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# On Racism: A New Standard For Publishing On Racial Health Inequities

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Racism is, perhaps, America’s earliest tradition. Its practice pre-dates the founding of the nation, as settler colonialism and Indigenous genocide powered the land theft that established the United States. And enslaved humans were the capital that generated this stolen land’s economy. In spite of centuries of legal advancements that endeavored to excise racism from the roots of this republic, racism remains a bloodying force, structuring every facet of US life.

In the wake of the police killings of Elijah McClain, Breonna Taylor, Tony McDade, and Rayshard Brooks, the heart-wrenching public murders of Ahmaud Arbery and George Floyd, and the premature and disproportionate deaths of tens of thousands of African Americans from COVID-19, our national racism bleeds anew, into the open, exposing the intersecting forms of violence that continue to threaten Black lives.

In short, racism kills. Whether through force, deprivation, or discrimination, it is a [fundamental cause of disease](#) and the strange but familiar root of [racial health inequities](#).

Yet, despite racism’s alarming impact on health and the wealth of [scholarship](#) that outlines its [ill effects](#), preeminent scholars and the journals that publish them, including *Health Affairs*, routinely fail to interrogate racism as a critical driver of racial health inequities. As a consequence, the bar to publish on racial health inequities has become exceedingly low. There is no uniform practice regarding the use of race as a [study variable](#) and little to no expectation that authors examine racism as a cause of residual health inequities among racial groups. Absent rigorous standards, the praxis such scholarship offers can be conflicting, potentially dangerous, and ultimately ineffective.

For example, *Health Affairs* recently published an Ahead-Of-Print [article](#) that evidenced striking racial disparities in COVID-19 hospitalizations in California. Overall, the study found, “Compared with non-Hispanic white patients, African

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Americans had 2.7 times the odds of hospitalization, after adjusting for age, sex, comorbidities, and income.” In an initial version of the article published online, the authors explored “several possible explanations for the observed disparities.” They noted that “one hypothesis is that there may be some unknown or unmeasured genetic or biological factors that increase the severity of this illness for African Americans.” They then discussed additional “societal factors” that could have contributed to the disparity, including unconscious provider bias, patient distrust, and financial stress. [*Editor’s note: The final published version of the paper has been revised to clarify the authors’ conclusion that the disparities are most likely explained by societal factors.*]

But this analytical framing ignores racism as the mechanism by which racial categorizations have biological consequences. And despite exploring potential “societal” drivers, the term “racism” is never mentioned in the piece. This is unfortunately common and occurs across disciplines. A recent [JAMA article](#) exploring the association between air pollution, heat exposure, and adverse birth outcomes noted corresponding racial disparities but failed to examine how racism structures environmental exposures and health outcomes. Another recent study in the [Journal of Public Health](#) looked at racial disparities in knowledge, attitudes, and practices related to COVID-19 yet ignored how racism shapes access to information and information-sharing technology such as the internet. A quick search of the [Health Affairs](#) website reveals only [114 pieces](#) include the word racism in the 39-year history of the journal. As was noted in a 2016 article in [The Lancet](#) on [structural racism and health inequities](#), most articles in the medical canon that use the term “race” do not additionally use the terms “structural racism” or “systemic racism.” A 2018 [systematic literature review](#) of the public health literature additionally found only 25 articles that used the term “institutionalized racism” between 2002 and 2015. And a [Pub Med Database search](#) done on June 23, 2020, revealed as few as 86 articles that included both the word “race” and the terms

“structural racism” or “institutional racism.” Of the 86 articles found, 32 were published in the past 18 months.

## Denouncing Biological Race And The Insidious Harms Of Patient Blame

In the absence of a rigorous examination of racism, assertions that unmeasured genetic or biological factors may account for racial differences in health outcomes are [troublingly frequent](#). Within four days of *Health Affairs'* now revised article, a *Journal of Internal Medicine* article offered a similar hypothesis in a paper outlining racial disparities in COVID-19 infection and death rates stating, “It also remains to be determined whether there is a genetic difference in susceptibility, especially to severe disease, to COVID-19.” Claims such as these resurrect [long-refuted](#) and [disproven](#) theories about biological race. Historically, [these theories](#) were advanced to affirm the violent subjugation and painful experimentation forced upon enslaved Africans and other historically oppressed groups, such as Jews and women of color. In such cases, science, through the guise of objectivity, has abetted the indignities forced upon non-white populations by probing their innate propensity for disease and thus their biologic inferiority. In 2020, such [unsubstantiated claims](#) have no place in scholarship on racial health inequities.

