



## Editorial

## Structural Racism and *JAMA Network Open*

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Like so many in our academic community, we were distressed by the February 2021 *JAMA* podcast and corresponding tweet suggesting that structural racism does not exist and that no physicians are racist. Although we have not written about this issue until now, these events have prompted a deep internal reexamination of how we engage constructively to acknowledge and reverse structural racism and of our own contributions to perpetuating it. We are challenging ourselves to consider how we can be truly antiracist in our roles as physicians, scientists, editors, and members of the communities in which we work and live.

First, we, the editors of *JAMA Network Open*, affirm the entrenched history and ongoing harms of structural racism. In recent times, the horrific killings of George Floyd, Breonna Taylor, Philando Castile, and hundreds of other individuals who were members of racially/ethnically marginalized groups, such as Black and Latinx individuals, at the hands of police have forced critical and long overdue conversations about this centuries-old problem. Structural racism persists in essentially every social system in the US, including, but not confined to, housing, employment, education, health care, finance, transportation, law enforcement, the environment, criminal justice, and politics. Although not always visible, prejudice is embedded in all aspects of US life. Acknowledging the problem is necessary but insufficient. Structural racism requires active dismantling, not only to reverse the status quo but also to counteract ongoing efforts to worsen structural racism through active steps, such as legislation targeted at impeding voting rights.

Second, structural racism has deeply and adversely affected health and health care specifically, as manifested by reduced life expectancy,<sup>1,2</sup> higher burden of various illnesses,<sup>3</sup> and higher infant and maternal mortality,<sup>4,5</sup> especially among Black and Hispanic or Latinx individuals. This stark disparity has become further exacerbated during the COVID-19 pandemic. Black and Hispanic or Latinx populations have experienced rates of hospitalizations and deaths due to COVID-19 that are 3-fold higher than White populations.<sup>6,7</sup> This discrepancy has led to a further widening the nearly 6-year lower in life expectancy among Black persons compared with White persons in the US.<sup>8</sup> This distressing trend is a direct manifestation of the disparities in the availability of and access to high-quality health services, with associated inferior treatment and outcomes. Uneven access to highly effective vaccines risks deepening these disparities, which have been documented for decades, in many cases without any evidence of improvement over time. The disparate risks of infection with SARS-CoV-2 and subsequent death from COVID-19 among people of racial and ethnic minority backgrounds, such as Black and Hispanic or Latinx individuals, have appropriately attracted attention but must be viewed in the context of systems that have failed the communities in which people of racial and ethnic minority backgrounds live, go to school, and work for generations.

The persistent underrepresentation of racial and ethnic minority groups among trainees and clinicians and the myriad obstacles to their professional advancement contribute to these challenges. The resulting lack of clinicians with intimate understanding of and commitment to people of racial and ethnic minority backgrounds, compounded by other structural issues, including disparities in funding, further contributes to the standard of health care that these communities receive. As an example, a 2019 study<sup>9</sup> estimated that if the 5 historically Black medical schools that closed owing to the 1910 Flexner report had remained open, there would have been more than 35 000 additional

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Black physicians by 2019, with a 29% increase in the number of graduating Black physicians in 2019 alone. Increasing diversity among medical school matriculants must happen, for example, by establishing other medical schools associated with historically Black colleges and universities and by attention to the experiences of medical students and trainees who are members of racial and ethnic minority groups.<sup>10,11</sup>

The recognition that structural racism plays a major role in so much of what needs to be changed on a system-wide level does not absolve us of individual responsibilities as clinicians and leaders. It remains incumbent on all of us to actively engage in antiracist efforts. At *JAMA Network Open*, we are making concerted efforts to right these wrongs and are cognizant that our efforts must evolve and expand over time. We will continue to publish studies<sup>12-14</sup> and commentaries<sup>15-17</sup> that examine the innumerable ways in which racism affects health and health care, and the potential means to mitigate these effects. Ten months ago, we issued a call for papers on the effects of systemic racism in health.<sup>18</sup> The accompanying editorial<sup>19</sup> challenged us, and all medical journals, to directly address racism, in all its forms, and to incorporate racial diversity in thought, as well as focusing on publishing papers that propose and evaluate interventions and changes that can truly make a difference. We understand that our efforts are insufficient to fix structural racism, but we are firmly committed to moving forward in a constructive direction with the staff and editors of the other journals in the JAMA Network,<sup>20</sup> and to continually reassess how we are addressing and contributing to dismantling structural racism through our work as *JAMA Network Open* editors.

