



Statement on Racism as a Public Health Issue

Student National Medical Association
Health Policy and Legislative Affairs Committee

Statement on Racism as a Public Health Issue

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INTRODUCTION

Established in 1964 by medical school students of the Meharry Medical College and Howard University School of Medicine, the Student National Medical Association (SNMA) is the nation's oldest and largest organization focused on the needs and concerns of medical students of color. Additionally, the SNMA is committed to practices leading to better health care for minority and underrepresented communities. Historically, these communities have been and currently are disproportionately subjected to the consequences of systematic oppression and discriminatory practices, particularly racism. The SNMA strongly opposes any legislation or practices that create and/or maintain barriers to healthcare access due to the promotion of racial/ethnic discriminatory practices, and support legislation that recognizes that racism should be addressed as a public health issue in order to decrease disparities in medicine.

BACKGROUND

In recent years, the discussion of social determinants of health (SDoH) has inched towards the forefront of public health and in improving healthcare.¹ According to the World Health Organization, SDoH “are shaped by the distribution of money, power and resources at global, national and local levels.”² Appropriately, those external drivers should also be addressed in discussions about SDoH. Unfortunately, many of the conversations on SDoH in the United States (US) avoid use of the term “racism,” and thus fail to acknowledge its monumental impact on social determinants, including economic stability, neighborhood and physical environment, education, food security, community and social context, and the healthcare system. As a result, the root cause of disparities in health outcomes in this country isn't being adequately addressed. These determinants are heavily influenced by and are essentially a byproduct of this country's history, which was built on and continues to perpetuate institutionalized and systemic racism.³

The story of the Black/African American largely commences with the forced migration of Africans who were uprooted from their homes and forced to live as chattel on what is now considered United States soil. Although the story for the Black/African American does not end with slavery, it is still heavily influenced by the ideals that initiated this tale: racism. Blacks/African Americans would eventually gain freedom and seemingly equal footing as humans, but during the civil rights era, they found themselves fighting for housing, education, and

employment opportunities on par with their White neighbors. Today, that fight is still evident through protests by social justice organizations, which serve the purpose of declaring equality.

“Race” is defined as a social construct with no biological basis.⁴ Although this term was created with the intent of separating individuals across the world into categories based on their physical appearance, the 21st century has embraced this term to promote diversity within our own nation. Today, it is acknowledged as an important identifier for citizens who seek places of employment, enrollment in education, and healthcare. On the other hand, “racism” refers to a social system that reinforces racial groupings and assigns deferring levels of value to the lives of people based on that grouping.⁴ This reinforcement of racial group identity in all aspects of daily living has been shown historically to have a negative impact on those who it was designed to “other”: people of color.⁵

By 2060, the US non-White population is projected to increase dramatically, primarily due to increases within the Hispanic/Latinx (111 million), Black/African American (61 million) and Asian (37 million) populations.⁶ This turning point in the demographic makeup of the US will largely be seen by the healthcare field, where it becomes particularly evident the sharp disparity that exists in lived experiences between White and non-White populations, with non-White groups presenting with significant history of vulnerability and higher social health needs that must be addressed in order to resolve their chief medical complaints. Regardless of attempts to improve SDoH for these populations, without addressing the structural issues, particularly structural racism, that continual serve as barriers to adequate care outcomes, non-White groups will increasingly be at risk for experiencing racial discrimination, evident by the worse health outcomes seen despite receiving the same standard of and access to medical care.⁷

The remainder of this position statement will focus on specific examples of social determinants of health, as defined by the Henry J. Kaiser Family Foundation, which have been proven to disproportionately impact communities of color and discuss how these are driven by structural racism.

