

<http://somatosphere.net/2014/06/addressing-raciaethnic-health-disparities-a-conference-report.html>

“Addressing Racial/Ethnic Health Disparities”: A Conference Report

2014-06-10 12:57:37

By Elizabeth Lewis

An interdisciplinary group of experts on health and medicine gathered in Austin, Texas on September 23-24, 2013 for a two-day conference and working group, “[Addressing Racial/Ethnic Health Disparities: Best Practices for Clinical Care and Medical Education in the 21st Century](#)” (ARHD). Organized by [Deborah Bolnick](#), ARHD invited participants and attendees to examine how erroneous beliefs regarding the relationship of race, ethnicity, and biology persist in contemporary medical research, training, and clinical practice, and to brainstorm possible interventions for new futures in medical education. How might insights from innovative interdisciplinary and transdisciplinary collaborations diminish the legacy of discrimination and scientific racism in modern medical training and practice?

ARHD grew out of Dr. Bolnick’s earlier discussions with [Rayna Rapp](#), [Jonathan Kahn](#), and [Dorothy Roberts](#) during the [Tarrytown Meetings](#), an invitational event in the summers of 2010-2012 hosted by the [Center for Genetics and Society](#) (CGS). Tarrytown brought together top scholars and researchers to probe the human impact of new biotechnologies. (For further information, CGS has extensive coverage of the meetings on its YouTube channel, found [here](#).) _

Building on the excitement during Tarrytown, and Dr. Bolnick brought in anthropologists [Michael Montoya](#) and [Karen-Sue Taussig](#), as well as epidemiologist [Jay Kaufman](#), to help the group organize a conference to delve into these issues. The result was ARHD, which brought together cutting-edge scholars and practitioners committed to developing innovative approaches to social medicine and systemic change in medical education in the U.S.

The conference location was far from incidental. The University of Texas is preparing to launch the [Dell Medical School](#), which plans to admit its first class in 2016. It is the one of the few new medical schools to open at a major U.S. research university in the past half-century. Since the school was announced in 2013, Austin has grown into a hotbed of discussion and ideas about strategies to address current health needs and problems,

including the very real issues of persistent health inequality.

ARHD hosted [20 speakers](#) from across the U.S. and Canada, who presented on such diverse topics of addiction, mental illness, medical program administration, genomics, and migrant health. Presenters and audience members engaged in a critical discussion and analysis of the potential role of interdisciplinary approaches to yield insights into the complex interplay of race, ethnic, health, and inequality in the contemporary U.S. For anthropologists, this related to such classical areas of inquiry as power, difference, historical legacies, and embodiment.

As Dr. Bolnick explained in her opening remarks, human genetic variation does not map cleanly by racial or ethnic group, yet widespread erroneous beliefs regarding race, ethnicity, and biology combine with structural inequality to generate disparate health outcomes. Working from this starting point, Dr. Bolnick outlined two broad aims for participants: first, to use the presentations to help clarify what we know about these health disparities, their roots, and their persistence; and second, to map a course for interventions, with a focus on changing the ways that knowledge is both generated and disseminated in today's medical education system.

Navigating deftly between theory, method, and ethnographic vignettes, participants attacked scientific racism in its modern iterations. Bolnick's early reminder that race and ethnicity are poor proxies for genetic ancestry resonated throughout many of the presentations, such as in NIH genomics expert [Dr. Charles Rotimi](#)'s explanation of human genetic variation: "We are all mutants, but we are mutants in different ways." He pointed out that the vast majority of human genome studies focus on people of European descent, creating a significant bias from the outset.

Conference presenters launched multi-faceted and full-force attacks on the persistent slippage between race, ethnicity, and genetic determinism. As Dorothy Roberts stated, "Race isn't a biological category...It's a very real political category." She went on to say that the persistent medical tendency to use race to explain differences in disease leads to a nefarious tendency to use it to explain inequality itself. Racism is embodied, not simply social. It plays out through disparate infant mortality rates for African Americans, in the bifurcated realities of the link between skin color and who does (and does not) receive pain medication or organ transplants. Racism emerges in medical and legal approaches to illicit drug use in different populations, as illustrated by [Helena Hansen](#)'s study of opioid addiction among white Americans, which she referred to as "the drug war that wasn't."

