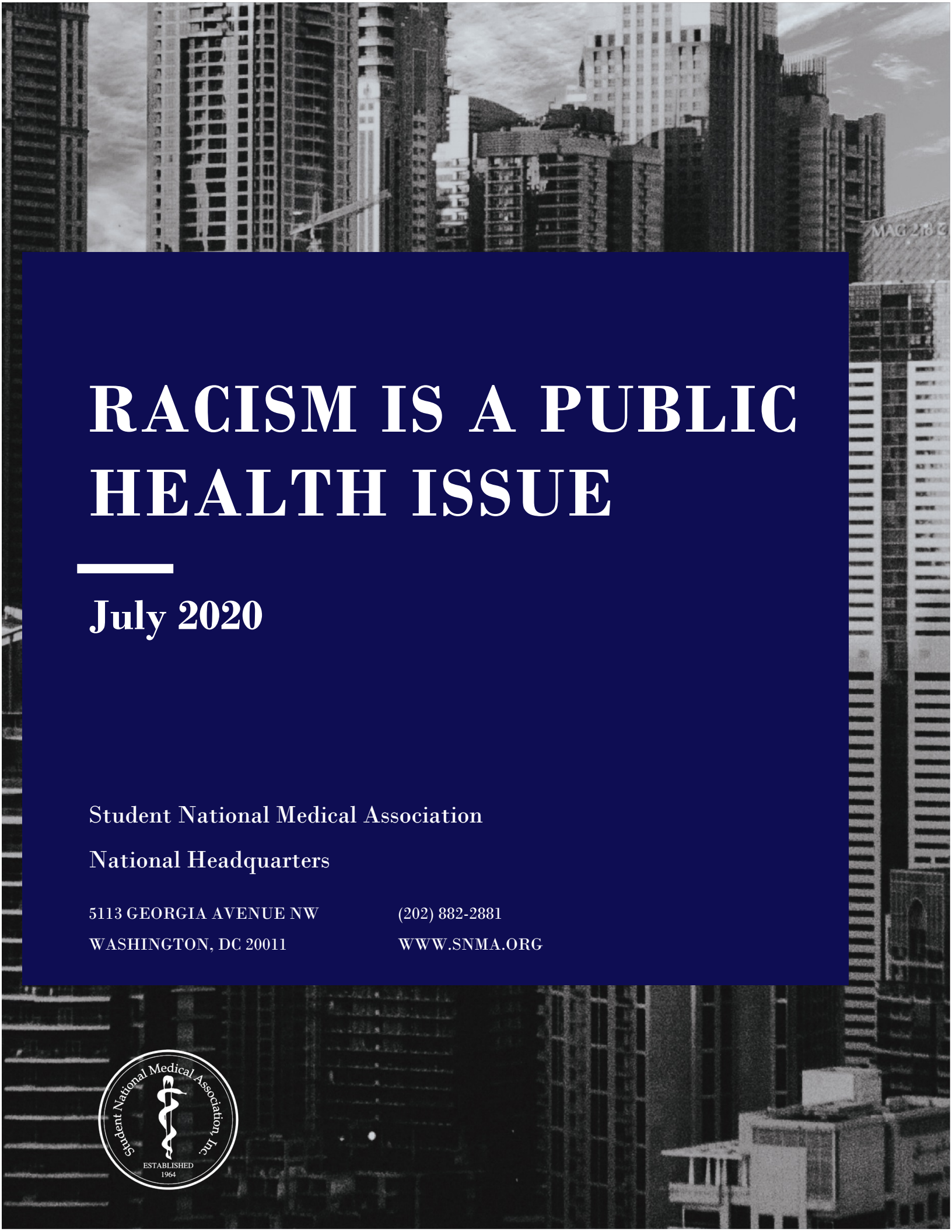

# RACISM IS A PUBLIC HEALTH ISSUE

## July 2020


Student National Medical Association

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# Preface

We, the members of the Student National Medical Association (SNMA), as current and future medical students are saddened and appalled by recent events against the Black community. We mourn the wrongful murders of George Floyd, Ahmaud Arbery, Breonna Taylor, Tony McDade, Nina Pop, and thousands more, and grieve with their families as they navigate these tragic circumstances. We stand with the Black community in solidarity against the acts of police brutality that continues to occur across our nation. These incidents reflect a pattern of systemic racism which has been ongoing since the inception of the United States.

In recent times, we have seen migrant children of color separated from their families and housed in cages along the US-Mexico border, body bags instead of personal protective equipment (PPE) sent to Native American clinics, and racist acts against Asian Americans as a result of the COVID-19 pandemic. These acts, unmet by justice, continue to plague the health and wellbeing of communities of color. Therefore, we denounce all incidents of violence and racism against Black, Indigenous, and People of Color (BIPOC).

As the next generation of physicians aimed at addressing the health and medical needs of underrepresented communities, we recognize that health is multifaceted and includes socioeconomic and psychosocial wellness. Racism is a public health issue – it affects all communities, regardless of race, ethnicity, documentation status, or socioeconomic background. Systematic racism, defined as a system of advantage based on race, drives economic instability, health inequity, mass incarceration, food insecurity, and more, is the significant contributor to the racially disparate health outcomes seen in hypertension, diabetes, cardiovascular disease, and now COVID-19. Racism affects not only communities of color, but the entire healthcare system. Health inequities strain the resources of our medical system and affect how medicine is both regarded and carried out in *every* community. Now more than ever, it is crucial that we counteract the effects of systemic racism on our most vulnerable communities in order to end all health disparities.

During this time, it is also important to address the violent actions against communities of color, particularly against Blacks/African Americans, Native Americans, and Hispanics/Latinx by law enforcement and by the majority. Police violence is also a public health issue, and is a tactic of the justice system that utilizes fear to suppress and control the masses of Black and Brown bodies. Violence against BIPOC communities unmet with justice not only destroys lives but perpetuates grief, stress, and mental trauma. As future physicians who take an oath to serve these communities, we acknowledge that our silence is not acceptable and stand alongside these communities in denouncing violence against the oppressed.

We must first acknowledge that systemic racism directly impacts our ability to carry out the oath we take as incoming members of the medical profession: "*I solemnly pledge to dedicate my life to the service of humanity; the health and well-being of my patient will be my first consideration*." As future physicians, we will be the ones to heal the wounds of our communities and the illnesses that plague them. Not only will we have to heal the visible physical wounds, but also the invisible emotional and psychological wounds that take a toll on the human spirit. Racism is an illness and it is one that has continued to wound BIPOC communities all around this country in various ways, with the latest example being police brutality against Black people. The Association of American Medical Colleges (AAMC) reported in 2019 that out of a total of 21,863, only 1,626 (7.4%) of medical school matriculants were Black/African American. This is in sharp contrast to the the US Census Bureau 2019 report that 13.4% of the United States population identifies as Black/African American, though this report does not reflect the numbers unrecorded. As such, not only must we work *harder* to ensure our communities are equitably represented in medicine, we must also intentionally adopt the guiding principles of cultural and structural humility, and – above all – we must commit to becoming active and fervent anti-racists for the sake of our patients.

Yours in SNMA,

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**National President**

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# Introduction

Established in 1964 by medical students from Howard University College of Medicine and Meharry Medical College, the Student National Medical Association (SNMA) is the nation's oldest and largest, independent student-governed organization focused on the needs and concerns of medical students of color. Additionally, the SNMA is committed to practices leading to improved healthcare and health outcomes for communities of color. Historically, Black, Indigenous, and People of Color (BIPOC) communities have been and continue to be disproportionately subjected to the consequences of systematic oppression and discriminatory practices, particularly racism. This has resulted in the decades-long endurance of many racial and ethnic health disparities and inequities within United States (US). Given this disproportionate impact on the health and wellbeing of communities of color, the SNMA strongly opposes any policy or practice that creates or perpetuates inequality. We support policies or practices that recognize that structural racism should be addressed as a public health issue and actively works towards dismantling systems of inequality in order to decrease disparities in health outcomes.

