INTRODUCTION: Race and Ethnicity in 21st Century Health Care

Laura Specker Sullivan and Robert M. Sade

ABOUT THIS SYMPOSIUM

The 26th Annual Thomas A. Pitts Memorial Lectureship in Medical Ethics was scheduled for March 2020, but was cancelled owing to the SARS-CoV-2 pandemic. This symposium issue consists mostly of papers from that conference. The endowed lectureship, held annually since 1993, is funded by the Medical University of South Carolina Foundation through a bequest from Dr. Pitts, who served on MUSC's Board of Trustees for 36 years, including 25 years as its chair. The conference is presented by the Medical University of South Carolina, the Institute of Human Values in Health Care, the South Carolina Clinical and Translational Research Institute, the Humanities Office, and the Office of Continuing Medical Education of the MUSC College of Medicine.

The 26th Annual Thomas A. Pitts Memorial Lectureship in Medical Ethics was planned in 2019, before the pandemic, protests against racial injustice after the killing of George Floyd, and the 2020 presidential election. The social upheavals since our plans began have been enormous. Prominent bioethics journals have dedicated special issues to race and racial injustice, including the *American Medical Association Journal of Ethics* and the *American Journal of Bioethics*; this will not be the first or last issue focused on racial injustice found in the pages of the *Journal of Law, Medicine & Ethics*.[1] This groundswell of critical consciousness, building on decades of hard work by scholars and practitioners, has led to real changes. The University of Pennsylvania recently announced that race would no longer be used in eGFR equations at Penn Medicine, reflecting work by Ameaka Eneanya.[2] The eGFR helps determine candidacy for kidney transplants and has been shown to disproportionately reduce the numbers of Black individuals who receive transplants (and is discussed by Nicolle Strand in this issue).

While this conference was initially designed to address current issues at the intersection of race, ethnicity, law, and health care, this is now a fast-moving space. Yet current progress does not negate the importance of a historical understanding of these issues, and our interests reflect our positions as scholars and practitioners in Charleston, South Carolina, a city with a deep and complex past. One of our goals in planning the conference was to bring leading scholars on race and ethnicity in medicine to Charleston and to the Medical University of South Carolina in particular. Charleston has been consistently rated the number one tourist destination in the United States and occasionally, in the world, by *Travel+Leisure* and Condé Nast; it is also a port city through which 40% of enslaved persons brought to the United States passed. Less than a mile from the city's French Quarter, with

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its cobblestone streets and pastel homes, is the Emanuel African Methodist Episcopal Church, where nine people were shot and killed by a 21-year-old white supremacist in 2015.

The complexity of Charleston's past encompasses the university, which as the Medical College of Charleston taught Dr. J. Marion Sims, who experimented on enslaved women.[3] It is the locus of *Ferguson v. City of Charleston,* a 2001 U.S. Supreme Court decision that found drug testing of pregnant women, most of whom were Black, violated the Fourth Amendment.[4] These are not cases of merely local interest. The *Ferguson* case opens Dorothy Roberts' landmark *Killing the Black Body*; a statue of J. Marion Sims was removed from New York City's Central Park in 2018.[5] The theme of "Race and Ethnicity in 21st Century Health Care" was intended to acknowledge this past while creating a forum that looked towards a more equitable future.

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The original schedule for the conference organized speakers and themes across four broad areas relevant to academic medicine: admissions, education, clinical practice, and research, with two speakers invited to speak on each theme. After the conference was cancelled, some speakers were not available as writers, so the organization of this special issue has changed from the original conference plan. In the current issue, we include two personal narratives by Black physicians, four perspectives on medical school education and admissions, and three analyses of clinical practice and research. These articles showcase the span of issues involving race, ethnicity, and racism across the activities of academic medical centers.

The two personal narratives present the authors' perspectives over decades-long careers in medicine:

Thaddeus J. Bell describes experiences throughout his 44-year career as a primary care physician and his creation and leadership of the Closing the Gap in Health Care (CGHC) program, which focuses on health disparities that affect African Americans and other underserved populations.[6] He describes his difficulties in gaining admission to medical school as a Black man in the 1960s and the influence of such events as the assassination of Martin Luther King, Jr., and the Charleston Nurses' Strike of 1968.

Lenworth Jacobs reflects on racial inequity in medicine and describes the roles of education, mentoring, and professional associations in addressing inequity.[7] He describes his own experiences as a surgeon and his perception of the social rules of this space, observing that professional training in surgery is governed by social norms and rules that are largely out of trainees' control, while nevertheless dictating success in the field.

The four articles on education and admissions come from scholars with a range of backgrounds and experience across law and medicine:

Nancy Zisk, a professor of law, reviews the development of law in the United States that upholds the use of race as a criterion in admissions, then argues in favor of a consideration of race by all undergraduate and graduate schools, including medical schools, as one factor of many in admissions programs.[8] She ultimately concludes that "to best serve people of all races, backgrounds, and ethnicities, the pool of physicians should be drawn from all races, backgrounds, and ethnicities."

Richard Sander, also a professor of law, draws three lessons from his analysis of affirmative action policies in medical schools, and in particular the experience of the University of California system: (1) racial preferences are not a substitute for other forms of affirmative action, (2) building pipelines, reducing science mismatch, and improving outcomes can be more effective than relying on preferential admissions, and (3) educational attachment to racial preferences is not always justified by underlying data.[9]

Zisk and Sander have opposing perspectives on the use of race in medical school admissions, Zisk arguing in favor of the practice and Sander arguing against it. Attorney Jason Arnold presents a third perspective.[10]

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After reviewing the work of both Zisk and Sander in the context of U.S. Supreme Court decisions on affirmative action, he finds that "If affirmative action policies are to survive current legal challenges, proponents will need to identify a consistent set of metrics and develop a philosophical foundation that justify its continued use."

Jennifer Tsai, an emergency medicine physician, argues that, because many race-based health inequities are due to racist social practices, not inherent biological differences, it is important to teach medical students to distinguish between these two sources of disparate health outcomes so that they will be better able to practice medicine with an eye toward equity.[11] She found in an empirical study that students who received a Critical Race Theory-based intervention showed an increased ability to address practices that exacerbate health inequity. She describes the skill that students come away with as one of structural empathy.

Finally, three articles review issues of race and ethnicity in clinical practice and research:

Ronit Elk, professor of medicine and gerontology, and Shena Gazaway, professor of nursing, describe health disparities that African Americans experience at the end of life.[12] They explain how implementing Community-Based Participatory Research (CBPR) methods that are based in the cultural values of African Americans can help develop palliative care programs, goals of care conversation guides, and training methods for clinicians that meet community needs.

Nicolle Strand, an attorney and professor of bioethics, argues for eliminating clinical algorithms that "correct" for race in scientific research.[13] She examines the regulatory authority of Institutional Review Boards (IRBs) to impede protocols that conflate race with biology. She then provides a conceptual model that IRBs could use to review the use of race in scientific protocols, and explores other options, including an evidence-based framework for peer review of NIH research proposals that use race as a variable.

Melissa Creary, professor of health management and policy, describes the concept of bounded justice, explaining that policies and interventions intended to counter injustice are hemmed in by greater socio-historical constraints.[14] In contrast to "quick fixes" that may superficially advance fairness and equity, she calls for practices that acknowledge colonialism as the source of inequity, that posit health equity as a human right, and that address the bases of everyday injustices and limitations in socio-historical conditions.

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