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Review Article

Views on Racial and Ethnic Equality in Health Care and Research

Silbermann M[1], Rassouli M[2], Mwaka AD[3] and Gafer N[4]*

[1]*Middle East Cancer Consortium, Israel*

[2]*Shahid Beheshti Univ. of Medical Sciences, Iran*

[3]*Makerere University, Uganda*

[4]*Radiation and Isotope Centre, Sudan*

Abstract

The present article deals with the still existing inequalities in health care services and to a lesser extent in the scientific community. The above feature refers mostly to population ethnicity which involves disparities in cultural identity (language, traditions, beliefs, and religion). The element of race which relates to ancestral origin and physical characteristics also plays a role in the above injustice. These social problems express themselves in patients suffering from cancer, COVID-19 virus and other life-threatening diseases. The problem has become even more acute with the increasing numbers of refugees from developing countries entering Europe and North America. This feature of racial and ethnic discrimination can be solved in part by improving housing conditions, education, employment, by a basic change in the attitude of the local population toward newcomers to their territories, and by accepting the notion that strangers deserve respect, tolerance, and compassion.

Keywords: Ethnicity; Equity; Health-Care; Research

Introduction

Our health care system is a microcosm of Western society: its resources are not allocated fairly among races [1]. Therefore, it is wrong to explain away racial health disparities by citing poverty or lack of access to health care without acknowledging centuries of barriers intentionally placed to shut out poor and underprivileged communities [2]. Historically, 'ethnicity' has referred to a person's cultural identity (language, customs, religion), whereas 'race' encompasses a broad spectrum of people who are arbitrarily categorized based on ancestral origin and physical characteristics [3]. Evidence to date indicates that patients from ethnic minority backgrounds may experience disparities in the quality and safety of health care they receive due to a range of socio-cultural factors: they have higher rates of hospital-acquired infections, complications, adverse drug-related events and dosing errors when compared to the wider population. Language proficiency, beliefs about illness and treatment and interaction with their caregivers contribute to the increased incidence of safety mishaps among these populations [4]. In Western societies, physicians' implicit racial biases can account for racial disparities in health care [5]. For some poorer socio-economic ethnic groups, this is the primary driver of ethnic health inequalities. Ethnicity may impact health care due to the following factors: communication issues, culture, attitudes and the difference in disease prevalence [6]. This is one of the reasons why Black women in affluent societies are more likely than White women to be diagnosed with breast cancer at later stages and to die [7]. The higher rates of illness and death of people of color from the COVID-19 virus reflect the increased risk of exposure to the virus, likely due to cramped housing and employment conditions. Further, the pandemic has taken a disproportionately large toll on the mental health and well-being of these patients [8]. For more than a century, researchers have investigated inequality in the realm of science, and a number of analyses have shown that this inequality is the outcome of a non-meritocratic scientific system. "The problem of the twentieth century is the problem of the color line," says Du Bois, the American sociologist, and, to some extent, science has confirmed his words. It was the time when the enterprise of eugenics - improving the genetic quality of White, European races by eliminating the people who were considered inferior - was scientifically supported and extremely popular, having proponents in both North America and Europe. This view seems to have continued into the 21st century by imposing further restrictions and barriers for these seemingly 'inferior' groups. Studies have shown the systemic obstacles which prevent minorities from entering the domain of science; however, just a few have adopted an intersectional approach and studied the impacts of this discrimination on scientific knowledge. The discussion of Social Determinants of Health (SDHs) has attracted attention for years. The roles of some social factors, such as race and ethnicity, on health outcomes has been under investigation. Studies in this area are more focused on the direct effects of these factors on individual's health; however, what has not been widely mentioned or examined is the indirect effects these social factors have on health outcomes, including education and research in the field of health. In many societies, based on an unwritten agreement, access to health services has been defined by ethnicity, adversely affecting the distribution of health services for minorities. Rarely do people think about equitable access and fair distribution of resources in education and research, although everyone