## Structural Racism and the Social Construct of Race

A discussion on racial and ethnic health disparities is incomplete and inaccurate without a discussion on the social construct of race and the underlying structures and systems that create and perpetuate inequality. Racial categories are historically created and not biologically derived, thus differences in outcomes based on race must be discussed within the societal context rather than the biological.[1] Whenever there is a consistent difference in health outcomes based on race, it is by definition a health inequity, because there is no genetic basis for race. However, because of the US legacy of slavery, imperialism, and mass massacre and internment of racially minoritize groups and the ideology that was used to justify such policies and practices, perceived racial category dictates a person's walk-through life. This includes their interactions with the healthcare system and social services, and thus, their health outcomes. As a result, *structural racism*, is the primarily driver of health disparities and inequities and must frame all further discussion.[2]

# Background

In recent years, the discussion of social determinants of health (SDoH) has inched towards the forefront of public health and in improving healthcare.[3] According to the World Health Organization (WHO), SDoH "are shaped by the distribution of money, power and resources at global, national and local levels."[4] Appropriately, those external drivers should also be addressed in discussions about SDoH. Unfortunately, many of the conversations on SDoH in 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 has not been 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.[5]

The story of the 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 US soil. Although the story for the 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. However, 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 and collectives that serve the purpose of declaring equality.

"Race" is defined as a social construct with no biological basis.[6] 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.[6] 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.[7]

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 American (37 million) populations.[8] This turning point in the demographic makeup of the US will 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 continually 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.[9]

## Scope of the Problem

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."[10] 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 were shown to mostly affect minority populations regardless of income level. Through this report, the IOM uncovered that "[r]acial 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…"[10]

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, had twice the likelihood of undergoing a major (above or below knee) lower extremity amputation.[11] In a 2005 study looking at racial differences in primary and repeat lower extremity amputations at several Chicago teaching hospitals, it was demonstrated 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."[12] Some would contribute this difference in outcome to the co-morbidities that are prominent among Black/African American patients, such as insulin-dependent diabetes mellitus. However, this study demonstrated that Blacks/African Americans had increased risks for primary and repeat amputations *regardless* of diabetic or nondiabetic status.[12] Though behavioral risk factors (i.e., smoking, obesity, and physical inactivity) play a role in the prevalence of amputations, diabetes, and other cardiovascular-related diseases among Blacks/African Americans, it alone cannot explain the racial differences seen in literature. The medical field must also take into account racial risk factors, such as hypersegmented, high-stress, socially isolated communities, as contributing factors to these disparately poor medical outcomes.[12]

Disparities in health outcomes can also be seen within cancer screenings, specifically, breast cancer. "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."[13] This has been attributed to late stage diagnosis among Black/African American women, longer intervals between mammograms, and lack of timely follow-up of suspicious results.[14] This can be associated with health disparities as many Black/African American women lack access to screening due to insurance status, negative perception of the diagnosis, and lack of time and social connections with others, which all can impact their ability to get screened.[15–17] In addition, Black/African American women have also endorsed confusion with screening

guidelines and lack of BIPOC representation in material produced by breast cancer awareness organizations, which also impacts their desire to be screened.

*Unequal Treatment* opened the door for the healthcare system to examine, research, and identify the types of health disparities that are present in the US healthcare system in order to effectively address and find solutions to resolving them.

