



FOCUS ISSUE – Celebrate Diversity with the AUA

Structural Racism



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What is structural racism? According to the Aspen Institute's (an organization committed to working with people to improve their communities) glossary of terms, structural racism is a system in which public policies, institutional practices, cultural representations and other norms work in various, often reinforcing ways to perpetuate racial group inequity.¹ Structural racism undermines equity in health care by making access to goods and services available to those members of the power hierarchy only and intersects with other systems such as housing, employment, education and criminal justice in our society that reinforce racism. Structural racism is so deeply embedded in our country's history that we as a society conform to perpetuating policies and practices without recognizing the devastating consequences our actions and inactions may have on people of color. The COVID-19 pandemic has revealed and exposed that health care disparities result from these policies and practices.

African Americans, Latinx and

Native Americans/Alaskan Natives have higher rates of infection, hospitalizations and death when compared to Whites from the COVID-19 pandemic (see figure).² However, the first media reports blamed preexisting, comorbid conditions as the sole reason for the disparity. Obesity, diabetes, asthma and hypertension were listed as the reasons why African Americans, Latinx and Native Americans/Alaskan Natives had worse outcomes when infected with COVID-19. Instead of examining the policies that perpetuate inequity, we presumed a blame-the-victim stance when people of color have worse health outcomes.

We must also reasonably accept that people of color are dying from COVID-19 infection at such an alarming rate that the numbers from the Centers for Disease Control and Prevention are a lowball estimate and do not include comprehensive information from uncontested hotspots for COVID-19 deaths, eg nursing homes, residential facilities, jails/prisons and factories that are often overrepresented by African Americans, Latinx and Native Americans/Alaskan Natives.³ What's more, the data do not include the scores of people who were prematurely sent home from the hospital, those who feared

incurring costs by going to the hospital or who feared dying in the hospital. These individuals may have not have been tested and died at home without a cause of death being clearly determined.

When we examine how structural racism in health care intersects with other facets of American society, it is clearly elucidated that there exist social risk factors that expose people of color to far greater risk of getting infected with and dying from COVID-19. As eloquently stated by Dr. Camara Phyllis Jones, people of color are more exposed and less protected.⁴ African Americans, Latinx and Native Americans/Native Alaskans make up the workforce of frontline/essential workers (nursing home attendants, meat packing factory workers, bus drivers, grocery store workers etc) at a higher proportion than their White counterparts. They also may live or work in areas where personal protective equipment and testing centers are scarce. People of color may also live in overcrowded housing, use public transportation, have fewer financial resources such a health insurance, and have a greater chance of being homeless or incarcerated. Now when you examine the social risk factors that compound your chances of being infected with COVID-19 if you belong to a racial ethnic group, it is not simply a function of comorbid illnesses but an uncovering of the

deeply embedded racist constructs that direct how resources are distributed in our society.⁵ It exposes how this society tolerates and is complicit with racial ethnic minorities making less, having less, living worse and dying first.

The COVID-19 pandemic unveiled some very ugly pervasive truths about how American society operates and functions on the backs of the those who are the most vulnerable. But we have the ability to transform ourselves. We can learn from this awful time in our lives. We can examine what needs to be changed and make powerful, bold moves to change it. In urology, one of the ways structural racism manifests itself is in the paucity of ethnic minorities who represent our profession. Latinx, African American and Native American/Alaskan Natives make up 18%, 13.4% and 0.9%, respectively, of the United States population.⁶ Currently, according to AUA census data, Latinx, African American and Native American/Alaskan Native make up 6%, 5% and 0% (unverified number) of residents in urology residency training programs, respectively.⁷ The low numbers of underrepresented minorities in urology training programs and faculty positions further reinforce the status quo for disenfranchised members of our society.

One of the most important catalysts for a much-needed change to diversify the face of urology is that having more underrepresented minorities in urology will assuredly translate into improved health care for underrepresented minorities (URM). URM providers are more likely to practice in under-resourced areas.⁸ The Society of Academic Urologists (SAU) created a taskforce to address URM in urology.⁹ The taskforce update and recommendations are readily accessible on the SAU website. There are many creative ways that urology residency programs can

Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases ¹	1.8x	0.6x	1.4x	1.7x
Hospitalization ²	4.0x	1.2x	3.7x	4.1x
Death ³	2.6x	1.1x	2.8x	2.8x

Figure. COVID-19 hospitalization and death by race/ethnicity.²

readily implement to successfully increase the numbers of underrepresented minorities in our profession. A few ideas not mentioned on the SAU website are creating alliances with underrepresented minority premed clubs at the local university, creating a partnership with national minority physician organizations such as the National Medical Association and establishing a pipeline from a historically Black college or university to urology residency through summer externships and mentorships.

I am hopeful that the tragic loss of life due to COVID-19 will not be in vain. For those of us who remain,

let us honor humanity by fighting for health care equity and dismantling structural racism.

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