination toward any patient or group of patients must not be permitted.
- (4) Participatory decision making should be encouraged with all patients. This requires trust, which in turn requires effective communication. Physicians should seek to gain greater understanding of cultural or ethnic characteristics that can influence patients' health care decisions. Physicians should not rely upon stereotypes; they should customize care to meet the needs and preferences of individual patients.
- (5) Physicians should recognize and take into account linguistic factors that affect patients' understanding of medical information. In particular, language barriers should be minimized so that information is exchanged in a manner that both parties can understand.
- (6) Increasing the diversity of the physician workforce may be an important step in reducing racial and ethnic health care disparities. Physicians should therefore participate in efforts to encourage diversity in the profession.

(7) Physicians should help increase awareness of health care disparities by engaging in open and broad discussions about the issue in medical school curricula, in medical journals, at professional conferences, and as part of professional peer review activities. Research should continue to investigate health care disparities, including the development of quality measures.

Issued March 1992 based on the report “[Black-White Disparities in Health Care](#),” adopted December 1989; updated June 1994 and November 2005 based on the report “[Racial and Ethnic Health Care Disparities](#),” adopted June 2005.

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MEDICAL EDUCATION

Exploring Matters of Race through Dialogue in the University of Michigan Medical School's Longitudinal Case Studies Program

Katherine Bakke, Kartik Sidhar, and Arno K. Kumagai, MD

Teaching is the practice of freedom.

-Paulo Freire

In teaching medical students about the social determinants of health, too often do educators omit discussion of how clinicians themselves contribute to health inequity. It is far easier to shine a critical light on disparities that exist in access to care, safety in neighborhoods, and economic opportunity than it is to interrogate individual clinician's biases that inform his or her views about race, gender, sexuality, and economic class. Yet these are the conversations that all medical students should be having because such biases, conscious or not, contribute to patient health, frequently with negative outcomes. The challenge facing medical educators is how to engage medical students in conversations about bias effectively in order to instill a commitment to social justice and promote action toward the eradication of health disparities in the next generation of physicians. The following is an examination of the ways in which clinician bias against black patients affects health outcomes and how, through both student-driven and curriculum-mandated efforts, the University of Michigan Medical School is engaging its students in dialogue about bias and privilege and their impacts on patient care.

Race-Related Bias in Medicine

When considering the social determinants of health, physician bias is rarely cited as a possible contributor to the health disparities that exist between white and black patients. A growing body of literature suggests that physicians do not treat their patients impartially and that black patients, for example, often receive less aggressive medical treatment, are presented with fewer medical treatment options, and spend less time talking with their physicians during the clinical encounter [1-3]. Studies explicitly examining physician racial bias and disparities in decision making suggest that implicit bias can affect treatment decisions, patient satisfaction, referrals for interventional procedures, physician-patient communication, and the amount of information received from a physician during a clinical encounter [4-6]. Of note, Janice Sabin and colleagues found that physicians implicitly associated black patients with noncompliant behavior, despite reporting absence of explicit bias [7]. In a study by John Ayanian, physicians cited patient preference as an important reason why black patients are less likely than white patients to be evaluated for kidney transplantation in the presence of renal failure [6].

These studies do not examine the social and cultural aspects that may inform a clinician's belief that a black patient is more likely to be noncompliant or refuse treatment based on patient preference. In *Black and Blue: The Origins and Consequences of Medical Racism*, John Hoberman suggests that, in the post-civil rights era, physicians' description of African Americans' refusal to consent to certain kinds of treatment as "patient preference" fails to recognize that black patients have legitimate reasons to feel afraid of and disempowered by the medical system [8]. This lack of trust in clinicians and the system as a whole has been shown in qualitative studies documenting the experiences of African Americans with chronic illness [9]. Failure to probe deeper into a patient's refusal of a treatment, merely attributing it to personal preference, may appear innocuous, just as labeling a patient as noncompliant may appear to be a statement of fact instead of a judgment potentially rooted in stereotypes of African Americans as lazy. But it also shows a lack of personal insight into one's own biases; in these ways, health professionals inadvertently contribute to racial health disparities. However, it is here that conversations about bias stand to impact how medical students engage with future patients from all cultural backgrounds.

The conversation about physicians and racial bias demands space and opportunities for critical self-reflection and requires an admission that physician bias may contribute to disparities in levels of care. Instead of these uncomfortable confrontations, health care disparities are often attributed to other social determinants of health, such as the education system, the criminal justice system, and food policy [1]. Despite being another behemoth institution, medicine itself is left unexamined.

Given these circumstances, we assert that medical education has a responsibility to its students and their future patients to design and implement effective curricula for teaching social justice. These curricula should involve giving students space and opportunities to examine personal bias critically in an effort to help close health disparities based on race. Creating medical school curricula that effectively address racial bias is a huge challenge. These types of curricula are often regarded as "nonessential" or "add-ons" in both the minds of medical educators, who typically schedule sporadic islands of time for these discussions rather than aim for their cohesive integration into the curriculum, and medical students, many of whom work under the assumption that "if it's not tested, it's not important." Furthermore, the concept of "cultural competency" itself has been criticized as an overly simplistic, formulaic approach to diversity and culture that ignores issues of bigotry, power, and injustice in health care settings [10, 11]. Implementing an effective curriculum to address issues of racial identity, bias, and its impact on the health of black patients requires a cultural shift in medical education. Fortunately, the environment in medical schools today, largely due to the change in the students who occupy the lecture halls and hospital wards, is ripe for change.

Dialogue as Pedagogy in Medical Education

Medical students today are diverse in both educational background and experience. The past decade has seen a substantial increase in the number of students entering

the University of Michigan Medical School (UMMS) with undergraduate degrees in non-science fields and previous experience in service work benefitting underprivileged communities, such as Teach For America, Americorps, and Peace Corps (R. Ruiz, Office of Admissions, personal communication). These programs provide participants the opportunity to work directly with those whose circumstances differ from their own. More incoming medical students are now equipped with experiences to enrich discussion on race, identity, stereotypes, and bias within the context of medicine. The breadth of student experiences opens doors to a different style of pedagogy.

A potential solution to the naïve simplicity of “cultural competency” is to introduce a new style of teaching and learning in medical education: that of dialogue. Patricia Gurin and colleagues [12] explain that dialogue differs from the teaching in traditional educational settings in that it uses personal sharing and self-reflection in a small group setting with facilitators to guide the participants through thought-provoking and challenging activities. Dialogue is learner-centered rather than teacher-centered. When planned and executed correctly, dialogue-as-pedagogy has the ability to promote “understanding of one’s racial-ethnic, gender and other social identities as well as understanding those of others” [13].

What follows is a discussion of the conceptual underpinnings of this approach to teaching and learning about race, racism, bias, and privilege in medical education, as well as discussion of a specific program, the Longitudinal Case Studies course at the University of Michigan Medical School (UMMS), which implements dialogical principles in the education of future physicians about diversity and social justice. It should be emphasized that the use of race in this discussion is meant to serve as an example of teaching and learning about all kinds of diversity, including gender, ethnicity, sexual orientation, national origin, religion, and socioeconomic class.

The dialogic approach described by Gurin and colleagues has four stages. The first, “forming and building relationships,” encourages active listening and gaining trust within the group. The next stage, “exploring differences and commonalities of experience,” furthers group cohesion, creating comfort to challenge and learn from each other’s experiences. The third stage is “exploring and dialoguing about hot topics.” In medicine, these hot topics may include physician bias and privilege. Ideally, with the development of comfort among the group members during the first two stages, there is space and trust for participants to bring up their biases and privileges, even if it may be difficult to acknowledge. Because clinicians cannot afford to isolate themselves in the sterile world of science but must work in the chaos of everyday life, critical reflection and dialogue on such uncomfortable subjects is mandatory in the education of physicians. In fact, the very idea of discomfort is a major pedagogical tool used in this approach.

The final stage of dialogical learning, “action planning and collaboration,” moves learners beyond understanding to action, which is the ultimate goal of dialogue-as-pedagogy. Application can be as simple, yet as effective, as students having the skills

to reflect on their own emotions, biases, and privileges while interacting with patients to ensure they are providing the best care possible. Gurin and colleagues report that, after the dialogue course, students are more likely to say they would “recogniz[e] and challeng[e] the biases that affect my own thinking,” “avoid using language that reinforces negative stereotypes,” “challenge others on derogatory comments,” and “reinforce others for behaviors that support cultural diversity” [14].

While the dialogues described above were conducted with undergraduate students, the same can be done in medical education. A short dialogue series modeled after these four stages was designed and implemented by one of us (KS) over the course of one month at UMMS. Dialogue among a group of ten, mostly first-year, medical students was facilitated by a medical student (KS) and a class counselor. Overall feedback was positive (unpublished data), and students reported that they appreciated the space for in-depth conversation with their peers about issues of race, gender, socioeconomic status, and sexuality in regards to bias and privilege. Student participants unanimously voiced support for more sessions of the dialogue series and expressed openness to a long-term commitment to such a group.

The larger challenge is incorporating this approach into the formal curriculum. The major principles of dialogical learning have been implemented in a required, small group-based course for first- and second-year medical students at UMMS, the Longitudinal Cases (LCs) course.

The UMMS Longitudinal Cases Course

The best approach to address diversity and social justice in medical education is still contested territory. The notion of cultural competency—“achieved” through the memorization of “cultural characteristics” or learning of “special skills” for dealing with “special people”—has itself been problematized and subjected to critical inquiry [10, 11, 15, 16]. Instead, we assert that by incorporating ideas of critical reflection and understanding of the self, others, and the world into various aspects of the curriculum, a balanced and integrated understanding of bias, privilege, and their impact can be attained and applied to caring for patients.

Although developed separately from Gurin’s ideas, the theoretical framework underlying Gurin’s work finds resonance within the approach of the LCs.

Forming and building relationships. The small LC groups, consisting of 10-12 students and a physician-educator, are formed during the orientation week of medical school and meet on a biweekly basis throughout the first and second years [11]. Four additional meetings are held during the third year to bring clinical experiences into the discussions. Creating ground rules, decided upon collectively by each LC group, and maintaining continuity of contact with the same group of students and clinician educator over several years helps create a safe environment for difficult conversations and dialogues on contentious or sensitive subjects.

Exploring differences and commonalities of experience. The materials and activities used to support small group dialogues include individual narratives—from patients, students, and faculty [11, 17]—and works of fiction and nonfiction. Issues of disparities and injustice are also explored through the creation of artworks, which are used to challenge assumptions and to reflect on experiences of illness [18]. A major requirement in these interactions is to call upon all participants to reveal themselves in these dialogues—their beliefs, feelings, worldviews, values, and lived experiences—for it is only through engagement of the self that transformation of perspective can occur [19, 20].

Exploring and dialoguing about hot topics. In the LC small groups, controversy is not avoided, it is embraced. Medicine itself is a virtual minefield of “hot topics,” such as prejudice and discrimination, abortion, problems with access to care and insurance, immigration, religion and faith, and many others. Confronting unfamiliar experiences, ideas, identities, and perspectives creates a sense of “cognitive disequilibrium,” which fosters critical self-reflection and formation of a worldview that is more discerning, inclusive, and capable of change [11].

Action planning and collaboration. Small group discussions ideally should be designed to culminate in a commitment to address inequities and the fostering of skills to identify and engage institutional, community, and societal resources to implement change. The educational emphasis is not only on development of skilled communication, but also on advocacy; not only on an awareness of the impact of poverty on health, but also on specific steps to be taken with individual patients and with communities to alleviate suffering and optimize health.

Challenges

This approach to education in social justice is more complex than the standard notions of training in “cultural competency” and admittedly comes with many challenges. These challenges include the risk of further marginalizing already marginalized groups (particularly when members of these groups are put in the position of acting as “spokespersons for their people”), the dangers of developing a sense of moral relativism that could leave participants apathetic, instead of outraged, toward inequity, the prevailing view that these subjects are “soft” in contrast to the “hard” biomedical sciences, the lack of curricular time and space for reflection and dialogue, and the difficulties of assessing learning in this area [11].

The design of the LCs as they currently exist at UMMS faces additional challenges, such as variation in the quality of interactions between groups and resistance on the part of some students to considering dialogue and self-reflection necessary to their education. Moreover, the first two stages of dialogue—establishing trust and exploring difference—are not allotted significant curricular time due to pressures to quickly move forward to applying principles to patient care. This results in insufficient time for students to learn and reflect on their own social identities and bias. The lessons learned through these dialogues cannot be fit into a standard one-hour lecture; personal reflection takes more time and a different environment to

develop. It is not a skill or a “competency” that can be mastered, but an organic, ongoing process. Rushing through the foundational stages may diminish the full benefits that dialogue as pedagogy can offer to medical education.

Furthermore, teaching for social justice requires having both students and faculty work towards an understanding of their own social identities. Faculty development is crucial. By teaching faculty and students simultaneously, both ground-up and top-down approaches to social justice education can be implemented. Faculty development for the longitudinal case studies small groups has consisted of emphasis on facilitation skills as well as self-reflection and an approach that involves having faculty model the types of reflective interactions they wish for their students [11].

Conclusion

In the face of evidence that physician bias impacts health care, it is critical to evaluate not only institutional causes, but also those present in individual clinicians. Having the difficult conversations of understanding, accepting, and moving beyond biases can contribute to reducing some disparities in health care.

In the words of Brazilian educator and theorist Paulo Freire, “Human activity consists of action and reflection; it is praxis; it is transformation of the world” [21]. Ultimately, in contrast to the imposition of a fixed set of “cultural competency” standards on passive medical students-as-learners, the dialogical approach above all emphasizes their agency. It is designed to foster reflection, critical awareness, autonomy, and empowerment among all learners (both students and faculty) and instill in them the conviction that to act in a socially responsible manner as a physician is to implement change in the world.

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STATE OF THE ART AND SCIENCE

Complex Systems for a Complex Issue: Race in Health Research

Abdulrahman M. El-Sayed, MD, DPhil

Population health research has, as its main aim, characterizing the causes and consequences of health and disease. The process of rigorously testing hypotheses about what influences population health is challenging, particularly when considering the health effects of inalterable or potentially deleterious exposures. While the design, execution, and interpretation of population health experiments is itself arduous, trials are only even possible when the health effects of alterable, potentially beneficial treatments are being interrogated. By contrast, analyzing the effects of inalterable, potentially deleterious exposures is substantially more problematic. Absent the luxury of clinical trials, and given obvious ethical or logistical limitations, the enterprise has largely been limited to the analysis of large datasets derived by following individuals over time to attempt to identify the effects of these exposures.

Race is one such “inalterable exposure,” the rigorous study of which is methodologically complicated. Race is doubtless among the most important predictors of health in heterogeneous societies such as the United States, associated with myriad health metrics. Race is an important predictor of birth weight, gestational age, and risk of infant mortality [1]; it is associated with health behaviors that may influence health outcomes throughout life, such as physical activity [2] and health services access and use [3]; finally, race is a robust predictor of the timing and nature of the end of life, associated with age-specific, cause-specific, and all-cause mortality [4].

It is similarly clear, however, that race is a poorly defined and nonspecific term [5]. It is but a proxy for a number of other (possibly causal) factors that may relate to health. The growing literature that has identified consistent associations between race and health outcomes sheds little light on the mechanisms that produce those differences [1-5]. There are a number of plausible hypotheses. Biological scientists point to concrete differences in the observable phenotypes that differentiate racial groups and argue that there must be genotypic differences underlying these observed differences and, therefore, that there may also be genotypic differences underlying differences in health outcomes [6]. However, genetic variation within racial groups is substantially greater than it is between such groups [7], and the minimal variation between groups has not been shown to have substantial relation with health outcomes [8]. Nevertheless, potential differences in the distribution of risk alleles or the epigenetic modification of alleles by race remains a viable hypothesis for racial differences in certain health outcomes [6].

By contrast, social epidemiologists contend that race shapes health by way of a number of social mechanisms [9-11]. First, variation in the experiences of discrimination and xenophobia both between and among historically marginalized groups is predictive of differences in health outcomes among them [9]. For example, Geronimus observed that black-white disparities in birth weight increased with increasing maternal age at parturition [12, 13]. She reasoned this “weathering” of black relative to non-Hispanic white mothers represented the cumulative effect of lifelong exposure to a caustic social environment experienced by black, but not non-Hispanic white, mothers as they aged [12, 13]. Race also has implications for the social environments to which people are exposed, the ways resources are allocated, and ultimately, the health experiences of members of each group. Supporting these arguments in the health literature are consistent correlations between race, socioeconomic position, and health outcomes, such that marginalized groups are persistently disadvantaged and suffer the health consequences thereof [14-16].

Understanding the mechanisms that underlie the role of race in shaping population health is particularly challenging. How do we, for example, disaggregate the effects of discrimination from those of individual and contextual socioeconomic disadvantage when considering the etiology of racial differences in health? This is especially challenging because these factors are mutually reinforcing: discrimination has implications for educational attainment and income prospects throughout the life course, which shape the neighborhoods and locales—the environments—into which individuals of different racial groups select, which ultimately feed back into their social experiences [9, 17].

As inherited traits are fundamentally inalterable, we are left with observational epidemiologic studies to attempt to isolate the effects of these influences. However, our limited methodology, founded upon regression modeling, forces us to make increasingly less tenable assumptions to that end [18, 19]. For example, traditional health research approaches are beholden to the assumption that individuals are autonomous agents whose interactions with others do not influence the individual agent’s outcomes. But what is discrimination if not a process resulting from human interaction—the influence of one agent’s actions on another? Similarly limiting is the incapacity of observational approaches to efficiently represent context [20], conflating aggregate characteristics of the individuals residing in particular spaces with the environmental influences of those spaces themselves [21]. For example, studies demonstrating associations between neighborhood poverty and poor health cannot accurately differentiate between the influences of these neighborhoods and the influences of the characteristics of the individuals living therein [21]. This limitation prevents us from teasing apart the health implications of individual and context-level socioeconomic deprivation on the health of people in marginalized groups. Lastly, because observational studies only represent levels of exposure and outcomes at specified points in time, they cannot deal effectively with the reciprocity or feedback between exposures or between exposures and outcomes that we understand to be important in shaping racial disparities in health [18, 19].

Complex systems approaches may be particularly important for understanding the mechanisms underlying the influence of race on population health [18, 19]. Whereas traditional epidemiologic approaches are designed to test hypotheses about population-level associations between exposures and outcomes of interest, systems approaches are designed to test hypotheses about the dynamics that underlie the data. They force investigators to represent and test hypotheses about the mechanisms that produce population health and disease while freeing them of some of the problematic assumptions imbedded in regression models. By embracing, rather than ignoring, important factors such as inter-individual interactions, environmental influences, and reciprocity and feedback, these tools enable us to understand why race is so strong a predictor of differences in health.

One particularly promising systems method for health research about race is agent-based modeling [19]. Agent-based models simulate individuals with various attributes and preferences who interact with one another via dynamic social networks and who are situated in particular contexts to which they contribute and that influence their behaviors in turn. Agent-based models can account for an individual with her particular characteristics, the neighborhood in which she lives, as well as the network of friends and family she has—all changing dynamically with time, according to the joint behaviors of the agents in the model. Hence, these models allow investigators to consider the population-level consequences of individual-level behaviors, and the population-level dynamics they model emerge from the behaviors of the individuals the population comprises. Agent-based models have already demonstrated their utility in health research. Investigators have employed them to demonstrate the social mechanisms that underlie differences in such activities as walking behavior in an urban environment and to analyze the value of using social networks to mitigate obesity [22, 23].

Agent-based models hold particular promise for the study of race and health because they allow investigators to explicitly articulate, represent, and, therefore, test the social and biological mechanisms hypothesized to underlie influences of race on health. Rather than continuing to rely on race as a nonspecific proxy for a number of underlying exposures of interest, agent-based models allow investigators to represent each of these underlying exposures explicitly as aspects of agent attributes or behaviors. From socioeconomic characteristics and experiences of personalized or structural discrimination to the locus-specific alleles that shape genotypes, agent-based models allow investigators to deconstruct race to its core components to better understand each mechanism contributing to the systematic racial differences in health that we so routinely observe.