Similarly, assertions that patient mistrust drives disparities obscures the etiologies of racial health inequities and tacitly blames affected patients for their disproportionate suffering. This is particularly true for Black patients. Any mistrust Black patients may harbor toward the US health care system is a result of their [never-ending mistreatment](#), not the cause of it. Suggestions otherwise essentially posit that trust, not racism, is the primary barrier between Black patients, equitable care, and positive health outcomes. This is simply untrue. And at this point, if Black patients harbor mistrust of the US health care system, a system that affords them [inequitable access](#) to every conceivable service save [amputation](#), it exposes their valid assessment of the health

care systems' performance to date, not the root of their poor outcomes.

Yet, article after article on racial health inequities, many written by long-time scholars from prestigious institutions, situate mistrust among the etiologies that create and widen racial gaps in health. This includes a recent *New York Times* article inaptly entitled, "[Race and Medicine: The Harm That Comes From Mistrust](#)." Despite identifying discrimination and racism as causing racial health disparities, the article relies upon research that attributes poor Black male health outcomes, in part, to patient mistrust. To do this, the author draws upon "[Tuskegee and the Health of Black Men](#)," a paper that focuses on how Black male patient mistrust, following disclosure of the Tuskegee Syphilis Experiment, shaped health care use behaviors and ultimately widened racial gaps in life expectancy in 1980. Yet, the focus on patient mistrust distracts from enrollees' abject exploitation, sanctioned undertreatment, inadequate financial reparation, and increased burden of familial disease (not to mention the structural factors that likely advantaged white adults living over the same time period). These plausible alternate foci only emerge if scholars position racism as a potential driver of the inequity. Instead, this approach remains an accepted way to investigate and interpret racial health inequities. And it illustrates a common misreading of the harms of the Tuskegee Syphilis Experiment, which stem from coercion and systematic exploitation, not mistrust. These harms include the creation and maintenance of an elaborate [economy of suffering](#) used to advance science. Since Tuskegee, decades of research have evaded the profitability of suffering to instead belabor patient trust as a cause of health disparities. As a result, innumerable interventions now aim, as a primary or secondary outcome, to increase patient trust as a solution to racial health inequities.

While patient trust certainly shapes health care use behaviors and is an important part of the patient-physician relationship, incessant racial health inequities across nearly

every major health index reveal less about what patients have failed to feel and more about what systems have failed to do. To be clear, patient trust will never solve racial health inequities or narrow gaps in outcomes, by race. The solution to racial health inequities is to [address racism](#) and its attendant harms and erect a new health care infrastructure that no longer profits from the persistence of inequitable disease.

## Obfuscating The Role Of Racism In Determining Health And Health Care

The academic publication process, through authors, reviewers, and editors, has legitimized scholarship that obfuscates the role of racism in determining health and health care. This renders racism less visible and thus less accessible as a preventable etiology of inequity. It enables the health care infrastructure to unduly blame individual patients for the neglect and harm of systemic processes that undergird [individual and population health](#) inequities. It subjects countless patients, spanning generations in communities of color, to ineffective behaviorist approaches to problems that are actually institutional in nature. It permits authors to publish despite failing to cite at least two centuries of work, much of which has been accomplished by scholars of color (particularly Black scholars), that articulates how racism shapes conditions germane to racial health inequities. This process unfairly advantages white academicians and disadvantages scholars of color whose careers may be stunted when the academy undercites and thus undervalues their contributions.

