Race and Health — A Persistent American Dilemma

Twenty-five years ago, H. Jack Geiger — physician, civil rights activist, founder of community health centers — implied in an influential editorial that racism within the medical profession was contributing to health inequities between Black and White Americans. He recommended that medical educators teach trainees about the dilemmas associated with race and health. A month earlier, I had started medical school, and though my working-class Black family faced premature chronic disease and death, I knew little of the health literature Geiger referenced.

In my classes, it seemed that whenever we learned about a new disease, the lecturers noted that it was more common among Black people, had worse outcomes among Black people, or both. Full stop. They never mentioned social drivers of health, such as insurance coverage or residential segregation, nor that health care practices themselves might be problematic, as Geiger suggested. Rather, they obliquely blamed genetic differences or an insalubrious Black culture.

Otherwise, the curriculum rarely addressed race. We attended a single session focused mainly on the possibility that some people around the hospital — uneducated patients, less-than-friendly security guards, but never enlightened physicians — would assume that a Black or Hispanic medical student or doctor was not a medical student or doctor. This limited teaching was the national norm.

Determined to redeem the civil-rights–era promise that my experience as a Black American would be better than my parents’, I forged ahead. Professors might mistake me for a maintenance worker, or patients describe me using racial epithets, but I received good grades and was headed toward a secure future as a physician. What I couldn’t shake, however, was the disproportionately poor health of many Black people I saw — uncontrolled diabetes and hypertension, kidney failure, strokes, late-stage cancers. Lacking the perspective to contextualize these problems, we mostly deemed them self-inflicted.

But I saw that we sometimes actively contributed to the worse outcomes: a doctor condescendingly applying a psychiatric diagnosis while dismissing physical concerns, or a health system providing two-tiered care, ostensibly based on health insurance status but precisely tracking along racial lines.

To make sense of these experiences, I began writing about them. As a fan of physician–patient narratives in medical journals, I sought to highlight medical stories through my own lens. I was a novice writer, and rejections flooded in; what troubled me were those questioning the relevance of the subject of race itself. “We only publish editorials on an issue of importance to academic medicine’s leaders,” read one. Others were more tactful in delivering the same message.

In the near decade between my residency training and the 2015 publication of my book, Black Man in a White Coat, medical education began to change. Medical students led the charge in a way my generation had feared to do. Soon, our institutions starting having “conversations on race,” and momentum built for modifying curricula accordingly. Medical journals published related commentaries. For the next 5 years, academic medical organizations gradually embraced the fight against health inequities, but their bureaucratic approaches — a cycle of subcommittee meetings, committee meetings, and so forth, spaced months apart and without actionable mandates — often stymied progressive calls for substantive reform.

Then 2020 happened. The early months of the Covid-19 pandemic revealed starkly worse outcomes for Black Americans. Protest movements galvanized after George Floyd’s murder placed racial issues at the center of national life. Facing pressure within their own ranks, once again led by medical students and young physicians, medical institutions issued urgent “antiracist” statements that would have been dumbfounding during my training.
Achieving health equity requires addressing larger socioeconomic forces, but there are things we can do as medical educators and administrators. First, we can change our language regarding race and health, seeking greater precision in discussing geographic ancestry and its relationship to disease-specific risks, while teaching future physicians about the powerful and problematic social influence of racial classifications. A recent article by Amutah et al. offers steps that academic institutions would be wise to implement.5

Second, we need to cultivate and sustain a workforce of thriving Black clinicians. Like many Black physicians, I’ve often been the only Black provider in groups that serve largely Black populations, and because of a long-standing mistrust of medicine, certain Black patients regularly request me as their doctor. As flattering as that may seem, carrying this added expectation can hasten burnout, exacerbating the dearth of Black clinicians. Efforts to create “pipeline programs” and implement “holistic” approaches to medical school admissions have been scattershot, and they too often rely on volunteer efforts by busy physicians. We need more robust strategies to assess the efficacy of interventions so we can amplify what works and discard what doesn’t.

In the quarter century since Geiger’s editorial, we’ve partially succeeded in expanding the vocabulary of race in medical education. Nowadays, most students receive preclinical instruction in this area; however, it appears increasingly clear that this teaching needs to continue throughout clinical training for durable benefit. The past 2 years have brought a renewed call to reckon with our racist history. We alone can’t fix all that has brought us to this moment, but changing what we can within medicine will bring us several steps closer in the next 25 years to resolving the American dilemma of racial health inequity.

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