



Family Matters

Elizabeth Ahmann, ScD, RN

The Meaning of Race in Health Care and Research - Part 1

The Impact of History

Cathy J. Tashiro

Questions about the relevance of genetics to health disparities, and evidence that racial and ethnic health disparities are strongly associated with social factors are impacting the understanding of health care needs and research. This first of two articles (see the next issue of the journal for the second) examines the history of understanding race and its impact on assumptions and biases in healthcare. The concept of race as we know it is relatively modern. Yet, in the United States, race has strongly influenced the development of social systems and relations. The legacy of early ideas about race, and centuries of unequal treatment based on those ideas, plague us as a nation even today. Increasing evidence suggests that this is true in the arena of health care. In fact, mounting evidence indicates that the race of patients can significantly influence the treatment they get. Nurses need to develop a sophisticated understanding of issues and concerns relevant to race and health care, including the history of race, current literature on race and health care, as well as stereotypes and biases regarding race.

An 8-year old boy, appearing to be of European ancestry, presented with acute abdominal pain and anemia. He was scheduled for surgery, which was subsequently cancelled when a routine blood smear led to identification of previously undiagnosed sickle cell anemia. The child was of South Asian, northern European, and Mediterranean ancestry (Witzig, 1996).

Incidence, prevalence, and mortality rates of common illnesses are calculated and reported based on the standard racial and ethnic categories used in the U.S. Census. This practice inevitably leads to associations between race and risk. In addition, certain conditions have been extensively reported in the media as associated with particular racial groups: sickle cell anemia among African Americans is one example. However, as the above case history demonstrates, relying on conventional wisdom regarding race and risk - such as sickle cell being a "black" disease - can be dangerous to patients and can blind healthcare providers to alternative explanations for health problems.

This article and one in the subsequent issue of this journal together explore the complexities and controversies surrounding the issue of race in healthcare practice and research. This article offers a brief overview of the history of the modern concept of race which is important for understanding our current views of race. The topic of racial/ethnic health disparities will be introduced based on a review of recent literature. The second article will explore some cur-

rent debates about the meaning of race in health outcomes, and whether the concept of race is actually useful in health care. Some emerging areas of research will be briefly discussed, and the article will conclude with implications for pediatric nursing.

What is Race and Where Did it Come From?

Have people always believed in the existence of race?

While there is evidence that most populations have distinguished themselves from those who were not members of their tribes or other group affiliations, the concept of race as we know it is a relatively modern one. Smedley (1993) associates the rise of a "racial worldview" with the European era of exploration and colonization of various indigenous populations in Asia, Africa, and the Americas, beginning about five centuries ago. This period brought Europeans into direct contact with populations that differed from them. The conquest of indigenous peoples and the institution of slavery in the Americas were associated with this contact.

The classification of populations into races began in earnest in the 18th century, with the rise of development of the natural sciences. In 1735, Linnaeus classified all known living organisms, including human beings, in the *Systemae Naturae*. Linnaeus demonstrated the common tendency of his time to associate behavioral traits with physiognomy in his descriptions of the different groups. For example, the physical description of the "Americus" group (presumably based on American Indians) is followed by the adjectives "obstinate, merry, free; paints himself with fine red lines; regulated by customs" (Smedley 1993, p. 164). The behavioral traits of the "Asiaticus" and "Africanus" groups are similarly distinguished from the positive behavioral traits of the "Europeus" group, i.e., "gentle, acute, inventive; covers himself with close vestments; governed by laws" (p.164).

The most influential racial classification system of the 18th century was that of Johan Blumenbach, considered to be the German father of physical anthropology (Schiebinger, 1993). Blumenbach divided humanity into five varieties with regional associations. They were

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The *Family Matters* section focuses on issues, information, and strategies relevant to working with families of pediatric patients. To suggest topics, obtain author guidelines, or to submit queries or manuscripts, contact Elizabeth Ahmann, ScD, RN; Section Editor, *Pediatric Nursing*; East Holly Avenue Box 56; Pitman, NJ 08071-0056; (856) 256-2300 or FAX (856) 256-2345.

Caucasian, Mongolian, Ethiopian, American, and Malay. According to Schiebinger (1993), Blumenbach theorized that humanity originated in the Caucasus, and that the darker races represented degeneration from the purity of the white-skinned inhabitants of that region. Blumenbach is remembered for his coining of the term "Caucasian" to refer to the descendants of that region.

The influence of classification systems like Blumenbach's was considerable. Eighteenth century classification schemes set rigid boundaries to human difference, linked physical characteristics with behavioral ones, rank-ordered human groups in a hierarchical fashion, and placed this ordered humanity within the natural world so that the ascribed inequalities between groups had the appearance of being inherent. Despite the passage of considerable time, our current racial categories don't differ substantially from Blumenbach's 18th century system.

Race in America

In the United States, an entire social structure and system of relations evolved based on race. Personal rights and roles were determined by one's position in a strict racial hierarchy. In particular, the conquest of native peoples and the role of black slavery were integral to the history and economic development of the United States. Belief in the racial inferiority of blacks was essential to the justification of slavery. As Stephen Steinberg states: "It is facile to think that blacks were enslaved because they were defined as inferior; it would be closer to the truth to say that they were defined as inferior so that they might be enslaved" (Steinberg, 1981, p. 30).

In the New World, racial boundaries and definitions were not immediately defined. The first legal acts to restrict rights based on ancestry were concerned with restricting interracial sex and designating the offspring of such unions (Williamson, 1995). In the U.S., a two-category system emerged in which children of mixed black and white parentage were considered as black. By the beginning of the 20th century, most southern states used the so-called "one drop rule" of hypodescent, meaning that any African ancestry whatsoever resulted in the person being classified as black (Davis, 1991).

With respect to the assignment of status to other racial groups, policies have fluctuated for Asian Americans, Mexican Americans, and other "non-white" groups. Designation of racial status was crucial, yet inconsistent. For example, both Armenians and people from the Indian subcontinent were initially classified as "Asiatics" in California, thus ineligible for citizenship (restricted to whites), until a federal court ruled in 1909 that Armenians were Caucasians, thus permitting them ownership and the leasing of farmlands (Almaguer, 1994; Haney Lopez, 1996). At one point, Chinese were considered "Indians," while Japanese were deemed "Mongolian," thus also ineligible for citizenship (Almaguer, 1994). Definitions of race have lacked consistency, and no more than two consecutive censuses have used the same classification schemes (Goldberg, 1997). While definitions of "whiteness" were unstable, the consequences of judicial decisions defining who was white were enormous. Citizenship, the right to vote, to own land, to hold a job, and to all the resources necessary for a decent life were based upon which side of the color line one fell. The combination of Jim Crow segregation, which began in 1875 and did not end until the Civil Rights era, and the extreme definition of blackness as "one drop" of African ancestry, meant that an unknown number of mixed African Americans "passed" as white.

Why Does History Matter?

Smedley (1993) and others (Bonilla-Silva, 2003; Omi & Winant, 1994) maintain that the legacy of early ideas about race, and centuries of unequal treatment based on those ideas still plague us as a nation. In the arena of health care, mounting evidence suggests that this is true. In 2003, the National Academy of Sciences published *Unequal Treatment*, the Institute of Medicine's exhaustive study of racial and ethnic disparities in healthcare (Smedley, Stith, & Nelson, 2003). To prepare the report, the authors searched peer-reviewed journals from the preceding 10 years and reviewed published studies that documented racial and ethnic differences in healthcare, while controlling for possible confounding factors like insurance status and socioeconomic status. The findings of these studies were notable in the arena of children's health care. They included:

- Less access to kidney transplants for black patients when compared to whites (Furth et al., 2000).
- Fewer psychotropic medications provided to African American than white youths (Zito, Safer, dosReis, & Riddle, 1998).
- Fewer prescriptions provided to African American and Hispanic children (Hahn, 1995).
- An association between non-English speaking families and both increased charges for diagnostic testing and length of stay in pediatric emergency departments (Hampers, Cha, Gutglass, Binns, & Krug, 1999).
- Parental reports of worse care by African American, American Indian, and non-English speaking Hispanic and Asian parents (Weech-Maldonado, Morales, Spritzer, Elliot, & Hayes, 2001).

More recent research has indicated racial and ethnic disparities in pediatric appendicitis rupture rates (Guagliardo, Teach, Huang, Chamberlain, & Joseph, 2003) and cardiac care for children (Milazzo, Sanders, Armstrong, & Li, 2002). A study presented at the Pediatric Academic Societies' 2004 meeting, conducted in 25 hospital emergency departments around the country, found that white children presenting with long bone fractures received 2.3 times more pain medication than black children for the same conditions (Race May Be a Factor..., 2004).

Mounting evidence indicates that the race of patients can significantly influence the treatment they get. Reasons for this are unclear. Although the studies in the Institute of Medicine report were screened for possible confounding factors such as insurance status, disturbing patterns of disparate treatment by race persisted. Unconscious biases may play a role, and for this reason, it is very important for every health care provider to take a hard look at his or her own assumptions to examine whether they are based on sound evidence or merely a reflection of prevalent stereotypes. Maintaining an awareness of race, its social history, and what race is and isn't, is an important step in this process.

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