SCOPE OF THE PROBLEM

1. Community and Social Construct

1.1. Economic Stability

The 1960's Civil Rights movement opened doors toward reforms in employment, education, labor unions, credit contracting mortgage and federally funded organizations for all Americans. This helped to improve the income of Black/African American families. Although, this movement did spark creation of anti-discrimination policies, it did not help to close the overall income gap between White and Black/African American families. Blacks/African Americans still remained in low-income levels of American society.⁸

This can be associated with persistent disadvantage and/or new patterns of inequalities arising despite societal advances. This can also be tied to the intergenerational racial disparity as children born to low-income adults compared with children from higher income families.^{9,10} For instance, family structure among Blacks/African Americans has changed drastically as many fathers increasingly are nonresidential parents. In fact, two-thirds of Blacks/African Americans children do not live with their biological father compared to one-third of Hispanic children and less than one-third of White children.¹¹ Therefore, many of these children are raised in households that are limited by income as: 1) Black/African American children are twice as likely to be raised in families that are at the poverty level than White children; 2) Black/African American children who are raised in low-income communities are more likely to grow up in high poverty environments than White children; and 3) Black/African American children are subjected to communities with high violent crime rates, racial segregation, and limited employment opportunities than their White counterparts.¹² This can have an effect on the economic stability a parent is able to provide to their child, as well as add to the continuity of intergenerational poverty as household and community resources are limited within these neighborhoods.

Economic instability is common among nonresidential fathers who are subjected to legal requirements of the provider role through the child-support system. This system has a negative effect on low-income fathers, as they do not take into account that many low-income fathers experience difficult economic circumstances (i.e., unemployment or incapacity to work) due to societal barriers. As a result, many fathers experience payment delays, as well as inability to provide other financial support for their children outside of the child-support payments. This causes low-income Black/African American families as a whole to experience more downward economic mobility that ultimately affects future generations. This downward economic mobility undermines possible accumulation of economic advantages that are linked to broad economic and demographic shifts, which influence the general population.¹³

At the federal level, an attempt was made to combat economic instability among Blacks/African Americans with the passage of Title VI of the Civil Rights Act of 1964, which barred institutions receiving federal funding from discriminating on the basis of race. This allowed for more employment opportunities for Blacks/African Americans. Despite these efforts, in 2017, the unemployment level for Blacks/African Americans was 7.5%, which was almost double that of White Americans (3.8%).¹⁴ Moreover, when it came to professional and high level paying management jobs, Blacks/African Americans and Hispanics/Latinx were less likely to be found in these positions in comparison to their White and Asian counterparts. Instead, Blacks/African Americans (24%) and Hispanics/Latinx (25%) were more likely to be employed in service occupations; specifically nursing/psychiatric/home health aides (34%), security guards (32%), and taxi drivers/chauffeurs (28%) for Blacks/African Americans, and painters/construction/maintenance (53%), agricultural workers (51%), and maids/housekeeping cleaners (49%) for Hispanics/Latinx.¹⁴

Blacks/African Americans age 55 and over who experience long term limitations of unemployment experience unemployment rates twice that of Whites, and are more than twice as likely to be living below the poverty line.¹⁵ Thus, being limited by employment opportunities, Blacks/African Americans are less likely to have a proficient pension package, as pension levels in the US, are largely determined by earnings and consistent job participation.¹⁵ Lower pension amounts and lower accumulated savings over the life span translate into less available funds for healthy purchasing in later life and overall economic stability.¹⁶

Without racial difference in how socioeconomic positions endure, racial disparities would have dissipated over the past 40 years due to changes in government policy. Changes in the economy, employment opportunities, and family structure are all contributing factors to the shaping of racial economic inequality trends.

1.2. Neighborhood and Physical Environment

Much literature has demonstrated that neighborhood context and the built environment in which an individual lives plays a significant role in their health.¹⁷⁻¹⁹ Due to the higher rates of poverty and lower economic stability that plague majority Black/African American and Hispanic/Latinx neighborhoods,²⁰ it is no surprise that these communities tend to have access to limited and subpar resources. Overt and covert racism have greatly influenced the housing

demographics in the United States and led to the racial segregation of neighborhoods and communities through housing policies and practices.^{21,22} Unfortunately, due to these historical and systemic inequities that produce housing and racial segregation, majority Black/African American and Hispanic/Latinx neighborhoods lack opportunities for a safe living environment and the political power necessary to change their circumstances.^{23–25} Poverty and food insecurity; environmental pollution and exposure to toxins; drug trafficking, gun violence, and subsequent policing – these are just few examples of the negative impact historically racist housing practices have had on neighborhoods that people of color have been redlined into, all of which influence health status and outcomes.^{19,25,34,26–33}