We also recognize that even with the best of intentions, all of us—as individuals—will continue to make mistakes. It is important that we listen to feedback and acknowledge and apologize for mistakes when we make them. However, since these behaviors are systemic and embedded, we must take substantive steps to constructively engage with each other in civil discourse about racism in our science and in our practice. This is the only pathway to develop meaningful interventions to bring about change. We should address important issues, including structural racism, as best we can, building on the work of and bringing in perspectives from those with appropriate expertise and relevant lived experiences. In disrupting a complex and entrenched system, we must be ready to learn from the mistakes we hope to avoid but will inevitably make in moving forward in this important direction.

To this end, we will engage in a listening process to identify and develop meaningful next steps that we will take as a journal. Specifically, we will conduct listening sessions that include *JAMA Network Open* readers, researchers, clinicians, and patients. In the process, we will identify next steps, for example, adopting publishing standards to address race and ethnicity appropriately, hiring editors and staff from diverse backgrounds, and developing methods to increase manuscript submissions, acceptance rates, and peer reviews from individuals of underrepresented racial and ethnic groups.<sup>20</sup> Another avenue may be to establish editorial and mentoring programs for trainees and junior faculty of underrepresented racial and ethnic groups. We will then follow up this editorial with a statement detailing the actions that we will implement.

The first step in counteracting structural racism is to acknowledge its pervasive presence and take responsibility, including the need for all of us as individuals to do our part in counteracting this going forward. The American Medical Association has started to acknowledge its own history of racism in medicine and recently released a strategic plan “to embed racial justice and advance health equity for all of our years to come.”<sup>21</sup> As editors of *JAMA Network Open*, we are also planning how we can embed racial justice and advance equity in our work. We are entrusted with the responsibility to help ensure that health care research improves the lives of all individuals. We are dedicated to that task and sincerely hope that authors, reviewers, and readers will join us in this effort, including letting us know where we can do better. Although we do not have the full answer, we desire to be part of the solution as aptly captured by the proverb: “It is better to light a candle than curse the darkness.” This initial step represents just 1 small candle that will light our path to addressing the issues of structural racism in academic medicine and public health.

## ARTICLE INFORMATION

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## REFERENCES

1. Woolf SH, Schoemaker H. Life expectancy and mortality rates in the United States, 1959-2017. *JAMA*. 2019;322(20):1996-2016. doi:[10.1001/jama.2019.16932](https://doi.org/10.1001/jama.2019.16932)
2. Akhter M. Assessment of linked associations in predictors of life expectancy inequality. *JAMA Intern Med*. 2018;178(4):563-564. doi:[10.1001/jamainternmed.2017.7893](https://doi.org/10.1001/jamainternmed.2017.7893)
3. Zhang C, Zhang C, Wang Q, Li Z, Lin J, Wang H. Differences in stage of cancer at diagnosis, treatment, and survival by race and ethnicity among leading cancer types. *JAMA Netw Open*. 2020;3(4):e202950. doi:[10.1001/jamanetworkopen.2020.2950](https://doi.org/10.1001/jamanetworkopen.2020.2950)
4. Hauspurg A, Lemon L, Cabrera C, et al Racial differences in postpartum blood pressure trajectories among women after a hypertensive disorder of pregnancy. *JAMA Netw Open*. 2020;3(12):e2030815. doi:[10.1001/jamanetworkopen.2020.30815](https://doi.org/10.1001/jamanetworkopen.2020.30815)
5. Kuehn B. Disparities in maternal mortality. *JAMA*. 2019;322(16):1545. doi:[10.1001/jama.2019.16156](https://doi.org/10.1001/jama.2019.16156)
6. Adhikari S, Pantaleo N, Feldman J, Ogedegbe O, Thorpe L, Troxel, AB. Assessment of community-level disparities in coronavirus disease 2019 (COVID-19) infections and deaths in large US metropolitan areas. *JAMA Netw Open*. 2020;3(7):e2016938. doi:[10.1001/jamanetworkopen.2020.16938](https://doi.org/10.1001/jamanetworkopen.2020.16938)
7. Ogedegbe G, Ravenell J, Adhikari S, et al Assessment of racial/ethnic disparities in hospitalization and mortality in patients with COVID-19 in New York City. *JAMA Netw Open*. 2020;3(12):e2026881. doi:[10.1001/jamanetworkopen.2020.26881](https://doi.org/10.1001/jamanetworkopen.2020.26881)
8. Arias E, Tejada-Vera B, Ahmad F. Provisional life expectancy estimates for January through June 2020. *National Vital Statistics Rapid Release*. February 2021. Accessed June 7, 2021. <https://www.cdc.gov/nchs/data/vsrr/VSRR10-508.pdf>
9. Campbell KM, Corral I, Infante Linares JL, Tumin D. Projected estimates of African American medical graduates of historically Black medical schools. *JAMA Netw Open*. 2020;3(8):e2015220. doi:[10.1001/jamanetworkopen.2020.15220](https://doi.org/10.1001/jamanetworkopen.2020.15220)
10. Rice VM. Diversity in medical schools: a much-needed new beginning. *JAMA* 2021; 325: 23-24. doi:[10.1001/jama.2020.21576](https://doi.org/10.1001/jama.2020.21576)

