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# American Journal of Preventive Cardiology

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## Race is not a risk factor: Reframing discourse on racial health inequities in CVD prevention



We respectfully submit this letter in response to the March 2021 state-of-the-art review article “Ten things to know about ten cardiovascular disease risk factors” [1]. Although the article effectively summarizes the latest evidence on CVD risk factors in a condensed, accessible format, we write to express concern about the discourse around racial inequities in CVD in Section 8: ‘Considerations of selected populations (older age, race/ethnicity, sex differences).’ Although this section summarizes valid epidemiological data—that racially and ethnically minoritized patients suffer disproportionate rates of morbidity and mortality from CVD—the authors misleadingly frame race, rather than racism, as a risk factor for CVD. In November 2020, the American Heart Association released a scientific statement emphasizing the need to “move beyond statements that report on the well-known disparities in burden of risk factors, disease, and outcomes among specific subgroups of the population to intentionally address racism and structural inequities” [2]. We affirm this statement and highlight ways the present article perpetuates historical harms.

First, the authors do not define race, race/ethnicity, or ethnicity. The authors seemingly conflate race with ethnicity even though these terms represent distinct categories. Further, discussions of race occur alongside age and sex in “considerations for selected populations” with respect to CVD. Unlike age and sex, which are valid biological entities [3], race is a dynamic sociopolitical category reflecting arbitrary clusters that do not reflect the gradual, largely geographically patterned variation in human genetic diversity [4]. As Dorothy Roberts puts it, race “is a political category that has been disguised as a biological one” [5]. Thus, race only deserves retention in assessments of population differences in health as an indicator of the impacts of sociopolitical conditions. Without explicitly defining race or ethnicity and specifying the reason for their inclusion, the authors may insidiously promote racial essentialism—the theory that members of different racial groups share innate biological traits that predispose them to higher rates of disease [6].

Second, amid discussions of race-associated CVD risks, the authors make no mention of historical trauma and structural racism. Historical trauma—including the enslavement of Black people, separation of Native American families through the relocation of children to residential boarding schools, and ethnic genocide—carry embodied effects [7,8]. In addition, structural racism—or the totality of ways in which societies foster racial discrimination via mutually reinforcing inequitable systems [9]—contributes to multiple health effects. Although the pathways by which these socio-structural exposures mediate health inequities have yet to be characterized, these relationships are both theoretically and empirically robust [10]. Given the stark racial health inequities outlined in the present article, we advocate for the inclusion of structural racism as a key risk factor for CVD, and for more attention and resources to be devoted towards studying and addressing it in CVD prevention efforts.

Finally, the authors use several instances of problematic and dehumanizing language. For instance, the authors refer to Black Americans as “Blacks” rather than “Black people” or “Black patients.” They also describe White people as “Caucasians,” a disfavored term that reflects antiquated and racist categories [11,12]. In addition, the authors persistently refer to the Akimel O’odham people as “Pima Indians,” using the settler colonialist term for the tribe, and also call them a “subset of Native Americans,” vastly underrecognizing the complexity and diversity of the Indigenous peoples of the Americas. Importantly, such terminology falls short of the *Journal’s* commitment to “use of inclusive language” as outlined in the Guide for Authors [13].

In sum, discussions of racial health inequities in the present article fail to define race and ethnicity or explore structural racism as a fundamental cause, which may perpetuate notions of racial essentialism by inappropriately framing race, rather than racism, as a risk factor for CVD. Boyd and colleagues have proposed robust new standards for publishing on racial health inequities [14]. We call upon the authors and the *AJPC* to incorporate these standards as an important step toward equity in CVD prevention.

### Declaration of Competing Interest

None.

### CRediT authorship contribution statement

**Naomi S. Bishop:** Writing – review & editing. **Jessica P. Cerdeña:** Writing – original draft.

### Acknowledgments

Author JPC is supported by the Robert Wood Johnson Health Policy Research Scholars Program and the National Institutes of Health Medical Scientist Training Program Grant T32GM136651.

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