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VIEWPOINTS

Faults and Standards in Publishing on Race: A Commentary and Recommendation

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The article by Norman C. Wang entitled, "Diversity, Inclusion, and Equity: Evolution of Race and Ethnicity Considerations for the Cardiology Workforce in the United States of America From 1969 to 2019," is a regrettable attempt to further the discussion on race and ethnicity in medicine, and society.[1] Unfortunately, this article is an openly prejudiced article masquerading as "research" that perpetuates racist thought and systems of institutional racism, clearly a point missed by the author. The article reads more as a condemnation of Black and LatinX communities rather than as a conscious understanding of race, ethnicity, and racism in America historically and today. In this commentary, I will examine several shortcomings in Wang's approach to defining and interpreting race and ethnicity considerations in medicine and cardiology and offer recommendations for future reviews of such articles in academic medicine.

Although it is admirable that the author took extensive time to explore medical, legal, and political histories of race and affirmative action, it is unfortunate that this exhausting, not exhaustive, effort does little to advance our understanding of race or racism and actually perpetuates a system of institutional racism; here, the institution is science. The author is broad in his "research," citing a variety of sources from Student Doctor Network (a public forum) and the former tennis player, Arthur Ashe, to his own previous opinion piece. More important, of approximately 8000 words and 108 references, the word "racism" is mentioned *zero* times, and "slavery" appears only twice, despite their importance in understanding the intersections of race, affirmative action, and health inequalities.[2–4] Admittedly, the author does rightly point out that Asians and other groups are often racially miscategorized given poor delineations in bureaucratic and political processes in documenting race. This is an important point, and in fact, an entire issue of the *American Journal of Public Health* was essentially devoted to this topic in the past.[5,6]

Nevertheless, Wang's argument appears to rest centrally on the idea that the pool of qualified Black and Hispanic individuals is small, and that this is a result of poor performance along the academic pipeline. First, some of the 45-year-old data cited that support his conclusion are unscientific at worst and faulty at best, with important data missing from his analysis and methods that lack statistical rigor.[7] Even if we were to take these ideas as fact, the conclusion from this article was that affirmative action programs should actually be started even earlier than they are currently. This article, among others, was selectively interpreted and deceptively used to support Wang's argument.

Second, the undertone that Black and Hispanic race is the primary reason for a small qualified applicant pool among these demographics is reminiscent of articles that seek to focus on and posit race as primarily a biological construct rather than emphasizing the role of racism as a determinant of outcomes or replacing racial "reductionism…with a more complex view of human biology that acknowledges the interplay of organisms and environments over the life course."[8–10] Interpreting data from the 1970s without a deeper exploration or conversation of racism at that time (or now) is wholly problematic. The discussion by

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Wang fails to consider systemic and institutional racism as inherent to the Black and/or LatinX experience. For example, a recent review article by Brunsma et al highlights 4 ways in which the graduate school experience for students of color is different, such as experiencing racial microaggressions and discrimination, isolation and lack of inclusion, mental health and stress, and a lack of mentoring.[11]

Another crux of Wang's article appears to claim that implicit bias in testing is unfounded. He states:

> *Considering the qualified applicant pool has added importance because of concerns that implicit bias, or subconscious racial or ethnic discrimination, contributes to the low numbers of blacks and Hispanics.[69] National data refute this hypothesis, given medical school acceptance rates for racial and ethnic groups when MCAT scores are considered.[55]* *(p9)*

His first piece of evidence reported here is his own opinion piece from a 2019 article, entitled "How Do Asians Fit Into the American College of Cardiology's Diversity and Inclusion Initiative?"[12] His selective interpretation of the cited study by Capers et al also fails to report Capers' actual findings: that among admission committee members who completed the survey, all groups displayed significant levels of implicit White preference, that one fifth of admission committee members reported knowledge of their implicit test results impacted their admission decisions in subsequent cycle, and that the class that matriculated the following year was the most diverse in the school's history at that time.[13] Furthermore, if the "qualified applicant pool" is a pipeline issue, as Wang suggests with his outdated references, it would be important for him to also consider the body of literature on teacher implicit bias or implicit bias in college admissions testing.[14,15] This is wholly absent from his article.