Obfuscating the role of racism in driving racial health inequities also gives frames such as implicit bias undue traction. This stalls progress to end inequities by entreating clinicians to tame “unconscious beliefs,” rather than confronting explicit practices that undergird systemic inequities. It also unfairly centers [white authors’](#) reflections on racial inequity without demanding corresponding solutions to end racial inequity. This practice undertheorizes



racism as a clinically relevant cause of poor health and underelaborates solutions to racism as a health intervention. As a result, patients who suffer the physical tolls of inequities are doubly burdened by the emotional toll of researchers interested in documenting inequities but not addressing them.

## Rigorous Standards For Publishing On Racial Health Inequities

To address the shortcomings listed above, we propose several standards for publishing on racial health inequities, intended for researchers, journals, and peer reviewers.

### Researchers

- *Define race* during the experimental design, and [specify the reason](#) for its use in the study. Such definitions should be couched within a sociopolitical framework, not a biological one, that explicitly reviews all relevant social, environmental, and structural factors for which race may serve as a proxy measure. For the reader, these additional details enable careful interpretation of study results and implications. But for authors, it engenders critical thinking about racial constructs that prevent the reification of race as a biological entity.
- *Name racism*, identify the form ([interpersonal, institutional, or internalized](#)), the [mechanism](#) by which it may be operating, and other intersecting forms of oppression (such as based on sex, sexual orientation, age, regionality, nationality, religion, or income) that may compound its effects. A [critical race theory framework](#) lends authors a vocabulary for discussing racism and its potential relationship to the study's findings. And naming racism explicitly helps authors avoid incorrectly assigning race as a risk factor, when racism is the risk factor for racially disparate outcomes.
- *Never offer genetic interpretations of race* because such suppositions are [not grounded in science](#). If race

and genetics are being expressed jointly, painstakingly delineate the intended implication.

- *Solicit patient input.* Use community review boards or form patient panels to ensure the outcomes of research reflect the priorities of the populations studied.
- *Identify the stakes.* “All policy is health policy,” and all research on racial health inequities has implications for broader public policy and clinical practice. Inform readers of these potential applications.
- *Cite the experts,* particularly scholars of color whose work forms the basis of the field’s knowledge on racism and its effects.

## Journals

- *Reject articles on racial health inequities that fail to rigorously examine racism.* This will require continuing education on the part of existing editorial staff and efforts to hire and promote new editors who are well versed in critical race theory and its application.
- *Revisit editorial and publication guidelines,* including the uniform requirements for manuscripts submitted to biomedical journals, regularly to ensure they capture the evolution of racial definitions and sociopolitical structures. Publicly share the guidelines online and with peer journals.
- *Consider compensating reviewers* particularly reviewers of color who are often asked to share their expertise without remuneration.
- *Use experienced reviewers* who have demonstrated, through their own scholarship and work, facility with racism and its pathophysiologic mechanisms.

## Reviewers

- *Be critical of work that reifies biological race* or provides a genetic basis for racial differences in health outcomes. Inform the editors and authors that such statements are unsubstantiated and request clear explanations of suggested genetic etiologies to ensure



such claims are not misinterpreted as biological race.

- *Review the citations* and when appropriate recommend authors expand their literature review to include the wealth of data on racism.
- *Consult experts* and inform the editors if one's individual expertise is insufficient to advise regarding an important aspect of the paper from study design and methodology to the analysis.

Closing the gap in racial health outcomes in the United States will only be accomplished by identifying, confronting, and abolishing racism as an American tradition and root of inequity.

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**Richard David** • a day ago

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**zelgo** • 2 days ago

I'm thrilled that, FINALLY, this is down in black and white. Researchers need to stop dancing around racism as the cause.

^ | ▾ • Reply • Share ›



**Richard David** • 3 days ago

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**kathy kastner** • 5 days ago

thank you for this astute and timely article. I wonder, however, why this isn't at the top of the list: involve patients to "ensure the outcomes of research reflect the priorities of the populations studied." To add to your historical note about the haunting song, 'Strange Fruit', it was the Meeropol's who adopted the orphaned sons of Julius and Ethel Rosenberg - executed by electric chair for allegedly passing secrets to the Russians.

^ | ▾ • Reply • Share ›



**Peter Sterling** • 5 days ago

Excellent and long overdue! For further support and explanation, see my What is Health?

<https://www.youtube.com/wat...>



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