1.3. Food

Low-income and majority Black/African American and Hispanic/Latinx neighborhoods often lack farmers' markets and adequately stocked grocery stores where residents can purchase high quality produce and whole grains – so-called “food deserts.”^{35,36} Instead, they are limited to convenience and corner stores which keep their shelves stocked with highly processed and non-perishable food items. The food insecurity rate among Black/African American households is more than double that of non-Hispanic White households. While the 105 counties in 2015 with a majority Black/African American population represent only 3% of all US counties, 92% of Black/African American majority counties fall into the top 10 of counties with the highest rates of food insecurity. Majority Black/African American counties, however, have an average unemployment rate (9%) and poverty rate (29%) that, while substantially higher than the national average (6% and 17%, respectively) are roughly the same as other high food insecurity rate counties (8% and 27%, respectively).³⁷

Children raised in homes struggling with food insecurity often experience a negative impact on their cognitive, emotional, and physical development and are more likely to have fair or poor health when compared to children of food-secure homes.³⁸ Research further shows that corporations have intentionally targeted low-income communities when planning for the development of fast food restaurants and convenience stores. A team of researchers found that fast food restaurants in majority Black/African American neighborhoods have significantly higher odds of using kids' meal toy displays to market their products to children compared to restaurants

in White neighborhoods.^{39,40} In addition, there has been an inverse relationship described between household income and density of fast food restaurants.^{41,42}

1.4. Education

Literacy is a valued attribute and is one of the strongest predictors of future success amongst adults however, 50% of adults cannot read a book that is written in an eighth grade level.⁴³ This poses a problem specifically where health is concerned. The capability of making appropriate health decisions is highly influenced by a patient's ability to obtain, communicate, interpret and comprehend health information and services.⁴⁴ Studies have shown that differences in health literacy amongst individuals are further exacerbated by race and socioeconomic status (SES). People of color and of low SES are less likely to benefit from interventions that may reduce mortality rates.⁴⁵ Specifically, reduced health literacy may be contributing to lack of awareness about screening tests that may detect early disease and allow for early intervention. This point is supported by the fact that there is a disparity in cancer screenings between Whites and minority races, which can be contributing to health disparities between the two groups.⁴⁴

High rates of illiteracy can be traced back to the educational system. Differences in the way Black/African American students are treated in their classrooms when compared to their counterparts may be contributing to poor academic performance and subsequent disinterest in education.⁴³ Black/African American students are overrepresented in special education program for students with disabilities and are underrepresented in programs for gifted students.⁴³ Lack of success in school can further perpetuate disinterest in school and subsequently dropping out.

The No Child Left Behind Act of 2001 has indirectly perpetuated the increase in criminalization of youth due to the zero-tolerance policy. This has forced educators to remove "problem" students from the classroom.⁴⁶ Students who subsequently drop out of school are eight times more likely to become incarcerated than students who stay in school.⁴⁶ Nevertheless, the presence of police in schools has also contributed to an increased incarceration of youth in many metropolitan cities. With police in schools, there has been an increase in arrests and criminal charges thus pushing students into the criminal system.⁴⁶

Maltreatment of Black/African American students in the classroom and criminalization of behavior have caused there to be a decrease in Black students graduating from high school. This is reflected in the number of Black/African American students graduating with an associates,

bachelors, masters, and doctoral degrees. According to the National Center for Educational Statistics, in the 2013-2014 academic year, the percentage of Blacks/African Americans that graduated with an associate's degree was 14%, 11% with a bachelor's, 14% with a master's, and 8% doctoral degree.⁴⁷

1.5. Adverse Childhood Events (ACE)

One of the most fundamental aspects of evaluating our current state of health is often to reflect upon our past medical history. An often-overlooked aspect of adult health & well-being revolves around the various childhood experiences, both positive and negative, that individuals may have encountered. One of the largest investigations into childhood abuse and neglect and later-life health and well-being was done by the CDC-Kaiser Adverse Childhood Experiences (ACE) study.⁴⁸ The premise of the study discusses how various ACEs can trigger a mechanism by which an ACE causes disrupted neurodevelopment which then leads to social, emotional, and cognitive impairments, encouraging the adoption of health-risk behaviors, increasing both disease and disability, and ultimately resulting in an early death.^{48,49} Surprisingly, ACEs are common throughout the population, however as the number of ACEs increase, so does the risk for alcoholism, depression, fetal death, ischemic heart disease, liver disease, financial stress, smoking, and many more disease states and health-risk behaviors.^{48,49} What is even more concerning, is that when adversities are further stratified into racial and ethnic groups, Black/African American and Hispanic/Latinx children are consistently exposed to more adversities compared with White children.⁵⁰ The presence of constant childhood stress and the exacerbation of further stress in adulthood may contribute to numerous disease states through persistent activation of the hypothalamic-pituitary-adrenal (HPA) axis.⁵¹⁻⁵⁴ Activation of the HPA axis due to persistent stress not only triggers the release of cortisol but also leads to decreased sensitivity of the glucocorticoid receptors that are needed to appropriately respond to inflammation and various disease states.⁵⁵

A grand misconception in the field of racial adversity is that education and wealth should equalize the outcomes; on the contrary, the greatest racial/ethnic differences have been found among children from the wealthiest families.⁵⁰ Implying that a highly educated and affluent Black/African American man will still succumb to greater health risks and earlier death compared to a less educated lower socioeconomic status (SES) White man, testifying to the devastating long-term effects of persistent racial discrimination and the ensuing constant level of stress.

Furthermore, when evaluating pre-term labor and low birth weights in neighborhoods with the lowest income tertial, Black/African American women were associated with a greater risk for low birth weights compared to White women with the same SES.⁵⁵ Of note, there was a distinction between children of immigrants, and children of US-born parents, identified as the “immigrant paradox.”⁵⁶ The further stratification into immigrant status, suggested the presence of protective factors in children of immigrants against the common consequences afflicting children in lower SES in US-born parents.^{56,57} Ultimately, many factors contribute to the development of disease states; however, we must not overlook the importance of ACEs and the role that racial discrimination and bias plays in exacerbating childhood stress and further affecting downstream adult health and well-being.

1.6. Medical Mistrust

“Medical mistrust is defined as the inclination to distrust medical systems and health care personnel that are believed to represent the dominant culture.”⁵⁸ An overwhelming body of research has shown that communities of color, particularly Black/African American and Hispanic/Latinx communities, are less likely to trust the healthcare system and providers than non-Hispanic White people.^{59–64} Given the extensive history of unethical treatment of communities of color by medicine and biomedical research, – e.g., the Tuskegee Syphilis Study,⁶⁵ Henrietta Lacks and the use and profit of the HeLa cell line without her or her family’s permission or knowledge,⁶⁶ J. Marion Sims’s experimentation on Native and enslaved women and children without proper anesthesia,⁶⁷ etc. – this distrust is not entirely farfetched. This mistrust negatively impacts patient satisfaction, adherence, and participation in medical care, as well as medical research, thus resulting in poor outcomes for individuals of color and lack of scientific knowledge of how potential interventions will impact the health of communities of color.^{62,63,68,69} Research has also shown that this mistrust in the healthcare system and of healthcare providers may be mitigated by patient-physician race concordance,^{69–71} thus making imperative the recruitment and retention of more physicians of color.

1.7. Cortisol Theory and Allostatic Load

Researchers are increasingly investigating the role of experienced discrimination in mental and physical health, and findings show that interpersonal, institutional, and systemic racial

discrimination all impact the health outcomes experienced by people of color.⁷²⁻⁷⁹ This has led to the development of the “Cortisol Theory,” a theory that names chronically high cortisol levels in the body as a mediator between chronic psychosocial stress and poor health outcomes.⁸⁰ Repeated or chronic exposure to stressors accumulate over time, a physiologic phenomenon known as “allostatic load,” and has been shown to manifest significantly more in people of color and to be independently associated with Black-White mortality and morbidity disparities.^{81,82} Such psychological stressors may be as overt as being the public target of racial slurs or as subtle as being on the receiving end of microaggressions – “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color” – on a daily basis.⁸³ A recent study described one specific pathway of this interaction, demonstrating that there exists a biological mechanism – albeit one that arises from a social construct – to explain the poor health outcomes experienced by people of color: “race → discrimination → experience of anger → subjective sleep quality → allostatic load.”⁸⁴

2. *Health Outcomes in Communities of Color*

2.1. *Hypertension*

In 2016, it was reported that the 75 million American adults are considered to have high blood pressure, and about half (54%) have their blood pressure managed. 1 in 5 American adults are unaware that they have high blood pressure. More importantly, it cost \$48.6 billion per year to treat high blood pressure, this cost accounts for needed health care services, treatment and missed days of work.⁸⁵ There is a higher prevalence of hypertension in Southeastern region of the country where there is a large presence of minority communities. Many Blacks/African Americans living in the Southeastern region are Medicare Part D recipients, and it has been shown that one fourth of Medicare Part D beneficiaries are non-adherent to their antihypertensive regimen.⁸⁶ This can be contributed to many flaws within the healthcare system such as lack of health literacy, follow up with patients, cost-sharing on antihypertensive medication and physician-patient relationship. Lack of adherence to antihypertensive medications has put minorities, especially Blacks/African Americans, at risk for higher mortality through increased cardiovascular morbidity. As uncontrolled blood pressure is a major risk factor for the 1st (heart disease) and 3rd (stroke) leading cause of death among individual less than 65 years old.⁸⁵

2.2. *Maternal-Child Health*

Not only does racism have an impact on older Blacks/African Americans' health, but preterm infants are also heavily affected with Black/African American mothers three times more likely to have very preterm births compared to non-Hispanic White women. As well as married, college-educated Black/African American parents who deliver their first born are more likely to have a very low birth weight child, despite receiving prenatal care within the first trimester. Preterm and low birthweight infants are at an increased risk of morbidity and mortality from neurological, pulmonary and ophthalmic disorders. Moreover, they will be more susceptible to poorer health outcomes and chronic diseases later in life such as diabetes mellitus. In terms of NICU setting, Black patients received worse quality care, have poorer access to care and less timely care when compared to White patients. In terms of community setting, many of these preterm infants are born to mother who live in both disadvantaged economic and social environments and are at higher risk of experiencing intimate partner abuse, strain from economic instability, and stunted economic growth and social mobility opportunities.⁸⁷

Disparities in birth outcomes amongst minority women and their offspring have been well described in the literature. In the United States, infant mortality amongst Blacks is two times the rate when compared to White infants. In addition, offspring of Black/African American women are more likely to have lower birth weight and preterm delivery.⁸⁸ Previously, it was believed that SES and education protected against this, however, studies have disproved that idea.⁸⁹ Researchers began to consider other causes that may be responsible for these disparities. Overtime, researchers have explored the idea that the disparity in birth outcomes can be partially attributed to the unique stressors Black/African American women are subjected to throughout their lives. This includes gendered racism and the abuse of Black women in the healthcare system particularly in the field of obstetrics.⁸⁸

Intersectionality of race and gender negatively impact Black/African American women because they experience racism, discrimination and sexism based on their identity. Normally, in times of stress, humans release hormones as a response to the stress that they are experiencing. However, Black women have chronic release of stress hormones as a result of the constant stressors they experience throughout their lives. When the effects of these hormones are combined with the mechanisms of labor initiation it can result in preterm birth.⁹⁰

All of these mentioned factors can contribute to the health disparities as well as the perceived racism belief many Black/African American patients obtained while receiving medical treatment. It is believed that Blacks/African Americans in particular, are more susceptible to hypertension, through the increased exposure to chronic and acute stress which is related to the subjective experience of prejudice or discrimination enduring while living as a Black/African American. Therefore, actions towards Blacks/African Americans deemed as expression of free will, can be taken as racial discrimination by Blacks/African Americans. Environmental factors that an increased likelihood of developing hypertension such as substandard housing, lack of access to skilled labor and managerial jobs, lower wages for Blacks/African Americans contribute to this perceived racism and lead to negative health outcomes in Blacks/African Americans. These negative environmental stimuli within the community setting as well as the hospital setting can be seen in as major influencers on the health of both the mother and ultimately the preterm child. Perinatal outcomes are known to be associated with chronic stress related events related to the mother's life due to neighborhood disadvantage.⁹¹

2.3. *CHIP, Medicare, Medicaid, Physician-Patient Relationship*

In 2003, *Unequal Treatment: Controlling Racial and Ethnic Disparities in Health Care* released by the Institute of Medicine (IOM) was the groundbreaking report, addressing the idea of health disparities.⁹² Health disparities as defined by IOM are “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.” These health disparities mostly affected minority populations regardless of income level. Through this report, the IOM discovered “Racial and ethnic disparities in healthcare exist. This disparities are consistent and extensive across a range of medical conditions and health care services, are associated with worse health outcomes, and occur independently at insurance status, income, and education...”⁹² *Unequal Treatment* opened the door to the healthcare system to examine, research, and identify the types of health disparities that are present in the health care system in order to effectively address and find solutions to resolving them.