## Health Outcomes in Communities of Color

Racial and ethnic minorities are among the fastest growing populations in the US.[18] By the year 2040, the US Census Bureau has projected that minority groups which include Black/African American, Hispanic/Latinx, Asian American, Native Hawaiian and other Pacific Islander, and American Indian and Alaska Native (AI/AN) will increase to more than 50% of the US population.[8] Because of the expected growth of the non-White proportion of the population and the high proportion of racial and ethnic minorities in the US represented among the medically underserved,[19] the future health of America as a whole will be influenced substantially by our nation's success in improving the health status of racial and ethnic minorities. It is imperative to address these disparities for the sake of economics and equity. The US spends approximately $93 billion in excess medical care cost and $42 billion in loss of productivity.[20] It is also evident given that communities of color and medically underserved populations continue to suffer disproportionately from disease. Black/African Americans and AI/AN are more likely to report a range of health conditions including asthma and diabetes as well as exhibit higher mortality rates in AIDS and HIV.[20] "Despite notable progress in the overall health of our nation, such as implementation of the Affordable Care, there are continuing disparities in the burden of illness and death experienced by African Americans, Hispanics, Native Americans, Alaska Natives, and Asian Pacific Islanders, compared to the United States as a whole."[19] The Patient Protection and Affordable Care Act (ACA) expanded coverage and increased funding to community health centers and created the Office of Minority Health within the Department of Health and Human Services (HHS) to coordinate disparity reduction. However, in recent years, there has been a reversal of such policies: the federal government has decreased funds for outreach and enrollment assistance; Congress negated the ACA individual requirement to have coverage; and more. Other notable barriers include limited capacity of the healthcare system to address the social determinants of health, decline in funding for prevention and public health initiatives, and gaps in data to measure and understand the full scope of disparities. While more BIPOC patients are now able to access care, many challenges also exist once care is accessed, including during the physician-patient encounter. They include provider bias, cultural, or linguistic barriers of communication.[20]

### *Burden of Diseases*

Since 1980, there has been a public health imperative to reduce and eliminate racial health disparities in the US, as defined by the health goals and objectives outlined by the Healthy People Initiative.[21–23] Though the health disparity gap between White and non-White populations has narrowed for some health indicators, for others, such as diabetes, the gap has actually widened since 1980, particularly among Native Americans.[24,25] Other chronic health conditions, such as obesity, asthma, hypertension, heart disease, and cancer, also occur in Black/African American, Hispanic/Latinx, Native Hawaiians and Pacific Islander, and AI/AN populations at much higher rate than in non-Hispanic Whites.[26] According to the CDC report, between 2012 and 2015, 24.5% of non-Hispanic Blacks/African Americans, 23.1% of Hispanics/Latinx, and 19.1% of AI/AN reported cost as a significant barrier to seeking healthcare, compared to 15.0% of non-Hispanic Whites.[27] Multiple chronic condition were reported by 40.3% non-Hispanic Blacks/African Americans and AI/AN, compared to 36.0% non-Hispanic Whites.[27] Healthy People 2020 reported in its midcourse progress report that most of its population-based trackable objectives for non-White and non-Asian American populations had made "little or no detectable change" in progress. For White and Asian American populations, those same objectives were reported as "target met or exceeded."[28] Thus, several decades of this nation-wide Healthy People Initiative has yet to achieve its intended outcome, and the burden of disease continues to fall on BIPOC communities, despite greater reduction in behavioral risk factors than their White counterparts and improved access to healthcare through health insurance coverage.[24,29]

***Hypertension***

In 2016, it was reported that the 75 million American adults had a diagnosis of hypertension, and only about half (54%) had their blood pressure managed. Even with such stark numbers, 1 in 5 American adults are likely unaware that they have high blood pressure. More importantly, it cost $48.6 billion per year to treat high blood pressure, accounting for health care services, treatment, and missed days of work.[30] There is a higher prevalence of hypertension in Southeastern region of the country where there is a large presence of BIPOC communities. Many Blacks/African Americans living in the Southeastern region are Medicare Part D recipients, and it has been shown that one fourth of Medicare Part D beneficiaries are non-adherent to their antihypertensive regimen.[31] This can be contributed to many flaws within the healthcare system such as lack of health literacy, follow up with patients, cost-sharing on antihypertensive medication and physician-patient relationship. Lack of adherence to antihypertensive medications has put minorities, especially Blacks/African Americans, at risk for higher mortality through increased cardiovascular morbidity. As uncontrolled blood pressure is a major risk factor for the 1$^{st}$ (heart disease) and 3$^{rd}$ (stroke) leading cause of death among individual less than 65 years old.[30]