For scholars of health and medicine, this disjuncture between medical practice and social scientific knowledge and inquiry represents a critical

opening for applied and theoretical interventions. As Jonathan Kahn succinctly stated, often times in the domain of medicine, “what we don’t know becomes racialized,” making this a particularly pressing area of inquiry for anthropologists and other scholars.

NIH researcher [Vence Bonham](#) cautioned audience members that doctors consistently regard race as biological and ethnicity as cultural. What might this mean in the context of modern genomics? The cost of gene sequencing has dropped literally tens of millions of dollars in the last decade, but at what social costs? What are the cultural and ethical implications of this shift, and how might unprecedented access to genetic information shape broader understandings of race, disease, and biological destiny? In our genomic age, how are new scientific technologies used to explain biological difference and also social classifications without respect to the dynamic and culturally shaped nature of such categories?

Of course, the conflation of race with genetics hinges on an ethnocentric understanding of race. If race determined biological destiny, then it must be a biological category itself; in turn, it must necessarily be universal. [Lance Gravlee](#)’s presentation did nothing short of destroy this misconception for any audience members with lingering doubts. Pulling a classic anthropological move, Gravlee asked how Americans might better understand their own constructed racial categories through an analysis of the groupings used in another cultural context. He presented a clear breakdown of the racial classification system in Puerto Rico to demonstrate that race is fluid, situated, and culturally determined. He then showed that certain health outcomes, such as blood pressure trends, correspond to the interacting forces of social class and racial categorization in Puerto Rico, rather than following the trends of U.S. populations. The information presented was so straightforward, yet powerful, that one wonders how the conflation of race and genetics has remained so persistent.

Nonetheless, historian [John Hoberman](#) warned of the persistent “silent curriculum” of contemporary medical education. Medical folklore continues to link race, biology, and health, despite incontrovertible evidence that race is a social marker. There is a long-standing and well-documented history of these oral traditions, from the notion that African Americans are somehow immune from depression to the idea that an individual’s pain tolerance is linked to race and ethnicity. Jonathan Kahn called on the audience to examine race as a “residual category” and to ask how, in the context of modern biomedicine and genomics, race might actually anchor underlying beliefs about biological and genetic determinism.

The legacy of medical folklore and scientific racism is evident in the role of

race and ethnicity in clinical interpretations of symptoms. Throughout the day, participants returned to a telling example from a *Chronicle for Higher Education* [piece](#) by fellow speaker Dr. Richard Garcia. Garcia shared the story of his childhood friend, Lela, who was not diagnosed with cystic fibrosis until the age of eight. Lela's family visited doctor after doctor, only to have them dismiss her as a black child with a common respiratory condition, like pneumonia or a cough. Indeed, she was only diagnosed correctly when a radiologist, who did not know of her racial background, saw her x-ray and asked about the child with cystic fibrosis.

Lela's story is just one example of the dangers of linking particular pathologies to American racial categories. Just as not all children with cystic fibrosis are white, not all babies born with Tay-Sachs are Jewish and many people with sickle-cell anemia – a quintessentially racialized disease – are not black. The misattribution of race as a biological category – or what Jay Kaufman referred to in his presentation as “the irrational use of race as a clinical indicator” – can prolong suffering and misdiagnosis, and even be deadly.

[Jonathan Metzl](#)'s fascinating presentation on race, stigma, and schizophrenia in the U.S. offered an important opening to include mental illness and disability in the discussion of racial health disparities. His talk offered a snapshot of his broader work in [The Protest Psychosis: How Schizophrenia Became a Black Disease](#). Metzl pushed audience members to think about how clinical terminology, such as for schizophrenia, becomes another way to discuss race. One might ask the same question about autism spectrum disorders, ADHD, learning disabilities, or other invisible disabilities in which race is not typically part of the conversation, yet lurks clearly in the background.

In terms of methodological approaches and research aims, panelists were closely attuned to the different approaches of academics versus clinicians. Multiple clinical and non-academic participants in the working group on the second day of ARHD mentioned the fundamental disconnect between these fields: while academics are largely content with open-ended research and are always looking for new questions to ask and avenues to pursue, medical practitioners are trained to do the opposite. Their task is to identify a problem and devise a solution; they are both more and differently outcome-oriented. As scholars looking at the embodied realities of social inequality, many scholars undoubtedly feel a push to effect change. In turn, our efforts would be fortified by an active attention to the potential and very real cultural differences between the academia and clinical care.