11. Yancy CW, Bauchner H. Diversity in medical schools-need for a bold new approach *JAMA* 2021; 325; 31-32. doi:[10.1001/jama.2020.23601](https://doi.org/10.1001/jama.2020.23601)
12. Janevic T, Glazer KB, Viera L, et al Racial/ethnic disparities in very preterm birth and preterm birth before and during the COVID-19 pandemic. *JAMA Netw Open*. 2021;4(3):e211816. doi:[10.1001/jamanetworkopen.2021.1816](https://doi.org/10.1001/jamanetworkopen.2021.1816)
13. Cervantes L, Martin M, Frank MG et al Experiences of Latinx individuals hospitalized for COVID-19: a qualitative study. *JAMA Netw Open*. 2021;4(3):e210684. doi:[10.1001/jamanetworkopen.2021.0684](https://doi.org/10.1001/jamanetworkopen.2021.0684)
14. Shi Y, Hunter Guevara LR, Dykhoff HJ et al Racial disparities in the diagnosis of attention-deficit/hyperactivity disorder in a US national birth cohort. *JAMA Netw Open*. 2021;4(3):e210321. doi:[10.1001/jamanetworkopen.2021.0321](https://doi.org/10.1001/jamanetworkopen.2021.0321)
15. Ornelas IJ, Ogedegbe G. Listening to Latinx patient perspectives on COVID-19 to inform future prevention efforts. *JAMA Netw Open*. 2021;4(3):e210737. doi:[10.1001/jamanetworkopen.2021.0737](https://doi.org/10.1001/jamanetworkopen.2021.0737)
16. Njoroge J, Rodriguez F, Albert MA. Dismantling structural discrimination in cardiology fellowship recruitment. *JAMA Netw Open*. 2021;4(1):e2031473. doi:[10.1001/jamanetworkopen.2020.31473](https://doi.org/10.1001/jamanetworkopen.2020.31473)
17. Hoskins K, Beidas RS. Intersection of surging firearm sales and COVID-19, psychological distress, and health disparities in the US-a call for action. *JAMA Netw Open*. 2021;4(1):e2034017. doi:[10.1001/jamanetworkopen.2020.34017](https://doi.org/10.1001/jamanetworkopen.2020.34017)
18. Rivara FP, Fihn SD. Call for papers on the prevention and the effects of systemic racism in health. *JAMA Netw Open*. 2020;3(8):e2016825. doi:[10.1001/jamanetworkopen.2020.16825](https://doi.org/10.1001/jamanetworkopen.2020.16825)
19. Ogedegbe G. Responsibility of medical journals in addressing racism in health care. *JAMA Netw Open*. 2020;3(8):e2016531. doi:[10.1001/jamanetworkopen.2020.16531](https://doi.org/10.1001/jamanetworkopen.2020.16531)
20. Fontanarosa PB, Flanagan A, Ayanian JZ, et al Equity and the JAMA Network. *JAMA*. Published online June 3, 2021. doi:[10.1001/jama.2021.9377](https://doi.org/10.1001/jama.2021.9377)
21. American Medical Association. Organizational strategic plan to embed racial justice and advance health equity: 2021-2023. Accessed June 7, 2021. <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>