REMINDEERS:

1. **Paper Competition: Deadline Extended**
   a. The deadline for the MSU Undergraduate Anthropology Club Paper Contest is extended until next Monday, April 1st!
   b. If you are planning on submitting a paper, please contact the E-Board at anthro@msu.edu so that we can help make arrangements for you to drop your paper off.
   c. Please remember to review the guidelines for the contest provided on our webpage!

2. **Brown Bags**
   a. Every Friday, C102 McDonel Hall, 12:00pm
   b. Bring a lunch and learn with fellow Department anthropologists in a fun, informal way!

3. **MSU Science Festival**
   a. If you missed tonight’s meeting but plan on volunteering with Kate Frederick and the MSU Museum for the archaeology portion of the Festival, please contact Kate Frederick ASAP for more information!
   b. Kate’s email information is: hammon85@msu.edu

4. **Our Next Meeting!**
   a. Dr. Ethan Watrall will be joining us for our next meeting!
   b. Monday, April 8th, 7:00pm, 155 Baker Hall

**PRESENTATION:**

- Dr. Linda Hunt:
  - “Racial Profiling in the Management of Chronic Illnesses”
    o Racial profiling retains a prominent place in chronic illness management and medicine
    o Many people view this topic as archaic, while others think that the scientific evidence is present
      ▪ Any scientific evidence is poorly defined and needs to be further researched
    o The government requires that race/ethnicity categories be used for all data submitted to them (the same that are present on the US Census)
      ▪ American Indian/Alaska Native, Hispanic/Latino, Asian, Native Hawaiian or Pacific Islander, Black or African American, White
        ▪ Each of these categories, unfortunately, are based on very different descriptors, which overlap and are highly conflicting
          ▪ E.g.: based on language, ancestral groups, geographic origin, skin color, etc.
    o “Black Box”
      ▪ Research reports racial disparities ➔ Black Box ➔ Explanations draw on assumed racial characteristics
The black box includes: biology, class, culture, access, genetics, racism

- A growing body of literature is present in trying to determine to what degree race is prevalent in medical decision making

  - Racial profiling in medicine:
    - Useful proxy for clinically significant differences OR stereotypes that worsen disparities

  - Paper:
    - How do primary care clinicians invoke race in everyday clinical practice?
    - How view racially labeled patients?
    - Providing race-based care?

  - Almost any paper you read that is clinically-based will have data divided into race categories with absolutely no description of what each of these categories mean

  - Clinicians regularly told race is clinically relevant:
    - Medical genetics literature, medical education, clinical standards for diseases and conditions

  - Literature encourages clinicians to consider race in many ways
    - Risk factor, disease incidence, genetic susceptibility, treatment adherence, interpretation of diagnostic tests, therapeutic response

  - Major issue: our society gives us a “race template” within which to think, act, and perform, and how do these racial “biases” contribute to how people within each category are treated, medicated, or otherwise?

  - Race is prominent in practice guidelines, but do not include:
    - Explanations for differences in race
    - Principles for interpreting these race differences
    - Instructions for their application of race

  - Labels are given based on these racial cultural lenses, and actions are taken based on them. If there happens to be a race correlation for a disease, and a clinician denies that a person is “black” or “white” or “Mexican”, etc., what would go wrong?

  - **RACE IS A POWERFUL CULTURAL LENSE**
    - Labels are completely arbitrary with no definition or meaning. They are simple place holders, and it is dangerous

  - Purposive snowball sample
    - Making sure that there was a good spread between race, age, and gender labels = purposive
    - Snowball = accepting interviews from willing people, and then asking those people if they knew other willing people
    - This can lead to a fairly biased sample, but there is still validity to be had from the statistical results
    - Began interviewing faculty at MSU and then went from there

  - Hardest part of the project: recruitment!

  - All but 1 of the 58 clinicians interviewed believed that race plays a large role in medical care and should be taken into account in all cases
How is race determined? (Question asked to the clinicians)
- By appearance
  - Most were unconcerned about using this method
  - Some hesitations:
    - Nervous laughter
    - “I hate to think I’m a bigot, but I do use visual cues.”
    - “I do what everybody else does—slap a label on them before they even open their mouths.”

Why is race important? (Questions asked to the clinicians)
- Importance of racial difference presented with scientific authority
  - “You hear a lot about it in school.”
- Asserted without specific reasons for differences
- Clinicians left to their own cultural understandings and assumptions in interpreting racial difference
  - Because there are no actual definitions or reasoning for these labels!

Biological differences? (Questions asked to the clinicians)
- Majority said there are biological differences between racial groups that affect health
  - Racial/ethnic groups have shared genetic inheritance
  - Susceptible to certain diseases
- Only 3 clinicians disagreed with focusing on race, and each of these clinicians belonged to racial minority groups

Class and Culture
- Majority stated socio-economic and cultural factors
- Some blamed minority patients for their own situations, while many were empathetic and tried to assist “under-education” minorities with understanding their situations
- Food choices were consistently mentioned, which suggested that these clinicians believed that food practices were directly related to cultural and, thus, racial practices

Racism
- Impact of racism—real or perceived—identified as reason for disparities
- All but 1 clinician stated that racism during treatment would lead to unequal or effective treatment
  - Interestingly, the 1 clinician in dissent was “African American”
- Some say distrust of the medical system may reduce compliance
  - One white, female clinician made particularly “racist” and shocking comments

How should race affect care?
- Prostate cancer
  - Early screening in African Americans
  - Various reasons why, with little agreement for “why”
- Diabetes
• “at-risk” racial/ethnic groups should be screened more vigilantly

Hypertension

• Clinicians were most consistent with describing that they proscribe and treat African Americans differently than other racial groups for this disease
• Some textbooks have entire chapters dedicated to hypertension in African Americans
• HIGH variability in the drugs that should be used in treating this condition, as well as high variability in “why” this differential treatment is done and is necessary

Discussion

• Serious problems with use of race in clinical care
• Clinicians regularly encounter authorization of race-based care
• But race remains a “black box” concept, without clear definition
  • Open to interpretation, regardless of relevancy or otherwise
• Clinicians struggle to interpret and apply message that race is important
  • Could this be due to education? Training? Personal biases?
• Varied ideas about what to do, why, and to whom it should be done illustrate roots of this concept to socially learned notions of racial differences
  • It is impressive how few clinicians actually question the saliency of race in the application of medical treatment
• Clinicians dutifully enacted race in their practices
• Treating minority patients as representatives of “groups”
• Correlation of clinically relevant factors to race should not become a distraction, and should be legitimized before such weight is given to them
• Respond to factors when present in individual patients, no matter what their race
  • Treat each patient as an individual, not a representative of a racial group

Questions

• The common denominator is poverty in terms of diabetes-ridden areas around the world.
  • Most are also “non-white”
• Using just socio-economic status as a descriptor has issues because there are so many parts that contribute to developing “socio-economic”

“Medicine is late-Capitalism at its greatness.”

• “People are in it for the money.”
  • Most people over the age of 60 are taking 5 medications or more at any given time