Participants demonstrated a steadfast commitment to the fundamental usefulness of anthropology and, more generally, social medicine. How

might an ethnographic attunement to race, health, and disparities help shape new era of medical training? How might scholars and practitioners replace current models of *cultural competence*, which stress practitioner understanding of an individual patient's so-called cultural membership, with what Jonathan Metzl and Helena Hansen have termed [structural competency](#) which focuses instead on the structural obstacles to equal health outcomes? The political implications of such a shift would be significant, demanding a renewed attention to intersectionality and the interplay of race and class in the contemporary U.S., rather than using culture as a foil for marginalization.

As participant [Seth Holmes](#) stated: "Theory *is* intervention." Holmes and others stressed the potential to use ethnography to break the pattern of making well-intentioned interventions that simply reify existing categories of difference. Holmes' presentation elaborated the concept of *structural vulnerability*, through the lens of his research with migrant farmworkers in California. Indeed, as Holmes argued in his presentation on the structural vulnerability of migrant farmworkers, even in medical settings racialized labels and corresponding assumptions all too often become tools to legitimize unequal treatment practices.

Ultimately, AHRD enabled scholars and participants to engage meaningfully and critically with pressing questions of health, race, and inequality. There is no doubt that health disparities are a critical area for research from medical anthropologists and others in the social sciences and humanities. Indeed, such stark differences in health outcomes, medical experiences, and life expectancy reveal the ways that race and ethnicity are *literally* embodied. They unfold on and through the body, and their continued presence belies the dominant discourse of progress that ignores the unequal distribution of suffering in the contemporary U.S. This is a significant area for potential interventions – both theoretical and applied – from scholars in the social sciences and humanities. Whether or not the innovative ideas that emerged from ARHD will be adopted, they were an important contribution to emerging discussions about furthering a robust discipline of social medicine.

[Elizabeth Lewis](#) is a doctoral student at the University of Texas at Austin. Her research focuses on shifting conceptions of disability, particularly deafblindness and multiple disabilities. She is particularly interested in the intersections of medical anthropology, affect, and disability studies, and her current research probes how dynamic realities of disability unfold in everyday life. She has conducted ethnographic research in Guatemala and Nicaragua, as well as in the U.S. She is also a regular contributor to Somatosphere's *In the Journals* series.

Relevant Readings:

Braun, L, Fausto-Sterling A, Fullwiley D, Hammonds EM, Nelson A, et al. (2007) [Racial Categories in Medical Practice: How Useful Are They?](#)

Betancourt, JR (2006). [Eliminating Racial and Ethnic Disparities in Health Care: What is the Role of Academic Medicine?](#)

Garcia, R (2003). [The Misuse of Race in Medical Diagnosis](#)

Additional Resources:

[CDC Health Disparities and Inequalities Report 2013](#)

[HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)

[Structural Competency](#)

[Disparities Reduction Efforts, Office of Minority Health](#)

[Office of Minority Health and Health Disparities \(OMHD\), CDC](#)

AMA citation

Lewis E. "Addressing Racial/Ethnic Health Disparities": A Conference Report. *Somatosphere*. 2014. Available at: <http://somatosphere.net/2014/06/addressing-raciaethnic-health-disparities-a-conference-report.html>. Accessed June 10, 2014.

APA citation

Lewis, Elizabeth. (2014). "Addressing Racial/Ethnic Health Disparities": A Conference Report. Retrieved June 10, 2014, from Somatosphere Web site: <http://somatosphere.net/2014/06/addressing-raciaethnic-health-disparities-a-conference-report.html>

Chicago citation

Lewis, Elizabeth. 2014. "Addressing Racial/Ethnic Health Disparities": A Conference Report. *Somatosphere*. <http://somatosphere.net/2014/06/addressing-raciaethnic-health-disparities-a-conference-report.html> (accessed June 10, 2014).

Harvard citation

Lewis, E 2014, "*Addressing Racial/Ethnic Health Disparities*": A Conference Report, Somatosphere. Retrieved June 10, 2014, from <<http://somatosphere.net/2014/06/addressing-raciaethnic-health-disparities-a-conference-report.html>>

MLA citation

Lewis, Elizabeth. "'Addressing Racial/Ethnic Health Disparities': A Conference Report." 10 Jun. 2014. Somatosphere. Accessed 10 Jun. 2014. <<http://somatosphere.net/2014/06/addressing-raciaethnic-health-disparities-a-conference-report.html>>