

# Short Communications

The *Nurse Practitioner* welcomes readers' comments and invites readers to share information with each other in the Letters to the Editor forum. This column is divided into three sections: **In Response, Info & Research Exchange, and NP Dialogue.** **In Response** features comments by readers and authors on articles and letters that have appeared in earlier issues of the journal; letters referring to a particular article are forwarded to the author for a response to be printed along with the letter. **Info & Research Exchange** enables clinicians to trade practice tips, information, and research findings. **NP Dialogue** gives practitioners the opportunity to share comments, thoughts, and experiences of interest to other NPs. Please note that all three sections may not appear in every issue of the journal.

Please address your correspondence to: Letters to the Editor, *The Nurse Practitioner*, 13424 W. Virginia Dr., Lakewood, CO 80228. Letters are subject to editing.

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## NP DIALOGUE

### Racial and Ethnic Identifications

"A 32-year-old black man presents with...." "A 63-year-old white male complains of...." "A 40-year-old Hispanic female presents with...." Age, race or ethnicity, and sex are the lead-off patient identifiers in most case presentations and written medical records preceding a description of signs and symptoms of the presenting illness. Race or ethnicity is thus the second or third piece of data that practitioners are given before processing any information about the patient.

Health care professionals may feel that racial and ethnic identifiers are useful in making a medical diagnosis and therefore conclude that these categories are grounded in science rather than constructed socially. However, what practitioners often overlook is that the social constructions of race and ethnicity serve to facilitate and maintain the concept that "biological" differences exist among people. Addi-

tionally, these constructs foster and reinforce racial and ethnic assumptions that practitioners may have about their patients [1]. The consensus among physical anthropologists, many health care professionals, and other researchers is that the concept of race is elusive, scientifically undefinable, steeped in social implications that are detrimental, and that its use should be discontinued [1-3].

During nursing school clinical rotations, I noticed that practitioners would often identify black and Latino patients but would sporadically identify white patients. This inconsistency led me to rethink the role of race and ethnicity in formulating a diagnosis, to consider the usefulness of these patient identifiers, and to question how race and ethnicity are constructed within the health care environment. Race and ethnicity have a minimal role in making a differential diagnosis and even less significance after the illness has been defined. However, practitioners continue to identify patients by race and ethnicity even when they're not medically relevant to the diagnosis. If practitioners use such identifiers when it's not necessary, then how and in what contexts are they being used and understood?

Race and ethnicity invoke strong impressions and enable the listener or reader to perceive patients in very specific ways—a subtle form of cuing. The following case presentation, observed by this writer, illustrates how race and behaviors can become paired constructs. The presentation opened with: "Thirty-four-year-old black cocaine-using mom just delivered her 11th child prematurely. The child is in the NICU and currently stable." The beginning of this presentation paired black mothers and cocaine usage. Often, these inadvertent pairings frequently reinforce positive or negative correlations of specific racial or ethnic

groups with particular behaviors [4]. Interestingly, the ensuing discussion had little to do with the mother but became entirely focused on women using cocaine during their pregnancies. The concomitant emphasis on the inadequacy of "these drug-using pregnant women" to understand their responsibility toward their children obscured the broader social problems of drug use, lack of substance abuse rehabilitation programs for pregnant women, poverty, and racism.

Race or ethnicity for many practitioners has become a shorthand explanation for patient behavior, economic status, and social history—a metaphor for class and social conditions assumed by practitioners but rarely confirmed directly. Identifying a patient's race or ethnicity without a critical analysis of racism and socioeconomic factors encourages health care professionals to routinely confuse race or ethnicity as the risk factor in place of the social conditions that contribute to illness and disease.

By means of a questionnaire, I examined the reasons that nurse practitioners (NPs) give for identifying or not identifying patients by race or ethnicity; how they learned the practice of using these identifiers; how they determine a patient's race or ethnicity; and how race and ethnicity are used in their clinical decisions. Reasons are summarized in Table 1.

Questionnaire responses indicate that most NPs use race and ethnicity for a myriad of reasons that aren't necessarily scientifically valid. In fact, race and ethnicity appear to be a proxy for culture and class as NPs indicated that race and ethnicity provide information about a patient's culture, socioeconomic status, health beliefs, some behavioral risk factors, religion, and compliance. These responses suggest that practitioners use race and ethnicity to generate assumptions about the pa-

### Reasons for Racial/Ethnic Identifiers in Medical Charts and Case Presentations

- Relevant to medical history
- Provides information about culture
- Assists in the diagnosis
- Provides a mental picture
- Required information or standard format

### Reasons for not using Racial/Ethnic Identifiers in Medical Charts and Case Presentations

- Irrelevant to medical history
- Minimal information/rarely need
- May bias readers/listeners

### How Practitioners Learned the Practice of Racial/Ethnic Identifiers

- Didactic settings (physical assessment course, clinical rotations)
- By example(s) (textbooks, medical records, written presentations)
- Clinical settings
- Heard in case presentations

### How Practitioners Identify Race or Ethnicity

- Skin color and appearance
- Accept other practitioner's identification
- Patient's language
- Patient's last name
- Make assumptions
- Ask the patient (only if can't readily discern)

### How Race or Ethnicity is Useful in Clinical Decisions

- Tells the practitioner about disease possibilities
- Tells the practitioner about culture
- Tells the practitioner about risk factors (STDs, smoking, HTN)
- Tells the practitioner about exposure to prior diseases (parasites, malaria)
- Tells the practitioner about religion
- Tells the practitioner about socioeconomic status
- Tells the practitioner about patient compliance

tient's lifestyle and other social indicators. Many of these assumptions are based upon the subjective meanings of race or ethnicity and often occur without assistance or clarification from the patient.

NPs indicated that racial and ethnic identifications largely rest on arbitrary indicators such as skin color and appearance, the patient's spoken language or accent, patient's last name, and other health care professionals' assessments. If it's true that we make assumptions about the patient's identity, then this undercuts the argument that race and ethnicity are necessary in formulating differential diagnoses because our identification can be wrong. Moreover, the subjective indicators

used (skin color, hair texture, speech patterns, and facial features) have more to do with our social understanding of differences than with biological differences. Our underlying beliefs about racial and ethnic identifiers stem from learning environments. Nursing schools and clinical environments often direct students and practitioners to persist with racial or ethnic identification. This practice is largely unquestioned—hence its persistence—and is carried out without benefit of guidelines that encourage practitioners to request patient self-identification.

Many health care practitioners contend that race and ethnicity are genetic variables necessary to the understanding of disease incidence and

prevalence in specific groups. Practitioners presume that the "biological" constructions of race and ethnicity operate in their patient encounters instead of social constructions. However, race and ethnicity *are* social constructions. Their use perpetuates the myths that real genetic differences exist among groups we have come to identify as black, Asian, Native American, white, Latino, and so forth.

This perpetuation affirms an institutional hierarchy that permits social constructions about race and ethnicity to continue. Social constructs contribute to thinking about groups along racial or ethnic lines, which frequently leads to stereotypical assumptions about particular groups. Denying the social constructions of race or ethnicity and couching their role in pseudo-scientific practices and beliefs permit health care professionals to ignore the reality that class, racism, and practices within our health care institutions contribute to inequalities in health care and diseases.

Practitioners may believe that knowing the patient's race or ethnicity assists in the diagnosis of a genetic disease for example, sickle cell, Tay-Sachs, or cystic fibrosis; however, they might be surprised to learn that genetic diseases taken together account for less than 2% of all patient encounters [5]. Race and ethnicity serve better as markers for racism and class in the United States than for disease. They have more to do with how patients are able to access health care systems, what treatment regimens they will receive, and what their morbidity and mortality statistics will be. When clinicians identify a patient as "black," their stated reason is that knowing the patient is black tells them to consider sickle cell disease. However, the underlying agenda may be less about sickle cell and more about assumptions relating to perceived cultural behaviors.