The Black U.S. experience with inequities in health started 400 years ago with the introduction of slavery and the physical, psychological and social damage inflicted by discriminatory policies, exploitive medical procedures, unethical experimentation and false narratives about biological inferiority articulated to “legitimize” slavery and other racist practices. Medical complicity with slavery continues to weigh on the minds of many African Americans and reinforce deep-rooted distrust about the value and integrity of the U.S. health care system, presenting modern day interracial and intercultural challenges to the quality of the patient-doctor relationship and elimination of the health disparity gap. To paraphrase Edward R. Murrow, we cannot escape responsibility for the results of our history.

It has long been understood that illness has, in addition to its biomedical context, an environmental, social and behavioral context that allows us to think of health disparities as being mapped to a complex set of interacting factors from access to care to unjust policies and practices. While race is not a biological construction, it is used often as a marker for morbidity and assigned to narrate the untruth of a racially different biology as the putative cause for health inequities within minoritized populations. It is racism — not race or ethnicity — that exists as a social determinant of health and a serious threat to public health and health equity. Racism has been declared by a number of municipalities, agencies and organizations (including the American Public Health Association, the American Medical...
Association and the Centers for Disease Control and Prevention) as a public health crisis and identified as a fundamental cause of racial/ethnic health disparities. For example, the body’s physiologic response to the cascade of chronic psycho-social stressors communicated through day-to-day exposure to racial bias and discrimination factors into the social determinants of health at the cellular level and contributes as an upstream etiology to higher rates of chronic illness among racial and ethnic minorities.3

Millions of Americans struggle with undiagnosed or untreated vision impairment and poor ocular health. Like other chronic conditions, vision impairment often reflects the broad social, economic, cultural and environmental disadvantages that take unnecessary tolls on communities of color. Black and Latinx people carry some of the greatest burden for ocular morbidity and the consequences of life-altering vision impairment. The projection of triple digit percent increases in vision impairment and blindness between 2020 and 2050 among Black and Latinx adults, compared to double digit percent increases for White adults, draws attention to a failed movement toward eye/vision health equity and questions the profession’s consciousness about the intersectionality of health equity and social justice.4

We have many issues before us that continuously challenge our moral, ethical and professional mission to transform disparity into parity, but we cannot allow today’s challenges to quiet our resolve and accept an unacceptable reality. We must embrace today’s truth that it is not acceptable for anyone to be treated unjustly and unfairly and to be without access to equitable health care. We have to go beyond the data and take a population health approach to understand the contextual issues around the social construct of race and ocular morbidity. We have to attack racial health inequity by looking upstream and mitigating the primordial determinants of health disparity, along with remedying the contemporary problems of patient mistrust, provider-patient discordance and implicit bias and their effects on increased risks for avoidable morbidity and widening the health disparity gap in communities of color. Within my professional lifetime I can recall at an American Academy of Optometry public health symposium on obesity the odd question of why were we discussing obesity at an optometry meeting, not immediately thinking of obesity as a near upstream cause of diabetes and diabetic eye disease. The same evolution of thought must occur with the social determinants of ill health in the context of increased prevalence of ocular morbidity among minoritized populations. It is common today to talk about being at an inflection point. If we are ever to overcome the dark penumbra that hangs over our country’s history and change today’s reality, we have to acknowledge and understand the truths that make it so and reconcile the complexities of those truths with positive action by celebrating the richness of our diversity with awareness and humility. We must confront our unconscious truths in the conscious space of racial equity and strive for a zero gap between current reality and a new American truth viewed through a lens of social justice, with parity of health and well-being across all human domains. Dr. Martin Luther King’s declaration of over 50 years ago continues to be relevant today in that, “We have come a long way, but we still have a long, long way to go.”

References: