O
n July 7, 2016, in our Minneapolis community, Philando Castile was shot and killed by a police officer in the presence of his girlfriend and her 4-year-old daughter. Acknowledging the role of racism in Castile’s death, Minnesota Governor Mark Dayton asked rhetorically, “Would this have happened if those passengers [and] the driver were white? I don’t think it would have.” Such incidents are tragic—and disturbingly common. Indeed, in recent weeks, our country has witnessed the well-publicized deaths of at least three more black men at the hands of police: Terence Crutcher, Keith Scott and Alfred Olango.

Disproportionate use of lethal force by law-enforcement officers against communities of color is not new, but now we increasingly have video evidence of the traumatizing and violent experiences of black Americans. Structural racism—a confluence of institutions, culture, history, ideology, and codified practices that generate and perpetuate inequity among racial and ethnic groups—is the common denominator of the violence that is cutting lives short in the United States.

The term “racism” is rarely used in the medical literature. Most physicians are not explicitly racist and are committed to treating all patients equally. However, they operate in an inherently racist system. Structural racism is insidious, and a large and growing body of literature documents disparate outcomes for different races despite the best efforts of individual health care professionals. If we aim to curtail systematic violence and premature death, clinicians and researchers will have to take an active role in addressing the root cause.

Structural racism, the systems-level factors related to, yet distinct from, interpersonal racism, leads to increased rates of premature death and reduced levels of overall health and well-being. Like other epidemics, structural racism is causing widespread suffering, not only for black people and other communities of color but for our society as a whole. It is a threat to the physical, emotional and social well-being of every person in a society that allocates privilege on the basis of race. We believe that as clinicians and researchers, we wield power, privilege, and responsibility for dismantling structural racism—and we have a few recommendations for clinicians and researchers who wish to do so.

First, learn about, understand and accept the United States’ racist roots. Structural racism is born of a doctrine of white supremacy that was developed to justify mass oppression involving economic and political exploitation. In the United States, such oppression was carried out through centuries of slavery premised on the social construct of race.

Our historical notions about race have shaped our scientific research and clinical practice. For example, experimentation on black communities and the segregation of care on the basis of race are deeply embedded in the U.S. health care system. Disparate health outcomes and systematic inequalities between black Americans and white Americans in terms of wealth, well-being and quality of life must be seen as extensions of a historical context in which black lives have been devalued. We would argue that health care professionals have an individual and a collective responsibility to understand the historical roots of contemporary health disparities.

Second, understand how racism has shaped our narrative about disparities. Researchers and clinicians have long used rhetoric implying that differences between races are intrinsic, inherited or biologic. Pre–Civil War physicians attributed poor health among slaves to their biologic inferiority rather than to their conditions of servitude. Such beliefs persist today: A study published earlier this year revealed that 50 percent of white medical students and residents hold false beliefs about biologic differences between black and white people (eg, black people’s skin is thicker; black people’s blood coagulates more quickly). Implicit bias and false beliefs are common—indeed, we all hold them—and it’s incumbent on us to challenge them, especially when we see them contributing to health inequities.

Third, define and name racism. In health care and health services research, we need consistent definitions and accurate vocabulary for measuring, studying, and discussing race and racism and their relationships to health. Armed with historical knowledge, we can recognize that race is the “social classification of people based on phenotype”—“the societal box into which others put you based on your physical features,” as Camara Jones of the National Center for Chronic Disease Prevention and Health Promotion puts it. Racism, Jones continues, “is a system of structuring opportunity and assigning value based on phenotype (race) that: unfairly disadvantages some individuals and communities; unfairly advantages other individuals and communities; [and] undermines realization of the full potential of the whole society through the waste of human resources.” If we acknowledge
and name racism in our work, writing, research, and interactions with patients and colleagues, we can advance understanding of the distinction between racial categorization and racism and clear the way for efforts to combat the latter.

To pursue those efforts, we will have to recognize racism, not just race. We frequently measure and assess differences according to race. Patients check race boxes on forms; clinicians and health systems may assess racial differences in care; and researchers include race as a variable in regression models. When a person’s race is ascertained and used in measurement, is it merely an indicator for race, or does it mask or mark racism? For example, race is often used as an input in diagnostic algorithms (eg, for hypertension or diabetes), which may deflect attention from underlying causes—beyond biology—that may be contributing to the medical condition. Black Americans, on average, have more poorly controlled diabetes and higher rates of diabetes complications than white Americans. Successful treatment of such chronic conditions requires attention to structural factors and social determinants of health, but antiracism strategies are rarely recommended for improving diabetes control. Perhaps if we shift our clinical and research focus from race to racism, we can spur collective action rather than emphasizing only individual responsibility.

Finally, to provide clinical care and conduct research that contributes to equity, we believe it’s crucial to “center at the margins”—that is, to shift our viewpoint from a majority group’s perspective to that of the marginalized group or groups. Historical and contemporary views of economics, politics and culture, informed by centuries of explicit and implicit racial bias, normalize the white experience. In describing Castile’s death, for example, Governor Dayton noted that the tragedy was “not the norm” in our state—revealing a deep gap between his perception of “normal” and the experiences of black Minnesotans.

Centering at the margins in health care and research will require re-anchoring our academic and health care delivery systems—specifically, diversifying the

A Minnesota physician on why he’s speaking out

INTERVIEW BY CARMEN PEOTA

After St. Paul resident Philando Castile was shot by a police officer during a traffic stop in Falcon Heights last summer, three Minnesotans felt compelled to put into words what they were feeling and thinking. The resulting article, “Structural Racism and Supporting Black Lives: The Role of Health Professionals,” was published online in October and in the December 1 issue of the New England Journal of Medicine. We asked one of the authors, Eduardo Medina, MD, MPH, who practices at Park Nicollet’s Minneapolis clinic to tell us more about why he chose to speak out on this controversial topic.

What prompted you and the other authors to write this article?

Throughout the summer of 2016, almost weekly there was a news story about someone getting shot or killed. It was very psychologically taxing. Then, when the incident happened so close to home, we really felt compelled to do something. We saw both the extrajudicial killings and the things that we deal with on a day-to-day basis in the health care system as intertwined. It was an opportunity to shine a light on something that was important.

Can you explain how you connect these issues?

You have to stand back and ask, Is it coincidence that a population that has historically been marginalized and exploited also happens to have the least economic opportunity, some of the largest challenges getting quality education and housing that is substandard? And then you look at the health care system and read the 2002 IOM report, “Unequal Treatment,” and you can clearly see that race is an independent variable in care. You could be of a mind that all these things are just happening to a population by chance. Or you can understand these things as a historical process, which is what we certainly ascribe to. Structural racism is somewhat invisible. Doctors aren’t actively racist. Police officers aren’t actively racist. But we inhabit a system that is. What allows structural racism to prevail is that it exists as a default. Our focus on structural racism does not excuse or ignore interpersonal racism, but it attempts to explore the underlying cause of persistent structural inequity.

How does structural racism affect the health care that people get?

There are many studies demonstrating this. One published this year in Emergency Medicine found that in Minnesota, African American, Hispanic and American (continued on next page)
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Indian pediatric patients were triaged differently than their white counterparts. Another showed that patients who were born in Somalia and/or who prefer to speak Somali get less preventive care than other patients. Only 22 percent are appropriately screened for colorectal cancer, for example. That compares with 70 percent of Minnesota patients overall.

**How does structural racism affect people’s health?**

The research showing this is extensive. A recent study published in Social Science and Medicine found that black Americans living in states with high levels of structural racism were more likely to report myocardial infarction than blacks living in states with low structural racism indicators. The Minnesota Department of Health has reported on health disparities. For example, we know African American and American Indian babies die in the first year of life at a rate twice that of white babies. That has been the case for more than 20 years.

**Why should the medical community take on this issue?**

If I told you there was a condition out there that increased your risk for disease, that increased the likelihood that you would not get the right treatment, that more or less can predict a pathology, you’d want to know what it is and how we could treat it.

As health care professionals, we go where problems are. If we see the problem is lack of vaccinations, then we need to study the issue. If the problem is a disproportionate number of African American men being killed by police, we need to address that. We conceive of this as any other public health problem. We want to identify risk factors and what interventions are helpful, just like we would any epidemic, any major chronic disease.

**What can physicians do?**

As a profession, if we’re really going to start taking care of the health of our populations, and we’re identifying racism as an underlying cause of health problems, then it’s incumbent on us to speak to legislators or professional organizations and say it is unacceptable.

We’d encourage physicians to address this issue like any other they would face in their clinical practice: to gather information including from high-quality research and expert opinion—in this case, that may mean going beyond medical journals and into the realm of public health, sociology and anthropology—and to form their own conclusions on how to address the problem. We’d recommend starting with the National Academy of Sciences 2002 report “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” and the Minnesota Department of Health’s 2014 report “Advancing Health Equity in Minnesota: Report to the Legislature.”

**What are you and your co-authors doing to further the discussion?**

Our first author, Dr. Rachel Hardeman, is working with her colleague, Dr. Brooke Cunningham, in the medical school on additions to the curriculum to help increase future physicians’ capacity to understand these things. The U of M produces the majority of physicians in Minnesota. We feel that anyone graduating from the U of M medical school should understand how structural racism relates to health and health care.

**Is there a reason to be hopeful?**

If there’s any state that can fix health disparities, it’s Minnesota. The tradition in Minnesota is to prioritize health and opportunity. If we thought this wouldn’t make a difference, we wouldn’t have written the article.

workforce, developing community-driven programs and research, and helping to ensure that oppressed and underresourced people and communities gain positions of power. Centering at the margins in clinical care and research necessitates re-defining “normal.” We can do so by using critical self-consciousness—the ability to understand how society and history have influenced and determined the opportunities that define our lives. For clinicians, that means reflecting on how they arrived at their understanding of a diagnosis or clinical encounter and being willing to understand how patients arrived at theirs. Centering at the margins not only provides an important opportunity to practice more patient-centered care but can also generate new findings and clinical insights about the experiences of people who are often overlooked or harmed by our institutions.

We believe that in Minnesota and throughout the country, health care professionals have an obligation and opportunity to contribute to health equity in concrete ways. Addressing violence against black communities can start with antiracist practices in clinical care and research. Do we have the courage and conviction to fight to ensure that black lives do indeed matter?

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**REFERENCES**