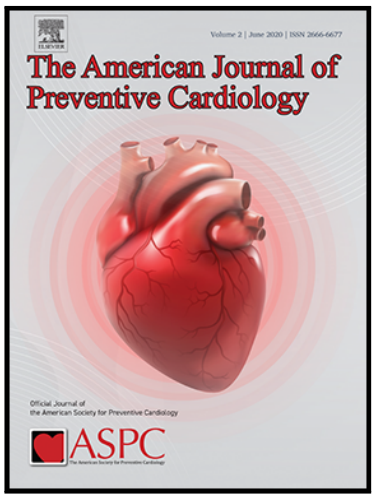

Race is not a risk factor: reframing discourse on racial health inequities in CVD prevention

Luke G. Silverman-Lloyd M.S. , Naomi S. Bishop M.L.I.S. , Jessica P. Cerdeña M.Phil.

PII: S2666-6677(21)00040-4
DOI: https://doi.org/10.1016/j.ajpc.2021.100185
Reference: AJPC 100185

To appear in: *American Journal of Preventive Cardiology*

Received date: 4 March 2021
Accepted date: 11 April 2021

Please cite this article as: Luke G. Silverman-Lloyd M.S. , Naomi S. Bishop M.L.I.S. , Jessica P. Cerdeña M.Phil. , Race is not a risk factor: reframing discourse on racial health inequities in CVD prevention, *American Journal of Preventive Cardiology* (2021), doi: https://doi.org/10.1016/j.ajpc.2021.100185

Race is not a risk factor: reframing discourse on racial health inequities in CVD prevention

Luke G. Silverman-Lloyd, M.S.,[1] Naomi S. Bishop, M.L.I.S.,[2] Jessica P. Cerdeña, M.Phil.[3,4]

[1] University of California San Francisco School of Medicine, San Francisco, CA, USA

[2] University of Arizona at Phoenix, Phoenix, AZ, USA

[3] Yale School of Medicine, New Haven, CT, USA

[4] Department of Anthropology, Yale University, New Haven, CT, USA

Corresponding Author

Jessica P. Cerdeña, M.Phil.

MD/PhD Candidate

Yale University

10 Sachem Street

New Haven, CT 06511

jessica.cerdena@yale.edu

(201) 618-7556

Declarations of Interest: None

Acknowledgments: Author JPC is supported by the Robert Wood Johnson Health Policy Research Scholars Program and the National Institutes of Health Medical Scientist Training Program Grant T32GM136651.

Contributions: Author LGSB led the conceptualization of the manuscript. Authors LGSB and JPC drafted the original manuscript and author NB revised the manuscript.

We respectfully submit this letter in response to the March 2021 state-of-the-art review article "Ten things to know about ten cardiovascular disease risk factors".[1] Although the article effectively summarizes the latest evidence on CVD risk factors in a condensed, accessible format, we write to express concern about the discourse around racial inequities in CVD in Section 8: 'Considerations of selected populations (older age, race/ethnicity, sex differences).' Although this section summarizes valid epidemiological data—that racially and ethnically minoritized patients suffer disproportionate rates of morbidity and mortality from CVD—the authors misleadingly frame race, rather than racism, as a risk factor for CVD. In November 2020, the American Heart Association released a scientific statement emphasizing the need to "move beyond statements that report on the well-known disparities in burden of risk factors, disease, and outcomes among specific subgroups of the population to intentionally address racism and structural inequities."[2] We affirm this statement and highlight ways the present article perpetuates historical harms.

First, the authors do not define race, race/ethnicity, or ethnicity. The authors seemingly conflate race with ethnicity even though these terms represent distinct categories. Further, discussions of race occur alongside age and sex in "considerations for selected populations" with respect to CVD. Unlike age and sex, which are valid biological entities,[3] race is a dynamic sociopolitical category reflecting arbitrary clusters that do not reflect the gradual, largely geographically patterned variation in human genetic diversity.[4] As Dorothy Roberts puts it, race "is a political category that has been disguised as a biological one."[5] Thus, race only deserves retention in assessments of population differences in health as an indicator of the impacts of sociopolitical conditions. Without explicitly defining race or ethnicity and specifying the reason for their inclusion, the authors may insidiously promote racial essentialism—the theory that members of different racial groups share innate biological traits that predispose them to higher rates of disease.[6]

Second, amid discussions of race-associated CVD risks, the authors make no mention of historical trauma and structural racism. Historical trauma—including the enslavement of Black

people, separation of Native American families through the relocation of children to residential boarding schools, and ethnic genocide—carry embodied effects.[7,8] In addition, structural racism—or the totality of ways in which societies foster racial discrimination via mutually reinforcing inequitable systems[9]—contributes to multiple health effects. Although the pathways by which these socio-structural exposures mediate health inequities have yet to be characterized, these relationships are both theoretically and empirically robust.[10] Given the stark racial health inequities outlined in the present article, we advocate for the inclusion of structural racism as a key risk factor for CVD, and for more attention and resources to be devoted towards studying and addressing it in CVD prevention efforts.