*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.[32]

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.[33] Previously, it was believed that SES and education protected against this, however, studies have disproved that idea.[34] 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.[33]

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.[35]

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 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.[36]

### *Coronavirus Disease 2019 (COVID-19) Pandemic*

As of July 1, 2020, the novel coronavirus (COVID-19) has claimed nearly 129,000 lives in the US.[37] Of that striking number of lives lost, Black/African American and Native American people make up a disproportionate sum compared to their representative populations. In their analysis of COVID-19 mortality by race, the American Public Media (APM) Research Lab found that Black/African Americans are dying at 2.3 times the rate of Whites and Asian Americans. In specific states, the rates are higher: 6 times in District of Columbia, 5 times in Kansas and Wisconsin, 4 times in Michigan and Missouri, and 3 times in Arkansas, Illinois, New York, South Carolina, and Tennessee.[38] In the greater Chicago area, Blacks/African Americans are dying from COVID-19 at a rate of 144.7 per 100,000 population, compared with 55.6 per 100,000 for non-Hispanic Whites and 96.9 per 100,000 overall.[39] In Louisiana, despite only comprising 30% of the state's population, Blacks/African Americans make up 53% of the total deaths due to COVID-19.[40] Collectively, Blacks/African Americans are dying at rates above their population share in 29 states and the District of Columbia. Despite making up 4% of the state population in Arizona, AI/AN people comprise 18% of deaths and 11% of the total cases of COVID-19. In Wyoming, AI/AN people account for 30% of COVID-19 cases, but only 2% of the population. And in New Mexico where AI/AN people are only 9% of the population, they are 57% of the COVID-19 cases.[41] It is currently estimated that if they had instead died of COVID-19 at the same rate as White Americans, at least 15,000 Black/African Americans, 1,500 Hispanic/Latinx Americans, and 250 Native Americans would still be alive today.[38]

As striking as these numbers are, they are yet another symptom of the structural racism that exists within the US. Every social determinant of health contributes to this vulnerability to COVID-19 infection and mortality, from housing inequality and economic instability, to higher rates of chronic disease and mass incarceration. BIPOC communities are more likely than Whites to live in large, multi-generational households, making self-isolation or quarantine away from their household almost impossible.[42] Many BIPOC communities, particularly in Indian Country have limited access to clean running water, which poses a monumental challenge to hand washing, a key public health strategy to reduce the spread of infection.[43] Additionally, Black/African American, Hispanic/Latinx, and AI/AN people make up a

disproportionate number of those incarcerated, a circumstance that forcibly places them in close quarters and further increases their risk of infection from COVID-19.[44]

Furthermore, BIPOC communities are more likely to be employed in the service industry – an industry ripe with jobs that are low paying and rarely provide health insurance and/or sick leave – and be included in the selection of workers deemed essential.[45,46] In times of extreme economic instability, such as recessions, those working in the service industry are particularly vulnerable to job loss and loss of income. With the massive rates of unemployment due to closures during COVID-19, Blacks/African Americans saw unemployment rates of 16.7% compared to the 14.2% for Whites.[47] With the concern of job losses, increasing economic instability, already low wages, and employment in fields where they are exposed to hundreds of individuals a day, for BIPOC communities, it is not a matter of *if* they will contract COVID-19, but *when*.

***Income, Insurance Coverage, and Healthcare Access***

Communities of color are more likely to receive healthcare later in the progression of disease and thus more likely to suffer greater mortality as a result of disease as demonstrated by the racial/ethnic disparities in age-adjusted mortality rates.[48,49] Since access to adequate healthcare is tightly associated with an individual's economic and insurance status, communities of color are sicker than their majority counterpart. Level of income is also associated with access to health insurance, with those with lower income being less likely to have health insurance than the general population. In households with annual incomes of less than $25,000, 13.9% were without health insurance, while 7.9% and 4.3% of households with incomes of $75,000-$99,000 and $125,000 or more were without health insurance in 2017, respectively. However, the poor and uninsured are disproportionately and inequitably Black/African American and Hispanic/Latinx, despite improved access to health insurance coverage for all Americans through the Patient Protection and Affordable Health Act of 2014. In 2017, Blacks/African Americans and Hispanics/Latinx had the highest rates of coverage by government health insurance[i] (44.1% and 39.5%, respectively), lowest rates of coverage by private insurance (56.5% and 53.5%, respectively), and highest rates of lack of any coverage (uninsured; 10.6% and 16.1%, respectively).[50] Not only are Black/African American and Hispanic/Latinx communities disproportionately impacted by poverty or near poverty,[51] these statistics demonstrate that they are also disproportionately experiencing lack access to adequate and affordable healthcare through the receipt of health insurance coverage. In 2017, non-Hispanic Whites made up 60.5% of the US population but only 42.8% (17 million people) of the entire population experiencing poverty. The poverty rates for Blacks/African Americans and Hispanics/Latinx were 21.2% (9 million people) and 18.3% (10.8 million people), respectively.[51] This lack of access to care, compounded by the

overwhelming poverty rates, allows preventable and manageable diseases to go untreated, eventually leading to disastrous health outcomes, including mortality for communities of color.

## Community and Social Construct

### *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.[52]

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.[53,54] 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.[55] 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.[56] 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.[57]

At the federal level, an attempt was mad 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%).[58] 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.[58]

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.[59] 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.[59] 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.[60]

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.

### *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.[61–63] Due to the higher rates of poverty and lower economic stability that plague majority Black/African American and Hispanic/Latinx neighborhoods,[64] 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.[65,66] 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.[67–69] 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.[63,69–78]

### *Food Security*

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."[79,80] 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).[81]

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.[82] 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.[83,84] In addition, there has been an inverse relationship described between household income and density of fast food restaurants.[85,86]

### *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.[87] 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.[88] 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.[89] 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.[88]

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.[87] Black/African American students are overrepresented in special education program for students with disabilities and are underrepresented in programs for gifted students.[87] 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.[90] Students who subsequently drop out of school are eight times more likely to become incarcerated than students who stay in school.[90] 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.[90]

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.[91]

### *Adverse Childhood Experiences (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.[92] 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.[92,93] 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.[92,93] 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.[94] 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.[95–98] 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.[99]

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.[94] 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.[99] Of note, there was a distinction between children of immigrants, and children of US-born parents, identified as the "immigrant paradox."[100] 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.[100,101] 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.

### *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."[102] An overwhelming body of research has shown that BIPOC communities are less likely to trust the healthcare system and providers than White people.[103–108] Given the extensive history of unethical treatment of communities of color by medicine and biomedical research, – e.g., the Tuskegee Syphilis Study, Henrietta Lacks and the use and profit of the HeLa cell line without her or her family's permission or knowledge, J. Marion Sims's experimentation on Native and enslaved women and children without proper anesthesia, etc. – this distrust is not entirely farfetched.[109–111] 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.[106,107,112,113] Research has also shown that this mistrust in the healthcare system and of healthcare providers may be

mitigated by patient-physician race concordance,[113–115] thus making imperative the recruitment and retention of more physicians of color.

### *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.[116–123] 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.[124] 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.[125,126] 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.[127] 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."[128]

## Patient-Physician Relationship & Medical Education

### *Recruitment and Retention of Physicians of Color*

An uneven distribution of physicians is a barrier to both access to care and to the elimination of health disparities.[129] Historically, communities with high proportions of Black/African American and Hispanic/Latinx residents have been described as four times as likely as other populations to have a shortage of physicians, regardless of community income.[130–132] Studies show that physicians of color are at least twice as likely as White physicians to practice in underserved areas and also more likely to provide care to underserved communities, communities of color, and/or patients from their own ethnic group.[133–136]

Not only are physicians of color more likely than White physicians to care for minority, low income, underinsured, and uninsured patients, patients also feel more comfortable with the decision-making style of physicians from their own ethnic group (race-concordant).[133,136,137] Patients seeing physicians of their own race have also been found to rate their physicians' decision making styles as more participatory.[114] Thus, physicians from racial and ethnic minority groups can help improve care provided to underserved communities and communities of color by serving these populations in a way that is most sensitive and attuned to their lived experiences and needs. Therefore, the continued failure of racial/ethnic representation

among US medical students and resident physicians to reflect the demographic characteristic of the US population further exacerbates the disparity in healthcare access and delivery among minority and low income patient populations.[138]

Even though there is a clear need for physicians of color, people of color are underrepresented at all levels of medicine. The number of Black/African American, Hispanic/Latinx, and Native American students enrolled in US health professions schools and entering the workforce has not reached parity with the increasing diversity of the US population.[138–140] As a result, significant numbers of people are not receiving high quality care. In light of these facts, increasing the number of physicians of color is an obvious and imperative step. Therefore, "...a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health and minority medical education..." must be developed.[141]

Although addressing the representation of patients in medical professionals should play a key role in solving the health disparities problem, it cannot be fully addressed until every healthcare professional is prepared to care for all patients regardless of race, ethnicity, culture, gender, language, religion, education level or socioeconomic status in a respectful, culturally-humble, and structurally-competent way. Therefore, health professional training and education must integrate the learning of and engagement with implicit bias, cultural competency, structural competency, and antiracism into the curriculum at all segments and levels.[142]

### *Anti-racism within the Medical Curriculum*

"Medical schools, residency programs, medical specialty organizations, and continuing medical education programs should incorporate, as essential elements of their required curricula, teaching methods and experiences that assure cultural competency in medicine."[143] Culturally humble providers have the academic and personal skills that allow them to appreciate and identify the healthy practices and behaviors of their patients across cultural and language barriers.[144] The structural competency framework emphasizes the consideration of social structures as key elements of cultural process, and thus, drivers of health outcomes.[145] It is important that medical students, healthcare professionals, and the healthcare system consider institutions, communities, policies, etc., that operate above the level of the individual but still determine the individual's health. Both frameworks provide health professionals the tools to dismantle false beliefs of race as a biological entity, which has permeated medicine for centuries, and appropriately and adequately address the health needs of communities of color. "Creating a socially conscious educational environment for students in health care professions is of vital importance if providers are to have a significant impact on racial inequities in health."[146] As such, it is imperative that implicit bias and antiracism

be incorporated into the development of culturally humble and structurally competent healthcare providers who will adequately address the atrocious health inequities that persist within the US population.[147,148]

***Recruitment, Retention, and Mentoring of Medical of Color***

Increasing the minority student applicant pool to medicine begins with recruiting "minority students to science early and to maintain and support them as they pass through the pipeline so that they are better prepared for admission to professional training, thus ensuring that they will graduate and be well established toward a professional career."[149] Building a strong science and math foundation throughout the educational lifespan is thus vital. The racial/ethnic diversity of physicians should be increased and can be achieved in part through cultivating and nurturing the preexisting and potential interest of minority students in math and science beginning in grade school. If the minority medical student applicant pool is increased, then this will facilitate the acceptance of more qualified students to health professional training programs. Additionally, mentorship for students who are underrepresented in medicine is crucial, and necessarily throughout all stages of the process: pre-medical student, medical student, and resident physician. With its proven track record of helping minorities pursue their aspirations and achieve their career goals, mentoring plays a critical role in increasing the number of minority physicians and healthcare professionals. Mentoring deserves to be more highly valued and to become a structured component of programs dedicated to a larger presence of health professionals of color.[149] Once matriculated, medical schools need to provide an atmosphere conducive to social acclimation and academic success for medical students who are underrepresented in medicine. Medical schools must develop policies and strategies that facilitate "ongoing, two-way process of critical (self-)[reflection] in all stakeholders on dominant social norms in academic medicine that involves the curriculum, as well as the medical school culture and structure."[150]