In his article, Wang also appears to claim that diversity does not save lives. His argument focuses on discounting a "non–peer-reviewed" publication on patient-physician racial concordance, although this article has now actually been published in a peer-reviewed journal.[16] He dismisses this article and its methods to support what appears to be a central sentiment in his article: that "[t]here exists no empirical evidence by accepted standards for causal inference to support the mantra that 'diversity saves lives'" (p12). He further posits that a "systematic review demonstrated that better communication was present on several metrics, but not quality" (p12). Sadly, Wang first failed to define what "quality" of care truly entails in this discussion (and thus negates other important contributions by individuals, such as Lisa Cooper, MD, on the positive aspects of physician-patient racial concordance).[17,18] Furthermore, he ignored a larger body of literature even within his own field that suggests the opposite of his claim (here, I am referring to gender diversity).[19]

Unsubstantiated claims and selective interpretation of his literature review for this piece appear to be a common theme. For example, in his section on diversity, Wang claims that "[t]he current model for racial and ethnic diversity is practically untenable." He continues, "[i]nterracial marriages add further uncertainties given multiracial offspring" (p7). As the "offspring" of an interracial marriage myself, I am truly baffled as to the purpose of such a statement.

For selective interpretation of the literature, Wang asserts that "[i]nclusion is not well defined, but generally a method to identify groups for preferences and advocacy" (p8). Fortunately, there is a large body of literature on diversity and inclusion with multiple definitions, interpretations, and expansions on defining what inclusion entails.[20–22] Wang's article could have benefitted from exploring and incorporating such literature. Finally, the inclusion of individuals from diverse backgrounds or involved in race, racism, diversity, or inclusion work and research may have identified flaws in this article early on in the review process. This brings me to my final point.

RECOMMENDATION

Although I commend the journal on the commentary and apology published by its Editor,[23] perhaps the most revealing aspect of this original article is its publication at all. The author purports to have submitted and provided a "white paper," defined broadly as a governmental or authoritative report on a specific issue; a "white paper" is also a specific type of article available to authors who submit to the *Journal of the American Heart Association* (*JAHA*).[24–26]

It is ironic and unfortunate that an overzealous opinion piece on race and affirmative action was submitted and accepted as a "white paper." The terminology, especially with this particular article, is problematic at best. Nevertheless, its publication highlights 2 important aspects of the publication process that merit further inquiry and action: (1) the need for a more public peer-review process and (2) the need for experts on race to be included in the review process for similar, future articles focused on race. Other journals, such a *PLOS Medicine*, publicize the correspondence between the reviewing committee and study authors along with the articles. This allows for more nuanced interpretation of study findings and the ability for readers to engage further in the conversation between the study authors and review committee at the time of submission and

publication. Second, the published article by Wang highlights a potential issue with the current review process. If an article discusses or focuses on a specific clinical pathological feature or statistical analytical tool, experts in the field are often requested to peer-review such articles. The same does not appear to be true for race or racial disparities work, despite a large body of literature and number of experts on this topic. I align myself with others who have suggested this be standard practice.[2] It is recommended such a process be implemented and that experts in the field of race, racism, and disparities work be sought out to review articles such as this. Although many authors who focus on race do happen to come from minority backgrounds, and this will create additional work for this group, this article by Wang clearly illuminates that this is still an important area to invest time and energy. The fear in allowing articles of this nature to go unchallenged is that such viewpoints will be used as evidence, possibly by Wang in his next article on the subject, that in turn only exacerbates racial inequities.[27]

Perhaps, as we progress in our understanding of structural racism and medicine, we will move beyond the naïve reference and false dichotomy of Fitzgerald's statement, "[w]e will have succeeded when we no longer think we require black doctors for black patients, chicano doctors for chicano patients, or gay doctors for gay patients, but rather good doctors for all patients"[28] into an understanding that one can be both "Black" and a good doctor, "LatinX" and a good doctor, and "gay" and a good doctor.

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