While agent-based modeling and complex systems approaches are fledgling methodologies in health research, they are well suited to characterizing the myriad influences of race on health. The benefits of these approaches are clear for investigators and policymakers alike. They allow investigators a more granular, hypothesis-based way to understand and disentangle the mechanisms that shape the racial differences we observe by enabling us to bypass several obfuscating

assumptions that limit our inference regarding the role of race in health. By deconstructing race in health research, we may better understand the dynamics that operate to produce race-related disparities in health and how mechanisms such as interactions, context, and feedback may be shaping them. For these reasons, complex systems approaches have important implications for policy as well. Equipped with a more comprehensive yet focused understanding of the dynamics underlying racial disparities, these approaches may provide policymakers interested in tackling these inequalities with better defined, more relevant levers on which to focus their efforts.

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STATE OF THE ART AND SCIENCE

Race, Discrimination, and Cardiovascular Disease

LaPrincess C. Brewer, MD, MPH, and Lisa A. Cooper, MD, MPH

It is now well documented that there are profound race-associated disparities among those who are affected by and die from cardiovascular disease (CVD) [1]. These disparities are deeply rooted within the history of race and medicine in the US. Blacks continue to have the highest burden of coronary heart disease (CHD) mortality among all ethnic groups in the US [2], despite an overall decline in CHD-related mortality among the general population [3]. Black patients also have a higher prevalence of CVD risk factors (e.g., diabetes, hypertension, hyperlipidemia, and obesity) than white patients [4]. This persistent incongruity has compelled investigators to look beyond traditional risk factors for CVD towards psychosocial risk factors in an effort to better comprehend and offer solutions to the issue [4]. Individual psychological stress has emerged as a potential nontraditional CVD risk factor that has garnered much attention [5]. There is a growing interest in elucidating how chronic exposure to racial/ethnic discrimination, a psychosocial stressor, contributes to observed CVD and cardiovascular care disparities.

Race as a Stressor

Racial and ethnic discrimination has been postulated as a multidimensional environmental stressor at the societal and individual levels. That is, there are physiological consequences of chronic exposure to fluctuating or heightened neural or neuroendocrine response that results from repeated or chronic stress. Over time, these stressful life experiences can have detrimental effects on the health of people in historically marginalized groups. There is now compelling evidence linking the perception of racism to cardiovascular health [6]. Race-related stress is perceived by many blacks as an influential factor towards their elevated CVD risk [6]. Whether personally or institutionally mediated, race-related stress may also increase the propensity to engage in negative health behaviors, which can have a deleterious impact on the management of multiple CVD risk factors by minority populations. There is a dearth of empirical data to truly encapsulate and assess the individual experience of chronic exposure to discrimination across the lifespan. Recent studies have examined novel measures of perceived racial/ethnic discrimination as surrogates of individuals' experience and awareness of race and their influences on CVD risk factors [7-9].

Race consciousness has been posited as a novel measure of perceived racism at the individual level that captures a heightened vigilance and anticipatory stress related to the threat of discrimination. Our study of a large sample of urban primary care patients (n=266) found that experiencing race consciousness was associated with

higher diastolic blood pressure and may be associated with higher systolic blood pressure among black but not white patients with hypertension [7]. Hicken and colleagues further examined the pathologic effect of racism-related vigilance, or chronic stress as a result of anticipation of or perseveration on racial discrimination, on hypertension [8]. They reported that blacks with the highest vigilance levels had a higher likelihood of hypertension than whites.

Prior studies investigating the effect of personally-mediated and internalized racism have been limited by the paucity of comprehensive measures encompassing the multiple dimensions of discrimination in varied domains (e.g., education, housing, health care). In an attempt to address this dilemma, Jackson Heart Study investigators assessed multiple measures of discrimination (including perceived everyday and lifetime occurrence, frequency, and attribution) and burden (extent of stressfulness and loss of productivity to one's life) and the relationship with hypertension prevalence among the African American cohort [9]. Higher quartiles of lifetime discrimination and burden of discrimination were associated with greater hypertension prevalence after adjustment for age, gender, and socioeconomic status.

Race Influence on Access and Quality of Care

Race-based discriminatory attitudes and behaviors by health care professionals may contribute to suboptimal diagnosis and management of CVD among patients from minority groups, particularly blacks. Additionally, entrenched institutional racism leads to inequities in access to and quality of health care. Studies have demonstrated pervasive disparities between treatment of blacks and whites in health care delivery in realms such as clinician adherence to prescribing guidelines, therapy intensification, and use of invasive cardiac procedures, even after controlling for clinical and socioeconomic factors [1].

Members of minority groups continue to experience inequities in the receipt of effective therapies for acute coronary syndromes, including cardiac catheterization, percutaneous coronary interventions, and surgical revascularization. Among patients presenting with acute myocardial infarction (MI), blacks are less likely to be admitted to medical facilities with revascularization capabilities and high-quality acute MI outcomes [1]. The authors of one study ascribed this disparity to unmeasured characteristics such as social and environmental barriers to care [10]. Furthermore, despite a number of national quality improvement initiatives such as the Get With The Guidelines-Coronary Artery Disease program, blacks have lower odds of achieving a door-to-balloon time of less than 90 minutes, a quality indicator in cardiac care, and see longer revascularization times than their white counterparts [11]. These reperfusion delays seem to be particularly worse for black male patients [11]. This warrants further investigation of the physician and system factors and other individual patient factors—beyond race—that perpetuate this disparity.

Cardiac clinicians, including cardiologists and cardiac surgeons are key players in the provision of appropriate and high-quality cardiovascular care, and many are unaware of the existence of racial/ethnic disparities in cardiac care. Among surveyed

cardiologists, only about one-third agreed that racial/ethnic disparities exist in cardiac care in the US, only 12 percent felt that they were in existence at their at own medical institution, and even fewer (5 percent), in their own patients [12]. Most thought-provoking was a lower perception of health disparities in the overall health care system and their own practice settings among clinicians caring for higher proportions of black and Hispanic patients. This may represent a lack of recognition among cardiac clinicians of race-based differences in their own delivery of care. One study showed a substantial variation by race and gender in referral of standardized patients with similar presentations of cardiac symptoms for cardiac catheterization [13]. This suggests a role for stereotyping or bias (whether conscious or unconscious) in physician decision making in the delivery of guideline-concordant care.

In addition, cardiac clinicians identified patient factors (e.g., nonadherence to therapy and health behaviors) as the greatest contributors to disparities in health care, rather than health system and individual physician practices [12]. Although many physicians reckoned that the majority of patients needed to adopt more effective self-management skills, more insight is needed among physicians in recognizing psychosocial risk factors (such as stress) that affect their patients' ability to do so. This is especially important because physicians play a critical role in educating, supporting, and motivating patients toward active participation in their own health care [14].

Race, the Patient-Clinician Relationship, and Adherence to Medical Therapy

The patient-clinician relationship can either promote or discourage patient engagement in self-management of chronic medical conditions such as CVD. The personal experience of racially discriminatory practices such as stereotyping and expressing prejudice in the health care setting can reduce patients' use of health care services and have a negative impact on patient adherence and satisfaction. Any impairment to the patient-clinician relationship through patient perception of discrimination can derail optimal health outcomes. Patients reported perceived racial discrimination by physicians during clinical encounters, ranging from subtle passivity or apathy towards reaching a diagnosis to more overt avoidance of touch, distressing and disrespectful [15]. Such physician behaviors ultimately led to a lack of trust of the medical infrastructure on the part of surveyed black patients with hypertension, which they postulated may be an important barrier to appointment attendance. Reactive medical nonadherence by such a high-risk patient population could further perpetuate CVD disparities.

But is patient refusal or rejection of medical advice or services driving cardiovascular health disparities? We would argue not so much, as patient refusal accounts for only a small proportion of observed racial variances [16]. It is more germane to address potential problems in patient-physician communication, the cornerstone to shared decision making and health outcomes. Blacks have been found to receive less patient-centered care as evidenced by less psychosocial and rapport-building and shorter medical visits than whites with similar CVD risk factor profiles

[14]. This may leave black patients at a disadvantage; they may receive inadequate medical counseling and have inaccurate perceptions about the seriousness of their medical conditions and the necessity of chronic therapy. This is of particular concern in CHD, because many of its risk factors (e.g., hypertension and hyperlipidemia) are asymptomatic until the development of potentially disastrous events such as acute MI.

Conclusion

An urgent need remains for research aimed at understanding the effects of experiences of race/ethnicity-based discrimination as psychosocial stressors on CVD risk and outcomes. This research could have a significant impact on future clinical and public health practice. Efforts are needed to educate physicians about race/ethnicity-based health disparities in cardiovascular care and the influences of psychosocial and environmental stressors on cardiovascular health. Additionally, medical education programs should help physicians develop skills to partner with and engender the trust of patients who are members of marginalized groups and to engage with community groups and organizations to identify innovative strategies to overcome health disparities.

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HEALTH LAW

The Racially Unequal Impact of the US Organ Procurement System

Richard Weinmeyer, JD, MPhil

In March 2007, state senators in South Carolina introduced legislation intended to address a tremendous problem facing the medical community. According to Senate Bill 480, the South Carolina Department of Corrections would be given the authority to reduce the length of a prisoner's incarceration period by as much as 6 months should he or she be willing to donate bone marrow or a kidney [1]. South Carolina's Senate Corrections and Penology Subcommittee approved the bill [1]. Democratic Senator Ralph Anderson, the bill's chief sponsor, stated that the legislation could be useful in beginning to address the nation's desperate need for viable kidneys and bone marrow, given the existing difficulties in persuading the American public to donate and that, if swayed, prisoners would most likely be happy to know that they had contributed to saving lives [2]. Proponents of the bill noted that it contained revisions to ensure that all donations were voluntary and that the state would ultimately determine which volunteers could and could not donate [3].

The bill did not proceed further in the legislative process. The federal law governing organ donation prohibits the exchange of human organs for "valuable consideration" [4], meaning anything of value, and the reduction of a prisoner's sentence by up to 180 days falls squarely within this statutory definition [5]. Critics of the proposed bill also decried the program as unethical and potentially dangerous. Lawrence Gostin of the Georgetown University Law Center stated that "for a prisoner to actually benefit from giving up an organ violates every ethical value I'm aware of" [3], while Jonathan Groner of The Ohio State University College of Medicine and Public Health commented on the higher incidence of HIV/AIDS, hepatitis, and tuberculosis in prisoner populations, saying "I don't think I would want a loved one to receive a 'prison kidney'" [2].

A less criticized (and less publicized) aspect of the program, however, was its racial undertones. In 2007, 65 percent of South Carolina's approximately 30,000 inmates were African American [6]. Senator Anderson, who is African American, proposed the prison donation program to address the historically low living donation rates among black men and women [6].

Efforts to meet the demand for organs have long had disproportionate effects on members of particular races, not only because of disparate levels of need for transplants but because of the way our donation system works.

The Altruistic Model

The current legal framework that determines how organs and tissues are obtained is guided exclusively by one principle: altruistic giving. For the last 30 years, Americans in need of organs or tissues have had to rely on the generosity of family, friends, and strangers to give of their bodies in life or in death.

The Uniform Anatomical Gift Act (UAGA) regulates the procurement of organs from cadaveric donors and establishes the legal and ethical guidelines for organ transplantation [7], all of which is based upon altruistic donation [8]. The original 1968 version of the UAGA did not specifically ban the sale of deceased-donor organs or discuss the matter of compensation, leaving the issue of incentives to case-by-case determinations at the state level [9]. In 1984, after the highly publicized actions of H. Barry Jacobs, a self-proclaimed organ broker who proposed creating organ markets that would buy and sell the kidneys of indigent populations from the US and the developing world [10], Congress enacted the National Organ Transplant Act (NOTA) to address the question of the compensation for organs and tissues directly [11]. Under NOTA, the buying and selling of organs is strictly prohibited—“It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce” [4]—with the penalties for this offense being \$50,000, imprisonment of not more than five years, or both [12]. This prohibition was incorporated into the 1987 revision of the UAGA and remains in the current version, which has been adopted by 45 states, Washington, DC, and the US Virgin islands [13].

The Organ Shortage

The altruistic model for organ and tissue donation, though admirable in its attempts to protect the populace from being exploited for their organs, has proven insufficient in developing a supply of organs and tissue that can be effectively and efficiently used. There are not enough organ donors to meet demand. This has multivalent racial implications. The organ shortage disproportionately affects members of some minority groups, in which there are higher rates of need for organs. Conversely, one reason for the organ shortage is that donation rates are particularly low among racial and ethnic minority groups, whose members have been historically less willing to donate their body parts than Caucasians [14]. Furthermore, attempts to increase the organ supply have ended up disproportionately targeting members of these same groups.

There are several hypothesized reasons for the low rate of organ donation among members of minority populations. One may be a lack of personal knowledge of a friend, family member, or acquaintance who has donated an organ, which might make people less likely to consider donating themselves: in one national study, African American respondents were three times less likely to report knowing a person who had donated organs or tissues than Caucasian respondents [15]. Other reported reasons for bypassing donation are the influence of religious or faith-based

objections to donating tissues or organs [16] and miscommunications between potential donors and their families about the intent to donate [17].

One of the most significant barriers to donation, especially in the African-American community, has been a distrust of the medical establishment [15]. One often-cited reason for this pervasive distrust is the looming shadow of atrocities like the Tuskegee syphilis study [18]. Scandals of that kind can engender fears that, if one has expressed willingness to donate organs, one will not receive needed medical care, so that one's death may be hastened or even that one's organs may be taken before death [15].

A Less Than Successful Alternative to Altruism: Presumed Consent

One widely used legal mechanism for increasing the supply of cadaveric organs seems to substantiate fears of unequal or exploitative treatment in the organ donation arena. This mechanism, which has been pursued for several decades, is enactment of "presumed consent" laws, where a state puts into place an opt-out donation process for certain people: those whose bodies come before coroners or medical examiners when there is no known objection by the deceased or by a family member [19]. Presumed consent laws have been implemented primarily for the authorized extraction of corneas, whole eyes, and other bodily tissues that can be harvested in a less invasive manner [20]. These laws first appeared in the 1960s as a response to shortages of organs and tissues needed for transplantation and other therapeutic purposes [19]. In some states that enacted presumed consent laws, corneal transplants increased substantially from a few hundred per year to more than a thousand transplants per year a decade later, and some states even ended up with more corneas than they could hope to transplant [21].

Although these laws appear to be neutral, in that they do not name any specific population, in practice, they disproportionately affect African Americans and Latinos [22]. An investigation by the *Los Angeles Times* into presumed consent laws and cornea removal unearthed startling statistics, reporting that 72 percent of autopsies were performed on homicide victims, with accident victims making up the second largest group of autopsies [23]. Especially in inner cities, young black and Latino men and women are at a greater risk for being the victims of violent crime, raising the chance that their bodies will come before coroners or medical examiners [22]. Indeed, 80 percent of those autopsied, meaning that their consent for tissue donation was presumed, were African American and Latino [23]. Only 16 percent of those autopsied were Caucasian [23]. As Michele Goodwin notes, "based on trends of death, gang violence, drug culture, and a host of other social problems that seem more concentrated in urban environments, it is not unforeseeable that legislative consent would disproportionately affect people of color" [22].

Presumed consent laws have increasingly fallen out of favor in the last two decades, not only because of their unequal impact on members of racial and ethnic minorities, but also because of objections by the families of the deceased, who have continuously challenged these laws in and out of court to prevent their loved ones'

tissues from being taken [19]. Presumed consent provisions were cut from the 2006 version of the UAGA, and many states subsequently followed this change in law [19].

Conclusion

The system in place for allocating organs and tissues in the United States has faltered. Too many sick patients have little-to-no access to the precious biological materials that can prolong their lives and end their suffering, and an overwhelming percentage of those patients are members of racial and ethnic minority groups. The current organ and tissue donation framework relies on altruistic giving, and many critics have called for reforms that create incentives for giving through monetary compensation to donors or to donors' families [24]. Increasing the supply of voluntarily provided organs (whether donated or sold) might be a more equitable alternative to presuming the consent of the already marginalized—but not if the very same people end up disproportionately selling their organs [25]. Whatever form the necessary legal changes take within the organ donation and transplantation arena, they will have to carefully balance the benefits and burdens they bestow on everyone and do their best to alleviate the current injustices.

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POLICY FORUM

Minority-Group Recruitment Goals in Federally Funded Clinical Research: What's in a Number?

Raegan W. Durant, MD, MPH

Last year marked the twentieth anniversary of the NIH Revitalization Act, which set forth guidelines for the recruitment of women and members of racial and ethnic minority groups in federally sponsored human subjects research. To address their longstanding underrepresentation in clinical research studies, the Revitalization Act mandated that members of racial and ethnic minority groups be enrolled in studies in adequate numbers to allow for “valid analysis” of differences among racial and ethnic subgroups [1]. Depending on the clinical research study context, this “valid analysis” may make it possible to achieve one of two methodological goals: either definitive testing of a priori hypotheses about race-related differences in study variables or outcomes or the discovery of novel race-related differences that could help generate new hypotheses about health disparities [2, 3].

In addition to these primary methodological goals, an ethical rationale for the mandate has also been highlighted: increased representation of minority groups in clinical research studies results in more equitable sharing of the risks and benefits of clinical trial participation [2, 3]. This goal of distributive justice in research participation may be particularly important in the context of some diseases, such as cancer or heart disease, in which trial participants have derived benefits such as improved survival compared to nonparticipants, even when accounting for demographic and clinical characteristics [4-6]. Since the Revitalization Act was issued, the Food and Drug Administration has also encouraged, though not mandated, investigators to increase minority group enrollment into clinical trials [7]. Despite these efforts to increase minority group participation in federally funded research, many clinical research studies still lack sufficient diversity among subjects to allow for any valid subgroup analyses [8-10].

Investigators have expressed concern that the Revitalization Act mandate inadvertently encourages misguided approaches to recruitment of minority group members [11]. To qualify for federal research funding, investigators are required to complete a target enrollment table (stratified by race, ethnicity, and gender) and to outline a brief explanation for these goals. Ideally, recruitment goals would be tied to clinical research objectives, but investigators admit to uncertainty about how the mandate should inform their recruitment goals [12]. Minority group recruitment goals can be based either on the group's representation within a disease population or within the general local population [13]. Methodologically, using a group's representation in a disease population or in a local population to guide recruitment of

its members may increase generalizability of study results to the broader disease population or local population [13]. From an ethical standpoint, either of these approaches would ensure some distribution of risks and benefits of trial participation in accordance with minority group representation.

Simply accruing a particular number of participants from racial and ethnic minority groups may actually have the unintended effect of increasing the burden of participation within a smaller sample population. Studies have demonstrated that clinical research participants are more likely to be insured, have access to clinical specialists, and reside in geographic areas of higher socioeconomic status [14, 15]. These patterns suggest that clinical research participants may represent a small, somewhat select population of people receiving care at institutions where clinical research is conducted. Within these institutions, investigators may repeatedly look toward an even smaller group of participants from minority groups in attempts to satisfy federal minority recruitment requirements. Conversely, those outside of the most accessible sample population are far less likely to be offered enrollment in a clinical research study. The result would be an inequitable distribution of opportunities for trial enrollment that would run counter to the distributive justice goal of the mandate.

A shift from a focus on absolute numbers to a broader consideration of the approach for minority group member recruitment may accomplish the Revitalization Act's goals more effectively. It may be beneficial for investigators to report their minority group recruitment methods in addition to enrollment goals. For example, a community partnership that gives members of a minority community an active role in conceiving and planning the research study might make them more likely to participate as equal partners in the research [16]. Extending opportunities for research to locations where larger proportions of patients from minority groups receive care would make research participation more accessible to them. The National Cancer Institute has adopted this approach in its Minority-Based Community Clinical Oncology Program, which has demonstrated increased minority group recruitment through engaging health care institutions that serve minority populations [17]. Federal funding agencies should continue to increase support for the testing of effective recruitment interventions, particularly through enhanced engagement of minority populations. Encouraging investigators to report minority group recruitment methods may increase their consideration of approaches aimed at expanding minority group engagement beyond the walls of more research-intense institutions and assuring a more equitable distribution of opportunities for research participation.