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***Corresponding author:** Michael Silbermann, Middle East Cancer Consortium, Israel, E-mail: cancer@mecc-research.com

knows that these two issues are among the most important factors influencing the development of medical knowledge and health; training health professionals and promoting the health of individuals and communities will produce scientific evidence aimed to improve care and treatment methods. In the field of research, some of the policies which are based on ethnic and racial inequality deprive the world of science of some important research articles and achievements. For example, in many cases, some journals refuse to accept articles written by Iranian authors simply because of the sanctions against Iran and related issues, regardless of the fact that the results of the research conducted by these scientists and researchers may be able to answer some scientific questions and solve existing health problems [9,10]. This discriminatory view takes another form when the same journals use Iranian researchers to review their articles in order to improve the quality of their journals. Therefore, the question that arises is: how is it that a researcher, whose article has been rejected on the pretext of methodological errors and low quality, deserves to be a reviewer? One of the challenges related to this issue is the inability to access some publishers' journals, obstructing the exchange of knowledge and information [11]. Nevertheless, with the progressing globalization, the free flow of information is expected to flourish, regardless of ethnic and racial differences. We witness such discrimination in the awarding of research grants or allocation of academic positions to certain racial groups. Some of these cases, especially at the regional level, may be due to historical background and ethnic and racial differences, a typical example of which exists in Middle Eastern countries. The remainder of these historical challenges between Arabs and Iranians has led to the minimization of relations among these communities in the areas of science, research and education. As a result, despite the similarities in their culture, society, religion and, sometimes, their health systems and public health needs, it is not always possible to reach any agreement or memoranda of understanding when it comes to health services. At the same time, such connections can be seen among ethnic minorities in a Persian-speaking country, such as Iran, and countries with similar ethnicities. For example, universities in Turkey are more inclined to admit Azeri-speaking students from Iran's bordering areas or Arab countries pay more attention to Arabic-speaking residents of the south of Iran, illustrating implicit obstacles to expanding social security agreements between countries and to facilitate workers' access to pension services. It is important to note that it is not just individuals who are the source of this discrimination; its roots must be sought in organizational or political structures, known as systemic racism. Systemic racism refers to the well-documented fact that most institutions - in politics, law, education, health care, etc. - have basically been established according to the presumptions and policies that work to the detriment of people of color. Therefore, it seems that the first step in addressing these issues is to acknowledge the existence of such discrimination instead of denying it. Although most people do not approve of such an approach, they take it unintentionally, and the scientific community is no exception. Once this issue is acknowledged, the second step is to develop policies that encourage greater racial diversity in all sectors of the scientific community - researchers, teachers, and policymakers - around the world. Many studies have emphasized the importance of this racial diversity, proclaiming that the improvement in outcomes in various areas of health are the positive effects of such an approach. Continuous monitoring of the policies adopted at the organizational level is essential to ensure their full implementation. Since many of these insensible, and sometimes unintentional, behaviors have their roots in historical conflicts, passed down from generation to generation, policies must be put forth endeavoring to correct individuals' attitudes, raise their awareness through education and encourage them to identify racist behaviors. The definitions of race and ethnicity are not precise, and the two concepts have sometimes been used interchangeably [12]. The US's population is a patchwork of races, made up from African Americans, Hispanics, Latinos, Asian Americans, Whites and more; similarly, the UK encompasses people from all races. It is fairly easy to distinguish between the nationalities of Africans within the African continent; although the differences are far and wide, they are of the same race. In this regard, the concepts of ethnicity and tribes have been used to differentiate among people within Africa, who may be described as Bantu, non-Bantu, Nilotic, Nilo-Hamites, etc. The essence of these categorizations becomes clearer when observing the cultural and socio-economic differences of those occupying particular physical spaces or engaging in particular activities, defined and shaped by a common culture. The literature is awash with the proclamations that minority races experience poor health outcomes for different illnesses mainly because of belonging to that race. A longitudinal study in the US showed that Black adults were significantly more likely than Whites to have poorer cardiovascular health outcomes, primarily based on their racial differences [13]. Similarly, differences in asthma treatment outcomes (n=2,128) were significantly poorer among Blacks compared to Whites, even after adjusting for several other potential confounders, including asthma severity [14]. Yet, it might be racism rather than race and ethnicity, that influences reported health outcomes [15,16].

Disparities in health outcomes between two or more groups refer to differences, as well as inequality and unfairness, when it comes to quality of and access to healthcare [17]. The definition of racial or ethnic health disparity has varied and been measured differently by scholars. The Institute of Medicine (IOM) defines racial/ethnic health care disparities as differences in healthcare services received by two (or more) groups that are not due to differences in the underlying health care needs or preferences of members of these groups [18]. Measuring racial/ethnic disparities in health is challenging, and most variables used to measure it include other socioeconomic elements that are not necessarily racial or ethnic in nature [19]. Several interacting and confounding variables may contribute to disparities in health care outcomes among different populations, and are difficult to tease out into their component parts. Racial, ethnic and tribal variables have social and historical meanings and underpinnings, although they are biological as well, with some genetic underlying basis [20]. Several variations occur between and within racial and ethnic groupings with respect to health outcomes; the actual measures used to determine health outcomes may relate to socioeconomic standings and other yet unidentified variables weaved within the socioeconomic status of the individuals [21]. Furthermore, the physical locale and social environment may also play a part in determining health outcomes. Cultural beliefs and values contribute to determining how individuals behave in general, and specifically, with regards to health-seeking [22]. Poor health-seeking, on its own, may lead to poor health outcomes. For example, patients who seek care at a late stage are more likely to be diagnosed with advanced cancers and experience poorer survival rates [23,24]. The value of using race or ethnicity to determine health outcomes is questionable, especially when such variables may not, by themselves, be amenable to interventions that can lead to improved health outcomes. Perceived discrimination cannot meaningfully explain differences in racial/ethnic health outcomes. People who report discrimination tend to hesitate to seek care and, hence, may

not benefit from available scientific and technological advances in health that promotes health outcomes, including preventive health services in other social categories [25]. Interventions geared towards race, ethnicity or tribe may only serve to systematize discrimination, isolating medicine from social sciences without improving health outcomes. The value of race/ethnicity becomes blurry as intercultural marriages and civilizations increase in societies across the globe, making services targeting racial/ethnic groupings ancient, divisive and discriminatory. Continuing to use the terms race and ethnicity only serves to entrench and justify racism and increase disparity in health outcomes. In order to address health disparity and minimize racial/ethnic discrimination associated with poor health outcomes, structural racism must be identified and diminished.

"Structural racism refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care and criminal justice" [26]. Authorities, policymakers and researchers could promote equity in housing, education, benefits, credit, employment and earnings as a way of improving health outcomes among different racial/ethnic groups [27]. Racial, ethnic or tribal dispositions influence appointments, directly and indirectly, through political positions of kin. Academics, consciously or unconsciously, perhaps influenced by associations rooted in racial and/or tribal dispositions, cite or do not cite certain studies that can potentially influence policies and practices, thereby systematically alienating those studies and their potential influence on policies for or against certain racial, ethnic and tribal groups. Slavery was premised on the construct of structural racism and is, historically, deeply rooted in the US societies. The construct was used to justify the oppression of Blacks and other races on the basis of skin color [28]. The effects of racism on health outcomes is an extension of the structural and interpersonal racism that has permeated American societies, devaluing the lives of Black people and exaggerating the importance and value of lives of White Americans [27,28]. Earlier researchers and clinicians wrongly attributed the poor health outcomes among Black Americans and slaves - not to their extreme deprivation and servitude - but to an imagined intrinsic, inherited or biological factor; these beliefs are still propelled by a large proportion of American people. For example, more than half of medical students hold the view that Black American's perception of pain is different from White Americans, a view that influences their assessment and management of pain by race [29]. Structural racism causes suffering, reduces the level of overall health and well-being, and increases the incidence of death for Blacks and other minority groups in the US [26,28]. In fact, structural racism has led non-White Americans into greater poverty levels and has increased disparities in health outcomes between minorities and the White American majority [30]. The deliberate segregation of residential areas for Black and White Americans, with the associated disparities in access to and provisions of social amenities, including education and health, have created artificial - not genetic - status and socioeconomic differences between the two races. This segregation, and the obvious contrast associated with provision and utilization of services, are responsible for most of the observed racial disparities in health outcomes, most prominently for cancers and COVID-19 positivity and mortality [31]. It is critical that scientists and all researchers, in general, realize the controversy around using race as a scientific and biological variable to explain disparity in health outcomes. Using race as a marker of genetic diversity has been faulted on several grounds as there is more diversity within a race than between races, and there is no firm scientific evidence that race is determined on the basis of underlying genetics directly related to observable phenotypes and conduct of individuals and/or groups. A pair of individuals randomly selected from very different populations tend to be more similar genetically than a pair of randomly selected individuals from the same population [32]. Yudell, et al. [33] have made compelling arguments, reflecting on the thoughts of others, regarding whether or not race is a valid variable that can be used as a tool to stratify data in genetic diversity research. They conclude that race does not serve as a good variable even for genetic research, let alone clinical research. Therefore, scientists and professional health researchers and practitioners may want to avoid the use of race to attempt to explain salient disparities in important outcome measures, including health and education. The continued use of race as a biological variable will only serve to entrench the deliberate social exclusion and discrimination against certain races, confirming a prior false assertion of inferiority, a form of the self-fulfilling prophecy. On the other hand, the alleged superior race will continue to attribute every favorable outcome to their race, a form of self-serving bias. The self-fulfilling prophecy and self-serving bias are psychological constructs that tend to undermine the proper understanding of the true underlying factors that created the original disparities, thereby making change and improvement less likely. We join Yudell and other scholars to call for the evaluation and use of other measures, including socioeconomic status, language and geographic location as a way to understand underlying differences in health outcomes and explain disparities between racial groups [33]. The scientific communities must avoid using race as a biological variable if they want to combat structural and interpersonal racism and promote health equity. Exposing people to fallacious research purporting that certain race genetically and inherently have poor health outcomes tends to normalize such notions, and psychologically disempowers members of the alleged inferior races, thereby promoting concepts of superiority and inferiority among races. The inferior races, knowing they are genetically destined to experience poor health outcomes, will perhaps lack the motivation to be proactive, and indeed end up doing nothing to improve their circumstances. Evaluation of the impact of the Affordable Care Act (ACA) on health outcomes showed that, even when physical access to health facilities was improved and costs of care were cut down, minority groups still experienced poor health outcomes compared to the majority Whites for reasons relating to low utilizations of services based on perceived unfavorable interactions with the health providers [34]. A substantial disparity in health outcomes between Blacks and Whites in the US have been attributed to unfair treatment and discrimination of Black people, regardless of their economic status [35]. The questions that remain unanswered, therefore, are; (1) for what purpose do researchers seek to use race as a biological variable in the study of health outcome disparities? (2) Do the scientific communities seek to develop interventions to promote health equity on the basis of race? (3) How, then, shall the implementers of such policies provide services without promoting discrimination among people on the basis of race, and end up promoting the racial divide more and more to the detriment of harmonious societal development?