## 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 BIPOC communities in the United States when engaging in discussion about this population's health. We acknowledge that we must first address the role that healthcare systems and the medical community has played in constructing and perpetuating systems that produce and uphold health disparities and inequities. We acknowledge that addressing the social determinants of health is necessary in the pursuit of health equity. The medical community is a social and structural determinant of health and acknowledging this is also 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:

1. Medical institutions to officially acknowledge how racism has influenced and continues to influence today's healthcare.
2. 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.
3. Medical institutions to allot time in the required, official curriculum for the discussion of racism in addition to other social determinants of health.
4. Medical institutions to broaden teaching to incorporate symptoms specific to patients of color.
5. Hospitals to routinely address cultural competency in the context of providing care for a diverse patient population.
6. 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.
7. 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.
8. Increasing access to healthcare must be addressed in order to decrease racial/ethnic health disparities by creating:
    - 8.1. Universal healthcare with equal access to care;
    - 8.2. More programs to address the gap in healthcare access seen in the poor and near-poor populations; and
    - 8.3. Incentives to encourage physicians and other health professionals to donate their services to treat the uninsured.
9. Mandate the incorporation of cultural and structural competency into training and life-long learning of health professionals through:
    - 9.1. Cultural and structural competency instruction at all levels of medical education, including continuing education, as outlined within the official SNMA Statement on Cultural and Structural Competency;[ii]
    - 9.2. The development of educational tools and programs that will sensitize health professionals to a variety of health belief systems and enhance provider communication skills; and

9.3. Medical schools to include a cultural and structural competency training in the medical school curriculum to help cultivate physicians who are critical aware of and prepared to address the needs of all of their patients.

10. The number of students of color who enjoy or have an interest in math and science at the elementary and secondary levels should be nurtured. Interests can be cultivated through increased exposure to the field of medicine and other science careers by providing:
    10.1. Funding for programs to increase minority participation in math and science classes through the use of innovative approaches to teaching;
    10.2. Funding for more science and math teachers in schools;
    10.3. Funding for the inclusion of creative uses of math- and science-oriented teaching during after school programs;
    10.4. Funding for special math and science summer programs to be held in medically underserved and/or areas with large minority populations; and
    10.5. Funding and financial incentives to academic medical centers that collaborate with other institutions to create and implement programs that increase the number of academically prepared minority students.
11. The availability of financial assistance to underrepresented minorities throughout all levels of education should be assured through public and private sector scholarships and loans. Existing programs, such as the National Health Service Corp (NHSC),[iii] should be broadened and utilized as a vehicle to increase financial aid to minority students interested in medicine and other health professions by receiving:
    11.1. Funding for scholarships for undergraduate minority students with the intention of attending medical school;
    11.2. Funding for obligatory summer experiences approved by the National Health Service Corps which give pre-medicine students valuable clinically oriented experiences, research geared toward eliminating minority health disparities, and/or preparation for the Medical College Aptitude Test (MCAT);
    11.3. Funding for programs that accept NHSC undergraduate scholarship recipients for the aforementioned obligatory summer experiences which will go toward the expenses created by the said recipient as well as money to be distributed to the scholarship recipient as a stipend during the duration of the obligatory summer experience; and
    11.4. Funding for scholarships for underrepresented minority medical students to matriculate into medical school, graduate from medical school, and prepare for and successfully pass the required United States Medical Licensing Examination (USMLE) and/or

Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) licensing examinations.

12. The number of programs that give children of color access to minority physicians and other healthcare workers in a mentoring/shadowing capacity should be increased by providing:
    12.1. A community service initiative embedded within the medical school curricula;
    12.2. Assisting in the creation of programs where pre-medical students at undergraduate institutions work with medical school students in their areas to do volunteer mentoring; and
    12.3. Funding to reimburse or provide incentives for physicians and health profession students who participate in the above programs.

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[i] Medicare, Medicaid, TRICARE, CHAMPVA, and care provided by the Department of Veterans Affairs and the military

[ii] https://snma.org/hpla

[iii] https://nhsc.hrsa.gov/