In addition to expanding the focus beyond the mere numbers of minority group members enrolled, investigators should consider sociodemographic factors other than race that contribute to health disparities. A narrow focus on race in setting recruitment goals can reify race as a reliable marker of biological or behavioral differences [18, 19]. Race is an imperfect social construct that may reflect some

differences in genetic lineages but confers few significant biological differences that impact study variables and outcomes [18].

Apart from the biological realm, race is also used to characterize groups presumed to share some common cultural norms and health beliefs, as well as exposures to environmental factors. However, the use of this imperfect construct is prone to stereotyping and misclassification not only of individuals, but also of the social environments that influence their health. Though reports on health disparities often associate certain deleterious traits or poor outcomes with particular racial or ethnic groups, other social determinants of health, such as education, income, insurance status, place of residence (e.g., rural or urban), are often more directly responsible for many of the differences observed [20]. The association of certain health outcomes with race is frequently due to the prevalence of other social determinants among members of particular racial or ethnic minority groups [20]. The need to disentangle the influence of race from that of other social determinants may be particularly important in clinical effectiveness and behavioral intervention studies, both research contexts in which participants' "real world" social environments can strongly influence study outcomes. Using race as the sole consideration for recruitment and subsequent subgroup analyses may lead to disparities in health status being inappropriately attributed to race or ethnicity instead of differences in other social determinants.

The goal of recruiting populations into studies to examine these health disparities may be better served by recruiting from sample populations in which there is significant variation in these other social determinants. Compared to factors such as income, education, or insurance status, race and ethnicity may be more readily identifiable traits for use in identifying particular groups for recruitment into clinical research studies. Yet investigators can enrich their study samples for other social factors related to poor outcomes by using clinical administrative data and area-level statistics to identify clinic- and community-based populations, respectively, for study recruitment. A direct focus on social determinants other than race could obviate the need to rely on race and ethnicity as proxies for the broader array of social determinants of health. As investigators shift away from race toward other social determinants of health disparities, federal funding agencies should encourage a parallel shift toward the consideration of social determinants when planning for study recruitment and pertinent subgroup analyses.

Over the last two decades, the Revitalization Act mandate has improved awareness among investigators of the importance of enrolling minority group members in clinical research studies. Though evaluating recruitment goals and study enrollment relies on the reporting of absolute numbers of individuals, the approaches to recruitment and enrollment should not be limited to reaching a distinct recruitment target group to the exclusion of considerations of other social determinants that contribute to health disparities. A dual focus on individual recruitment goals and proposed approaches for recruitment of minority groups and communities may better ensure that investigators have identified a reasonable means of achieving adequate

enrollment for valid subgroup analyses and expanding the distribution of research participation opportunities. When defining underrepresented subgroups deserving of special attention during recruitment, other social determinants of health bear consideration. The pragmatic focus on absolute numbers of minority group participants to allow for the examination of differences between racial and ethnic subgroups should evolve to include other elements that might be important to satisfying both the methodological and ethical rationales for the mandate.

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MEDICINE AND SOCIETY

Race: A Starting Place

Brooke A. Cunningham, MD, PhD

Health status, access to and quality of care, and numerous social factors associated with health vary across racial groups [1, 2]. Many applaud the collection and use of race data to identify and monitor progress in addressing health disparities [3-6]. The National Institutes of Health (NIH) requires and the Food and Drug Administration (FDA) recommends the collection of race data in clinical research [7, 8]; the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act provided financial incentives for health systems to collect race information through the Medicare and Medicaid Electronic Health Record Incentive Program (i.e., “meaningful use” of electronic health records) [9, 10]; and the 2010 Patient Protection and Affordable Care Act (ACA) mandated that the Department of Health and Human Services establish standards for race and ethnicity data collection [11]. Yet, in the face of increasing amounts of “race data,” we have created few opportunities for discussing “what race measures.” Some journals require authors to explain how race is conceptualized and collected in their studies, but the requirement is not standardized and rarely met [12-14]. Thus, race and racial data are frequently interpreted in conflicting ways. This article seeks to provide an overview of race as a foundation for an improved understanding of the relationship between race and health.

Many challenges await those who wish to consider the role of race in health outcomes critically. Careful consideration of race requires identifying and setting aside much tacit knowledge about race—those ideas that come easily, are taken for granted, and simply seem right. Although “race...appears obvious, intuitive, and in need of no special knowledge to discuss or analyze...[u]sing race in biomedical contexts requires great care and expertise” [15]. Such an approach is difficult because from childhood we learn the ways that racial groups are supposed to differ from one another [16]. Frequently the lesson has been that differences between the races are intrinsic or inherited, and those beliefs have justified discrimination against members of racial minority groups. Finally, it seems that, to many, newer understandings of race that have emerged from the social sciences seem less scientific, less reliable, and more political than the biological or genetic explanations that they seek to unseat [17].

Race has long been a system for classifying human beings according to easily discerned physical traits [18, 19]. There is debate over what race tells us and whether external markers of difference strongly correlate with important biological processes underneath the skin. Those who believe that race is highly informative about

underlying biology clash with those who understand race primarily as a social system of categorization. Members of both camps affirm that race is real. The latter draw on social science and describe race as a “social fact” and a social construct [20].

For social scientists and others, race is a social fact, because racial group membership shapes interpersonal relations and patterns opportunities and outcomes, and it is a social construct because human beings define race and those definitions vary over time and space. Race is contrasted with ethnicity, because the idea of race is grounded in ideas of biological difference, while the idea of ethnicity hinges on culture and differences in practices such as diet, language, and religion. As a system of stratification, in the United States, racial classification has historically shaped access to resources and opportunities to a much greater degree than ethnicity has. In addition, in lay discussions race is commonly considered fixed, while ethnicity seems more flexible and amenable to change [18, 19, 21].

To understand race as a social construct, it is helpful to review American history briefly. The idea of race emerged as justification for New World slavery in the seventeenth century and legitimized a social hierarchy that privileged whites [22]. At first, enslaved Africans “received treatment only marginally different from that afforded other members of the ‘lower ranks’” [23]. In the second half of the seventeenth century, slave laws were passed to secure the labor force for plantations and to prevent coalitions between black slaves and white indentured servants. Status differentials between blacks and whites solidified, and indentured servants from a variety of European nations began to see themselves as a “white race” for the first time [22]. As colonial governments granted privileges to even low-status whites that were withheld from all blacks, racial classification had real consequences. Thus it is not surprising that racial group membership became increasingly important to identity.

Because disparate treatment became custom and law, the government soon assumed the responsibility of tracking groups by race. The US government has collected data on race or color since its first census in 1790 [24, 25]. Since 1960, the gold standard for racial data collection has been self-reporting, after the Census Bureau discovered that, by relying on observation only, enumerators had significantly undercounted “nonwhites” [26]. Given their widespread use, the Office of Management and Budget race categories shape how individuals think about and report race in the United States, even though members of certain groups (e.g., people of Middle Eastern or South Asian descent) have expressed dissatisfaction with the available choices [27, 28].

Notably, rules for group membership have been inconsistently applied. From Reconstruction onward in custom and in the twentieth century by law, having any perceptible African ancestry led to classification as black through the practice of “hypodescent” [24, 29, 30]. In contrast, the federal government has historically set a minimum threshold for Native American ancestry that one had to meet in order to be

recognized as Native American [26, 31]. In addition, the response categories have changed over time. For example, Asians and Pacific Islanders were collected in one group in 1980; by 2000, they had become two groups. Data collection on multiracial heritage spanned the 1850 through 1910 censuses (e.g., mulatto, quadroon, octoroon) was then abandoned, and then reintroduced in the 2000 Census, which allowed individuals to select more than one race for the first time [25, 26, 29, 32].

Racial categories vary across the world [24]. Thus, identical twins separated and raised in different countries could end up identifying their race differently. Similarly, were we able to send a person back through time, his or her race might change. Social scientists point to this variation in racial categories across time and space to argue that race is a social construct [33]. Further support for the fluidity of race also comes from recent studies that show that some people report membership in different races at different times in their lives. The race that one selects often depends upon one's current social position [34].

These findings suggest that racial data reflect social rather than biological phenomena. However, because members of the same race, in aggregate, appear to be phenotypically more similar to one another than to members of other races, it is difficult to cast aside the idea that there may be important biological differences between groups. In addition, disease incidence, prevalence, and outcomes vary among racial groups. Although most researchers, health care providers, and policymakers acknowledge that differential exposure to social and environmental factors contributes to the variation among groups, many also strongly encourage investigation into underlying biological differences [35]. For them race is not just social; it's also biological, and thus may affect pathophysiology, drug efficacies, and norms for clinical test results.

Physicians have played and continue to play a role in how society thinks about race. During the antebellum period, many physicians' attributed poor health among slaves to their biological inferiority, rather than to their conditions of servitude [36]. Physicians' conclusions were supported by eighteenth-century Enlightenment scientists, such as Carl Linnaeus and Johann Blumenbach, who had extended their interest in taxonomy to rank humans by race [17, 37], and philosophers, such as David Hume and Immanuel Kant, who theorized that there were fundamentally different human types [38]. Until 2004, a Medline search for "race" under medical subject heading (MeSH) brought up "Racial Stocks," defined as "major living subspecies of man differentiated by genetic and physical characteristics" [39]. Today a search for "race" returns "Continental Population Groups," defined as "groups of individuals whose *putative ancestry* [my emphasis] is from native continental populations based on similarities in physical appearance" [40].

When clinical trials find differences in outcomes between racial groups, researchers tend to suggest a variety of possible biological and social mechanisms that may account for these differences. Often genetic differences are proposed, even though there is no genetic evidence for nonoverlapping or genetically homogenous racial

groups. Human genetic variation is *clinal*, which means that variation develops gradually and continuously over spatial gradients [41]. No one gene, pattern of genes, region of DNA, or set of “ancestral informative markers” reliably determines race [42]. Certain variants have been found to be more common in some groups than in others [43]. This occurs for a few reasons: (a) the variant or mutation is new; (b) an environment is conducive for that variant (positive selection); (3) gene flow has been partially restricted by environmental barriers (e.g., ocean, mountain range); or (c) the variant is tied to our common origins in Africa, which has the greatest overall genetic diversity [44].

In the midst of strong debates about biology and race, some researchers have carved out a middle ground. For them, race becomes “embodied” [45]. That is, there are not innate or inherent biological differences between races. Rather biological differences between groups develop over time as members of more disadvantaged or disparaged groups encounter greater stress [46, 47]. Greater exposure to socioeconomic disadvantage, discrimination, and other stressors may lead to greater activation of certain physiological mechanisms, such as the stress response, and different health behaviors. Greater activation of these physiological pathways, for example, may lead to increased cortisol levels, which over time may contribute to insulin resistance, obesity, hyperlipidemia, and hypertension [48, 49]. It is not that the pathways between groups are different; rather that individuals who regularly face greater psychosocial stress are more likely to have these pathways turned on.

In medicine, we create, interpret, and act on “race” data. Race is a complex demographic variable because it operates through multiple pathways to affect outcomes. When it is included in disease models, researchers and clinicians often state that race is a proxy for unmeasured social and biological factors. Part of our task is to develop and include robust measures of those factors for which race currently serves as a “stand-in” in clinical studies. To direct those efforts appropriately, we need to foster a critical and ongoing conversation about race among students, health care professionals and the larger scientific community. Race in medicine is “high-stakes,” and we need to proceed carefully and deliberately forward.

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HISTORY OF MEDICINE

The American Medical Association and Race

Robert B. Baker, PhD

“Race” has been a four-letter word in the United States for almost four centuries. It earned that status in 1619 when Dutch traders sold the first African slaves in Jamestown, Virginia, and continued to have that status after the passage of the Thirteenth Amendment in 1865, which officially ended slavery throughout the United States. By the mid-nineteenth century, the “peculiar institution” as slavery was called—the term “peculiar,” according to the *Merriam-Webster Dictionary*, derives from the Latin “pecus,” for cattle [1]—was largely based in the South and border states. When the Civil War ended with a Northern victory, the formerly enslaved people who had been treated like cattle—“freedmen,” as they were called at the time—came knocking on the door of American civil institutions requesting admission as equals, as fellow citizens. This essay narrates what transpired when an integrated group of Americans of African and European descent from Howard University, a newly founded institution for freedmen, and the associated Freedman’s Hospital (founded during the Civil War), knocked on the door of the American Medical Association (AMA)—and were repeatedly rejected. It then sketches the history of the AMA and African Americans from 1868, when the issue of race was first raised, until 2008—when the AMA publicly apologized for its century-and-a-half-long record of mistreating African American physicians.

The issue of admitting Negro physicians to the AMA first arose in 1868, in the aftermath of the Civil War, at the very moment when America was debating the Fourteenth Amendment, which forbids denying “to any person...the equal protection of the law” or depriving anyone of “life, liberty or property without due process of law” [2]. As it happened, the controversy at the AMA’s May 1868 national meeting was not initially about admitting Negro physicians but rather about admitting female physicians. In the spirit of the Fourteenth Amendment, the AMA’s Committee on Ethics ruled that since female physicians were qualified practitioners “according to the rules of reason unbiased by prejudice...[the AMA] has no right to refuse them [admission] simply on the ground of sex” [3]. Nathan Smith Davis, self-styled “father” of the AMA, objected to the committee’s recommendation. Injecting race into a discussion initially about gender, Davis argued that admission standards with respect to “sex or color” should be left to local societies and those denied membership “should not claim the legislative power of this Association to pass ex post facto laws for their especial benefit” [4]. Having stipulated that local medical societies should have a right to enact segregationist or sexist admission standards without interference from the national society, Davis moved that the matter be indefinitely postponed [5]. His motion carried, quashing the ethics committee’s

proposal that had upheld the right of qualified female physicians to be admitted to American medical societies and the AMA.

Nathan Smith Davis truly believed that he was the “father” of the AMA and had convinced the organization of that, even though, as the historical record attests, he did not actually propose or preside over the founding of the national medical society that became the AMA [6-9]. Nonetheless, Davis saw himself as a unifying force, responsible in the post-Civil-War era for reuniting the Northern half of the AMA with its alienated Southern brethren. From his perspective, controversies over who qualified for admission were an unnecessarily divisive matter, best decided at the local rather than the national level. In a series of debates over the admission of female and Negro physicians Davis urged “his” AMA to adopt a policy of deferring such issues to the local level. This would become the AMA’s policy until race- and gender-based discrimination was outlawed by the civil rights legislation of the 1960s.

Davis’s strategy of promoting national unity by leaving admission standards to local societies was directly challenged in 1870 at the AMA’s national meeting [8, 9]. The National Medical Society of Washington, DC, (NMS) and an integrated delegation of physicians from Howard University and the Freedman’s Hospital sought admission to the meeting. Leading the delegation was Robert Reyburn, a white former Union army officer, military surgeon, and the first dean of the Howard Medical College. His three Negro colleagues were Alexander Thomas Augusta, who was a Union army military surgeon, Charles Burleigh Purvis, and Alpheus W. Tucker. All four of these physicians were experienced and licensed to practice medicine who had received their medical training from allopathic medical schools, not from homeopathic or other alternative schools. Their integrated medical society, the NMS, had been founded in 1868-1869 because the established all-white Medical Society of the District of Columbia (MSDC) refused to admit Negro physicians. The NMS physicians had protested to Congress the MSDC’s practice of racial discrimination, and a congressional investigating committee confirmed that the all-white MSDC had indeed refused to admit Negro physicians “solely on account of color” [9]. This finding prompted an unsuccessful attempt by Republican Senator Charles Sumner to seek revocation of the MSDC’s charter.

Having rejected Negro physicians as members of their own society, the MSDC sought to block their admission to the AMA’s national meeting by charging them with “contempt of the organized Medical Society” by “attempt[ing], through legislative influence, to break down” the MSDC, because bringing charges of racial discrimination to the attention of the US Congress threatened the MSDC’s charter [10]. The NMS filed countercharges, accusing the MSDC of racial discrimination. The entire matter was then referred to the AMA’s Committee on Ethics, led by AMA President-elect Alfred Stillé of Philadelphia. Other members were Nathan Smith Davis, a delegate from the US Army (i.e., the Union army), and delegates from Delaware and Kentucky—both slave-holding border states during the Civil War.

Kentucky had recently enacted a segregationist “Black Code” legalizing racial discrimination [11].

The outcome of the dispute was predetermined by the members’ backgrounds: with the singular exception of Davis, the Northerners voted to admit both the integrated NMS delegation and the all-white MSDC delegation. The border state physicians, joined by Davis, voted to admit only the all-white MSDC society members. On its face, the issue was black and white: the whites-only society was in; the black-and-white society was out.

So Davis and his border state colleagues wrote a report justifying their acceptance of the segregationist all-white medical society and their rejection of the integrationist society. The Northerners answered by writing a minority report. The majority report stated that the Congressional determination that the MSDC had discriminated against admitting qualified physicians solely on account of color or race was “not of a nature to require the action of the American Medical Association,” because the alleged conduct “does not come into conflict with any part of the [AMA’s] code of ethics” [12]. The minority report held that since both the Negro and white “representatives of the National Medical Society, [and] the Howard Medical College...are qualified practitioners of medicine who have complied with all the conditions of membership...no sufficient ground exists for the exclusion of such institutions and physicians” on the basis of the AMA’s *Code of Medical Ethics* [13].

A vote was called to decide the question of which report to accept. By an overwhelming majority of 114 to 82, AMA members voted to deny admission to the integrated NMS delegation and to admit the delegates from the segregated MSDC [14]. A second vote was then called on a motion “that no distinction of race or color shall exclude from the Association persons claiming admission and duly accredited thereto” [15]. This motion was defeated 106 to 60 [14]. The AMA had put itself on record as rejecting racial integration. And then, by a feat of parliamentary legerdemain, the AMA voted to expunge the vote from the official record on the grounds

that inasmuch as it has been distinctly stated and proved that the consideration of race and color has had nothing whatsoever to do with the decision of the question of the reception of the Washington delegates...the report of the majority of the Committee on Ethics be declared, as to all intents and purposes, unanimously adopted by the Association [15].

This motion passed 112 to 34.

This whitewash could not cover up the evident racial issues. An 1870 *New York Times* headline on the AMA’s vote read, “The Doctors: The Question of Color” [16]; the *Boston Medical and Surgical Journal* (now known as the *New England Journal of Medicine*) that same year characterized it as “a muss over the question of giving

the Negro doctor his rights” [17]. In his 1871 address Alfred Stillé, the AMA’s next president, deplored the fact that “the colored physician, and even his white representative, [was] refused admission upon the ground that the proposal is an outrage to the Association and a personal insult to many of its members” [18], i.e., because Southern whites found the admission of Negroes an insult to their organization. In 1871 a white commentator observed in the *National Medical Journal* that the real question facing the authors of the majority report was “how were these colored men who claimed admission to be excluded, and yet make it to appear that they were not excluded on ground of color? Nothing less would please or satisfy the southern brethren and their sympathizers, and yet the thing was somehow monstrous, and would need a plausible excuse before others” [19]. This white commentator continues.

In all the [Civil] war I did not see a more acute attack of judicial hardening. I can conceive of how men may dispute the political status of the Negro...[yet] when a man of certified competence and character knocks at the door of a great national association, claiming to represent legitimate practice, and because of his color a body like ours goes manipulating about for some excuse to keep the man out, it is too trivial and sad to record. Why, that question was decided long ago. The equalities of science are older than that of politics...I doubt whether in the last fifty years, a national scientific society has convened anywhere that would have excluded a competent scientist on the ground of color, and least of all should a medical man take such a stand...We degrade not him but ourselves by such breaches of the law of ethics which indwells in science [20].

Any lingering doubts about whether race was an issue in the 1870s vote were removed in 1872, when Robert Reyburn again presented his credentials to the AMA as a delegate representing the integrated institutions of Howard University and the Freedman’s Hospital. A committee on ethics again refused to recognize his credentials, contending that Howard had been deemed in violation of the AMA’s code of ethics in 1870 and that, furthermore, Howard violated the AMA *Code of Medical Ethics* by allowing women to serve on its faculty [21].

Reyburn replied in a short speech.

Howard University...received all who applied for medical education, without distinction of color or of sex.... If the [American Medical] Association sees fit that institutions of that class shall not be represented, of course they have the power so to act, but, at the same time, they should consider well what they were doing before taking such a step [since] every human being should be allowed the right to the very highest development that God has made him capable of [22].

After the debate the AMA voted yet again to refuse to recognize the integrated DC medical institutions.

In 1873 and 1874, Davis fully implemented a stringent version of his “local” strategy, according local societies the prerogative of determining criteria governing membership in their organizations. State societies in the North would be free to integrate, Southern societies would similarly be free to segregate, and the national union of medical societies known as the AMA could pursue its business untroubled by issues of race or gender. This meant that segregationist state societies could freely discriminate against Negro physicians without violating the rules of the national society.

As a direct consequence of the AMA’s decision to preserve institutional tranquility by trading away the civil rights of Negro physicians, Negro physicians were denied membership in state, county, and municipal medical societies throughout the American South and in many of the border states. Exclusion from these medical societies meant more than just professional isolation; it also restricted access to training and limited professional and business contacts. Worse yet, since membership in a state medical society was required by most Southern hospitals, it resulted in the denial of admitting privileges, which, in turn, erected barriers to board certification and advancement in the profession [23]. To secure reunion with the well-established (white male) medical societies of the South, the AMA dashed Negro dreams of equality and the integrationist ideals of returning Union Army soldiers like Reyburn, shamefully wrapping discrimination in sophistry as it did so.

The AMA’s policy of tolerating racial exclusion was pivotal in creating a two-tier system of medicine in the American South and border states—racially divided, separate, and unequal. Within a decade African American medical societies were founded as an alternative [24, 25]. In 1895 these societies banded together to form an African American alternative to the AMA, the National Medical Association (NMA). In the words of one of its founders, the NMA,

conceived in no spirit of racial exclusiveness, fostering no ethnic antagonism, but born of the exigencies of the [segregated] American environment...has for its object the banding together for mutual cooperation and helpfulness, the men and women of African descent who are legally and honorably engaged in the practice of the cognate professions of medicine, surgery, pharmacy and dentistry [26].

The AMA’s whitewash of its actions became more effective with the passage of time. Abetted by the characteristic American indifference to history, by the twentieth century the AMA had blinded itself to its own complicity in racial discrimination. Thus in 1933 the AMA unblushingly protested “persecution in Germany” [27], voicing its opposition to Nazi discrimination against Jewish physicians and “condemn[ing] the persecution of any individual on account of his race or religion by any state or under any flag” [28]. Nonetheless the AMA tolerated institutional racism

in its affiliated societies. On more than a dozen separate occasions, starting in 1939 and repeated in 1944, 1948, 1949, 1950, 1951, 1952, 1963, 1964, 1965, 1966, and 1968, the AMA reiterated its condemnation of racial discrimination and yet, in very same year, invoked Davis's "local autonomy" principle to vote against motions prohibiting racial discrimination by member medical societies [25].

Institutional racism insidiously cloaks racial discrimination in the innocence of the accidental. Thus the network of institutional rules created by Davis obscured the impact of the AMA's policy of inaction so effectively that the association could at once condemn racism and yet fail to prohibit, or even acknowledge, the racial discrimination practiced by its own affiliates. One Negro physician likened this to

a man who is standing on the shoreline watching a fellow-man floundering in the sea and proclaiming to the world...that he does not believe in drowning. This alone does nothing for the man in the sea....Their conscience maybe eased so that they can sleep at night...but, it takes...positive action to rescue those caught in the sea of discrimination [29].

Rescue from the "sea of discrimination" for African American physicians came, not from the AMA, but from the African American community itself: from the NAACP (National Association of Colored People, founded 1909), the SCLC (Southern Christian Leadership Movement, founded 1957), and affiliated groups that organized the 1963 March on Washington, paving the way for the civil rights legislation of the 1960s that ultimately forced the AMA to cease tolerating racial discrimination.

It was not until a half-century later, however, that another physician named "Davis," AMA President Ronald Davis, commissioned an independent panel, the Writing Group for the History of African Americans and Organized Medicine [30], to analyze the AMA's history on issues of race. This group was convened in 2005 and delivered its report to AMA board in 2008. On July 30, 2008, Ronald Davis, by then the immediate past president of the AMA, met with the NMA members in Atlanta to offer an apology. "I humbly come to the physicians of today's National Medical Association, to tell you that we are sorry...on behalf of the American Medical Association, I unequivocally apologize for our past behavior. We pledge to do everything in our power to right the wrongs that were done by our organization to African-American physicians and their families and their patients" [31]. A formal written apology had appeared earlier in the *Journal of the American Medical Association* [32].

Davis summarizes the Writing Group's findings [33] as follows:

In an article published in this issue of *JAMA*, Baker and colleagues—review and analyze "the historical roots of the black-white divide in US medicine." This panel of experts, convened and supported by the AMA, found that (1) in the early years following the Civil War, the

AMA declined to embrace a policy of nondiscrimination and excluded an integrated local medical society through selective enforcement of membership standards; (2) from the 1870s through the late 1960s, the AMA failed to take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships—practices that functionally excluded most African American physicians from membership in the AMA; (3) in the early decades of the 20th century, the AMA listed African American physicians as “colored” in its national physician directory and was slow to remove the designation in response to protests from the National Medical Association (NMA); and (4) the AMA was silent in debates over the Civil Rights Act of 1964 and put off repeated NMA requests to support efforts to amend the Hill-Burton Act’s “separate but equal” provision, which allowed construction of segregated hospital facilities with federal funds.

These dishonorable acts of omission and commission reflected the social mores and racial segregation that existed during those times throughout much of the United States. But that context does not excuse them. The medical profession, which is based on a boundless respect for human life, had an obligation to lead society away from disrespect of so many lives. The AMA failed to do so and has apologized for that failure [34].

Apologies in themselves cannot right past wrongs, but they do indicate that those responsible acknowledge that a wrong was committed, that they feel ashamed of their role in committing it, that they resolve not to commit such wrongs in the future, and that they will attempt to rectify the wrong as best they can. Apologies offer an opportunity for progress—but only if one understands why an apology was needed. I end these reflections with a quotation from a fellow philosopher—George Santayana—who famously observed that “progress, far from consisting in change, depends on retentiveness.... Those who cannot remember the past are condemned to repeat it” [35].

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Disclaimer

I have collaborated with colleagues from the Writing Group for the History of African Americans and Organized Medicine to narrate versions of this tale elsewhere, and, although I acknowledge my intellectual debt to these colleagues, this is my personal version and neither the AMA nor the Writing Group is responsible for its contents.

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OP-ED

In Defense of Affirmative Action—By Any Means Necessary

Shanta Driver, JD

In April 2014, the Supreme Court ruled that Michigan voters' amendment to the state constitution, an amendment that bans affirmative action, does not violate the Fourteenth Amendment to the US Constitution. The Court's decision in *Schuette v. Coalition to Defend Affirmative Action, Integration, Immigrant Rights and Fight for Equality By Any Means Necessary* (BAMN) [1] will have a profound effect on race relations and this nation's continuing battle for racial equality. The decision robs the Fourteenth Amendment of one of its core intents—securing the “right of all citizens to participate meaningfully and equally in the process through which laws are created” [2].

Schuette v. Coalition was filed by BAMN in November 2006, the day after Michigan's largely white electorate voted to institute a state constitutional ban on affirmative action policies through a ballot initiative called Proposition 2. Michigan's electorate is 85 percent white [3]. Two out of three white voters voted for the ban. Nine out of ten black voters opposed the ban [3]. If every minority voter in the state had voted against Proposition 2, it still would have passed because of the large majority of white voters.

The campaign to get Proposition 2 passed in Michigan began less than two weeks after the Supreme Court ruled in *Grutter v. Bollinger* that the use of race-based affirmative action at the University of Michigan's Law School was not only constitutionally permissible, but essential to maintaining a critical mass of students from underrepresented groups at the UM Law School.

Anti-Equality Propositions, Educational Opportunities, and Health Care

Proposition 2 was modeled on Proposition 209, which was passed in California in 1996 [4]. The impact that Proposition 2 would have on enrollment of underrepresented minority group members was known before the vote in Michigan occurred. In California, Proposition 209 cut enrollment of students from underrepresented minority groups at the University of California, Berkeley and at UCLA by 40 percent or more [5, 6]. Despite extensive outreach, mentoring, and recruitment efforts and the implementation of socioeconomic affirmative action, the proportion of students from underrepresented groups at California's highest ranked and most selective public universities remains 30-40 percent lower than it was when affirmative action was legally permissible [5]. Enrollment of students from underrepresented minority groups at the University of Michigan has also plummeted. Black student enrollment has dropped by 45 percent since 1998 [7], when the

University of Michigan (UM) was sued for their use of affirmative action in undergraduate admissions.

Proposition 209 and Proposition 2 have a particularly bad effect on the admission of students from underrepresented minority groups in medical and law schools. The percentage of such students in University of California medical schools declined by 43 percent in 1995-1996, the first year that the ban on affirmative action was implemented. That percentage remained the same five years later [8]. Proposition 2 had the same disastrous effect on black, Latina/o, and Native American student enrollment at Michigan's medical and law schools [9, 10].

Any decline in doctors from minority groups will have a direct, immediate, and harmful effect on the care that members of minority populations receive. Doctors from minority groups serve 54 percent of patients from minority groups, 70 percent of non-English-speaking patients, and a disproportionate number of poor and uninsured patients [11, 12]. In California, where 36 percent of the population is Latina/o, only 5.2 percent of the doctors are Latina/o [13]. Only 4 percent of the doctors in Michigan are black [14]. If national trends are anything to go by, these doctors are concentrated in Detroit, Flint, and other overwhelmingly poverty-ridden cities with majority-black populations, serving patients with high rates of acute health problems [11].

Minority communities are already underserved. The loss of affirmative action will only make the marked disparity in access to health care between minority-group and white Americans more acute. The Supreme Court's allowing these bans to stand, opens the door to the enactment of laws akin to the voter registration laws that, without explicitly prohibiting black citizens from voting, swiftly disenfranchised them in the Reconstruction-era South—in effect, Jim Crow laws. This means the growing inequality in educational opportunity, the disparities in health care, and the rising segregation of neighborhoods and schools will continue unabated.

The Meaning of *Schuetz*

State constitutional bans on affirmative action have reified and reinforced unfair and insurmountable burdens on minority communities. As Supreme Court Justice Sonia Sotomayor wrote in her dissenting opinion on *Schuetz*,

the majority of Michigan voters changed the rules in the middle of the game, reconfiguring the existing political process in Michigan in a manner that burdened racial minorities. They did so in the 2006 election by amending the Michigan Constitution to enact Art. I, §26, which provides in relevant part that Michigan's public universities "shall not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, public education, or public contracting."

As a result of §26, there are now two very different processes through which a Michigan citizen is permitted to influence the admissions policies of the State's universities: one for persons interested in race-sensitive admissions policies and one for everyone else. A citizen who is a University of Michigan alumnus, for instance, can advocate for an admissions policy that considers an applicant's legacy status by meeting individually with members of the Board of Regents to convince them of her views, by joining with other legacy parents to lobby the Board, or by voting for and supporting Board candidates who share her position. The same options are available to a citizen who wants the Board to adopt admissions policies that consider athleticism, geography, area of study, and so on. *The one and only policy a Michigan citizen may not seek through this long-established process is a race-sensitive admissions policy that considers race in an individualized manner when it is clear that race-neutral alternatives are not adequate to achieve diversity.* For that policy alone, the citizens of Michigan must undertake the daunting task of amending the State Constitution (emphasis added) [2].

Campaigning for a second statewide constitutional referendum is an extremely difficult and costly endeavor. In Michigan, even if minority communities and other pro-equality citizens were able to gather the signatures needed to get a new initiative on the ballot, I see no way that such a measure would pass. At a moment when only one out of every seven applicants is accepted by the University of Michigan [15], white voters would be very unlikely to give up any advantage that benefits their children, no matter how unfair or unjust.

The Supreme Court's decision holding that a majority-white state electorate can ban measures to level the playing field means that we will have what amounts to legally sanctioned Jim Crow. The promise of equal opportunity for all will be rendered obsolete. At the very moment that America's population is poised to become no longer majority-white [16], inequalities that negatively affect Americans of other races will be protected by law.

The Meaning of Affirmative Action

Affirmative action was an acknowledgement by the government and the society at large that the only way to end institutional racism was through taking positive, conscious action. Affirmative action policies were won through the mass protests of the powerful civil rights movement of the 1960s led by Dr. Reverend Martin Luther King Jr. In 1965, when Dr. King brought the movement to the North to tackle de facto segregation, affirmative action policies provided the conscious action needed to redress the institutional racism and segregation that was as pervasive in the North as it had been in the old Jim Crow South. Winning affirmative action was the highest achievement of Dr. King's movement because it established that institutional racism had been created by conscious political and social governmental policies and decisions and should be ended through legal action. The winning of affirmative

action measures showed that the growing power of the civil rights movement could win both equality under the law and equality in results.

The assertion of black equality by Dr. King and the movement he led had a profound effect on the black ghettos of the North and on college campuses. It took the urban uprisings of the 1960s—the riots in Watts, Detroit, Newark, and so on—to win the adoption of the first government-sponsored affirmative action policies [17]. Student strikes united the mass, powerful campus antiwar movement and the black student struggles to open up the universities to black, Latina/o, other minority-group, and white working-class and poor students and forced university administrations to adopt affirmative action policies. By the early 1970s, affirmative action policies were extended to include students who were Latina/o, Asian, Native American, and members of other minority groups, and female, poor, and working class students of all races became beneficiaries of affirmative action. The loss of affirmative action in just a few states is rapidly reversing these gains.

Conclusion

America is changing. We are on the cusp of becoming a truly diverse nation. This phenomenon puts this nation at the crossroads of two very different paths. If we follow one path, we can bow to the fears of the many white Americans who see the increasing plurality of our society as a threat to their privilege and power. In my opinion, the right-wing attack on affirmative action, fuelled by desperate attempts to preserve white privilege, can only lead to the kind of social convulsions that gave birth to affirmative action in the mid-1960s, except this time on a greater scale.

Or we can choose the other path and continue the difficult but inspiring struggle to win equality, freedom, and democracy for everyone who calls America home. If we recognize and pledge to struggle against the poisonous and distorting effects of racism and the growing disparity between rich and poor, we can lift society from the cynicism, pessimism, and racial and political polarization that is keeping us divided and suspicious. We need the new, youth-led integrated civil rights and immigrant rights movement to grow and exert influence on this society. There is a place in the movement for every person who welcomes the opportunity to live in a multicultural America true to our core values. BAMN invites all who believe in the limitless potential of humanity and who are eager to shed their sense of alienation to join us in this historic march to save our nation. We promise you that you will not regret it.

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Shanta Driver, JD, is the national chair of the Coalition to Defend Affirmative Action, Integration, and Immigrant Rights and Fight for Equality by Any Means Necessary (BAMN). She gave the oral argument for BAMN to the Supreme Court in *Schuetz v. Coalition*; was the legal architect of the successful student intervention into *Grutter v. Bollinger*, the University of Michigan Law School case in which affirmative action was upheld by the US Supreme Court in 2003; and led BAMN's successful 2009 campaigns against anti-affirmative action referenda, among others. In addition, she handles labor, police brutality, and sexual harassment cases.

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OP-ED

Questioning the Rationale for Affirmative Action

Abigail Thernstrom, PhD

Affirmative action cases raise fundamental normative questions about American society and the place of ethnic and racial groups in it. Judges struggle to answer those questions within the narrow confines of legal precedents. In so doing, they make problematic assumptions about group identity and the best way to achieve equality of opportunity. These assumptions are: that a diverse student body is a “compelling interest” that has educational benefit and improves race relations, that racial diversity is a useful proxy for diversity more broadly understood, and that legally sanctioned race-based preference in higher education admissions is the best, or only, way to address the problem of the racial gap in learning, evident in the early grades of elementary school [1].

These problematic assumptions date back to the 1978 *Regents of the University of California v. Bakke* decision. Justice Powell, writing for the US Supreme Court, argued that it was legitimate for a school to make admissions decisions aimed at producing a “diverse student body” – what he called a “compelling governmental interest” [2]. Race could thus be taken into account as a “plus” factor in deciding which candidates to admit into institutions of higher education. But what did “diversity” mean? In the Court’s 2003 decision on *Grutter v. Bollinger*, diversity was defined as a “critical mass” of students from non-Asian minority groups [3]. And why has its meaning in Supreme Court decisions always been confined to race? Ideological diversity, for example, is not part of the definition of the diversity relevant to educational quality. That argument, of course, rested on the very stereotyping that the Fourteenth Amendment was supposed to bar—the notion that racial differences are a proxy for differences in what *Bakke* called “points of view, backgrounds, and experiences” [4].

Furthermore, the entire edifice of race-conscious admissions is built on a purely speculative promise that “diversity” will bring educational benefits. In the 2013 case *Fisher v. University of Texas, Austin*, Justice Anthony Kennedy claimed that “the attainment of a diverse student body...[enhances] classroom dialogue and the lessening of racial isolation and stereotypes” [5]. In *Grutter*, Justice Sandra Day O’Connor said more black and Hispanic students promoted cross-racial understanding and made for lively classroom discussion and more learning [6]. The theory that interracial contact combats racial stereotypes and increases the likelihood of interracial friendships has been discredited by more than half a century of research [7, 8]. Whether in former Yugoslavia or in Lebanon, mere contact between people of different racial and ethnic groups has clearly not reduced the likelihood of ethnic

tension and conflict. Simply bringing people who identify with different groups together in the same room, as it were, isn't a recipe for greater harmony and mutual respect [9]. Indeed, most whites and blacks in the Deep South before *Brown v. Board* [10] were in constant contact, far more so than they were in northern states.

Only under special circumstances does the contact theory work as we hope it will; Jackie Robinson earned the respect of teammates and Dodgers fans but he earned his status as a star by more than meeting the standards applied to white players. He was no beneficiary of racial engineering by well-meaning but misguided whites.

Much evidence suggests that race-based double standards in university admissions increase the self-doubt of minority students about their abilities to succeed academically and decrease their incentive to work hard, knowing they might continue to receive special treatment in admission to professional schools and in the workplace [11].

Lastly, we come to the matter of equality and inequality. The *Bakke* decision is perhaps best known for Justice Harry Blackmun's famous dictum in a separate opinion that "in order to get beyond racism, we must first take account of race. There is no other way. And in order to treat some persons equally, we must treat them differently" [12] This vaguely Orwellian notion that it was necessary to treat some persons "differently" in order to treat them "equally" had already, by 1978, become civil rights orthodoxy, and remains one of the crucial assumptions behind all affirmative action programs. Almost all institutions of higher education violate the *Bakke* standard that race can serve as an added consideration or simply a "plus" factor. Given gaps in academic performance between members of different racial groups [1], if a school wants a significant black and Hispanic presence, it cannot judge candidates from non-Asian minorities by the same standard used for white and Asian candidates and then consider minority group membership as a "plus" factor. Thus at almost all highly selective colleges and other institutions of higher education blacks and Hispanics, too often with weaker academic profiles, are given preference in the competition for admission.

But are race-based preferences in higher education admissions—racial double standards—the best way to address the racial gap in educational achievement? Asian Americans are on the losing end; preferences for blacks and Hispanics reduce the number of classroom seats for which they can compete, and in California they are beginning to rebel—a grassroots movement, including thousands of petition signatures and a flood of calls to lawmakers, has forced the tabling of a ballot referendum to reinstate the racial preferences measure [13]. Of course, if K-12 education did a good job at educating all students, there would be no need for admissions standards that vary with the color of a student's skin.

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Suggested Readings and Resources

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