The following is a personal account from one of the authors of this commentary:

"Quick question: a light-skinned candidate and a dark-skinned candidate are interviewed for the same job - who would be hired, if both are equal in qualifications and experience? Most probability,

the light-skinned one. Ethnic biases happen all the time, whether intentionally or subconsciously.

I asked my 28-year-old Sudanese friend if she had observed any racial or ethnic prejudices in her work as a primary school teacher; her answer was yes. Lighter-skinned children get hugged, teased and kissed more often (from both pupils and teachers) than those with a darker complexion, to the degree that she feels bad for them.

Another employee of Comboni College -Short Courses mentioned that segregation is even more pronounced in communities with poorer socio-economic populations. However, as education and travel has progressed, ethnic disparities have decreased, although people residing in rural areas are more often seen to practice segregation than those living in the city, who are generally better educated.

That reminds me, when I was young, I was raised to believe that the two tribes I related to (my mother's and father's) are the 'best' and 'superior' in the country - out of 20 major tribes. At that time, it was rare and more difficult to intermarry with other tribes. I grew up with the conviction that I descend from the best tribes in the country! But later, in my twenties, I discovered that those from major tribes in Sudan (whether from Northern or Southern tribes) were all very proud of themselves, each understanding that they are more worthy.

My friend from university was to pay a visit to my home. My aunt asked to what tribe she belonged, and I had no answer; for me it was not important, but for her, it was a serious matter.

Affixing meaning to skin color happens everywhere: in industrialized countries and, even more so, in closed communities. A colleague of mine happened to be the first Black man to set foot in a remote European village. Eyes accompanied him everywhere, and some people even asked permission to touch him and check if his color was real.

Hopefully, this will soon change. As traveling around the globe has become easier, people are now encountering and mingling with those of other races and cultures. With the Internet, you can access information and discover diverse societies all around the world, without even leaving your room.

In order combat and put an end to racism, we must intentionally familiarize ourselves with those who seem foreign to us, and to give a fairer chance to those oppressed due to their race/color/ethnic background.

My dark-colored colleague had a rough time, even from her patients who called her the 'purple doctor'. She was frustrated in the beginning, but I ensured her that this story has a silver lining. Yes, being fairer in color would have opened more opportunities, but staying as you are and overcoming constant obstacles is a recipe for perseverance and success. Sooner or later, people will judge you for who you are and not from which tribe you descend, and you will gain their admiration and respect."

Summary

To go beyond simple declarations and move forward in fighting racism in medicine, we must understand the racial biases in our response to past and present public health issues and plot an ethically and structurally different path to a new future [36]. Language that imparts bias toward or against people or groups based on characteristics or demographics must be denounced. Policy changes are essential for strengthening primary care and improving delivery of services.

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