For instance, when looking at the association between Peripheral Artery Disease (PAD) and amputations it was concluded that Blacks/African Americans, when compared to non-Hispanic Whites, have twice the likelihood of undergoing a major (above or below knee) lower

extremity amputations.⁹³ In a 2005 study, on several Chicago teaching hospitals, looking at racial differences in primary and repeat lower extremity amputations showed that “Black American patients were more likely to undergo both primary and repeated major amputations even at centers with high levels of vascular surgery capacity.”⁹⁴ Although, some would contribute this outcome to the co-morbidities such as insulin-dependent Diabetes prominence among Black/African American patients. This study presented that Blacks/African Americans had increased risks for primary and repeat amputations regardless of diabetic or nondiabetic status.⁹⁴ Though behavioral risk factors (i.e., smoking, obesity, and physical inactivity) does play a partial role in the prevalence of amputations, diabetes, and other cardiovascular diseases among Blacks/African Americans, it alone cannot explain the racial differences shown in literature. The healthcare field must also take into account racial risk factors, such as hypersegmented, high-stress, socially isolated communities as also contributing to these highly negative medical outcomes.⁹⁴

Disparities in health outcomes can also be seen within cancer screenings more specifically, breast cancer. It is known that “Black American women are more likely than other women to be diagnosed with breast cancer at a young age, to be diagnosed at a late stage and to die from the disease.”⁹⁵ This is due to late stage diagnosis among Black/African American women to frequency of and longer intervals between, mammograms and to lack of timely follow-up of suspicious results.⁹⁶ This can be associated with health disparities as many Black/African American women lack access to screening due to insurance status, negative perception of diagnosis, lack of time and social interactions with others have an impact on their ability to get screened.⁹⁷⁻⁹⁹ In addition, Black/African American women have also stated the confusion with guidelines and lack of minority representation from breast cancer awareness organizations have also impacted their desire to be screened. Knowing this it is important to address this disparity in screening as not only the high incidence rate among Black/African American women having breast cancer, but also, they have the greatest risk of mortality related to breast cancer.

When the health care system makes it a priority to identify, address and resolve the problems with breast cancer screenings, amputations and other medical diseases prevalent among Blacks/African Americans, it will help reduce incidence and mortality rates it will help to address health disparities.

STATEMENT OF POSITION AND RECOMMENDATIONS

We, the members of the SNMA, are dedicated to ensuring that medical institutions, health care professionals, and policy makers are intentional in considering both the historical and current racism suffered by Black/African American and Hispanic/Latinx citizens when engaging in discussion about this population's health. We acknowledge that addressing the social determinants of health is necessary in the pursuit of health equity. The SNMA firmly believes that acknowledging racism is an important step in facilitating the healing of our nation as we attempt to increase access to care and improve quality of care for all citizens. The SNMA therefore highly encourages:

- Medical institutions to officially acknowledge how racism has influenced and continues to influence today's healthcare.
- Medical institutions to intentionally recruit, accept and retain students of color in their undergraduate medical programs as these students are more likely to serve the populations which suffer from systematic oppression.
- Medical institutions to allot time in the required, official curriculum for the discussion of racism in addition to other social determinants of health.
- Medical institutions to broaden teaching to incorporate symptoms specific to patients of color.
- Hospitals to routinely address cultural competency in the context of providing care for a diverse patient population.
- Medical students to engage in advocacy on both the local and national level to lend their voice for communities often silenced by our political system to prevent the continuance and establishment of policies which are harmful for patients of color.
- Urging medical students and medical student organizations, medical communities and organizations, public health professionals and departments, and stakeholders at the local and national levels to advocate against laws that exacerbate health inequities and go against public health principles.

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