Finally, the authors use several instances of problematic and dehumanizing language. For instance, the authors refer to Black Americans as "Blacks" rather than "Black people" or "Black patients." They also describe White people as "Caucasians," a disfavored term that reflects antiquated and racist categories.[11,12] In addition, the authors persistently refer to the Akimel O'odham people as "Pima Indians," using the settler colonialist term for the tribe, and also call them a "subset of Native Americans," vastly underrecognizing the complexity and diversity of the Indigenous peoples of the Americas. Importantly, such terminology falls short of the *Journal*'s commitment to "use of inclusive language" as outlined in the Guide for Authors.[13]

In sum, discussions of racial health inequities in the present article fail to define race and ethnicity or explore structural racism as a fundamental cause, which may perpetuate notions of racial essentialism by inappropriately framing race, rather than racism, as a risk factor for CVD. Boyd and colleagues have proposed robust new standards for publishing on racial health inequities.[14] We call upon the authors and the *AJPC* to incorporate these standards as an important step toward equity in CVD prevention.

References

1. Bays HE, Taub PR, Epstein E, Michos ED, Ferraro RA, Bailey AL, Kelli HM, Ferdinand KC, Echols MR, Weintraub H, Bostrom J, Johnson HM, Hoppe KK, Shapiro MD, German CA, Virani SS, Hussain A, Ballantyne CM, Agha AM, Toth PP. Ten things to know about ten cardiovascular disease risk factors. *American Journal of Preventive Cardiology* 2021;5:100149.

2. Churchwell Keith, Elkind Mitchell S.V., Benjamin Regina M., Carson April P., Chang Edward K., Lawrence Willie, Mills Andrew, Odom Tanya M., Rodriguez Carlos J., Rodriguez Fatima, Sanchez Eduardo, Sharrief Anjail Z., Sims Mario, Williams Olajide, null null. Call to Action: Structural Racism as a Fundamental Driver of Health Disparities: A Presidential Advisory From the American Heart Association. *Circulation* 2020;142:e454–e468.

3. Witzig RS. The right to identity: Implications of using subjectively-assigned race in US healthcare. *Social Medicine* 2014;8:43–52.

4. American Association of Physical Anthropologists. AAPA Statement on Race & Racism. 2019. Available at: https://physanth.org/about/position-statements/aapa-statement-race-and-racism-2019/. Accessed March 25, 2020.

5. Roberts D. *Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-First Century*. New York: New Press; 2011.

6. Braun L, Saunders B. Avoiding Racial Essentialism in Medical Science Curricula. *AMA Journal of Ethics* 2017;19:518–527.

7. Ibrahim H, Ertl V, Catani C, Ismail AA, Neuner F. Trauma and perceived social rejection among Yazidi women and girls who survived enslavement and genocide. *BMC Med* 2018;16:154.

8. Running Bear U, Croy CD, Kaufman CE, Thayer ZM, Manson SM, The AI-SUPERPFP Team. The relationship of five boarding school experiences and physical health status among Northern Plains Tribes. *Qual Life Res* 2018;27:153–157.

9. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *The Lancet* 2017;389:1453–1463.

10. Hardeman RR, Murphy KA, Karbeah J, Kozhimannil KB. Naming Institutionalized Racism in the Public Health Literature: A Systematic Literature Review. *Public Health Rep* 2018;133:240–249.

11. Tsai J, Cerdeña JP, Khazanchi R, Lindo E, Marcelin JR, Rajagopalan A, Sandoval RS, Westby A, Gravlee CC. There is no 'African American Physiology': the fallacy of racial essentialism. *Journal of Internal Medicine* 2020;288:368–370.

12. Kaplan JB, Bennett T. Use of Race and Ethnicity in Biomedical Publication. *JAMA* 2003;289:2709–2716.

13. American Journal of Preventive Cardiology. Guide for Authors. 2021. Available at: https://www.elsevier.com/journals/american-journal-of-preventive-cardiology/2666-6677/guide-for-authors. Accessed March 3, 2021.

14. Boyd RW, Lindo EG, Weeks LD, McLemore MR. On Racism: A New Standard For Publishing On Racial Health Inequities | Health Affairs. *Health Affairs Blog* 2020. Available at: https://www.healthaffairs.org/do/10.1377/hblog20200630.939347/full/. Accessed July 23, 2020.

Declaration of interests

☒ The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

☐The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: