**Inequalities in Health**

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As I interviewed Jill, a podiatrist, clinical lead and researcher, it was clear how much reflection had been engaged following ***'Black Lives Matter'***. Behind this accomplished woman’s contributions to podiatry there are strong passions abut how she sees health delivery. While we discussed a wide range of topics related to podiatry, racial equalities in health emerged as a key topic.

*“I see myself as a passionate clinician first and an academic second. I have championed women in podiatry through my support of Podiatry Women Teachers and Researchers (PeWTER) but more recently I have felt I need to do more to address racial inequality. What’s horrible about COVID it’s really brought health inequality to the forefront. People are dying because we have systemic racism in our educational and NHS institutions”*

**New challenges**

With the world adapting to the effects of Covid-19, other matters such as diversity and misdiagnosis due to assumptions around a preoccupation with white skin have exposed deeper problems in clinical practice. Jill believed there was sufficient evidence available to support a change in our thought process. As a health journalist this peeked my interest and together we started some early digging around. Jill explained;

*“We need to think about our impact as leaders and our legacy. Right now the most emergent issue is of health inequality and racism.*

***Momentum creates change***

I asked her why she thought this was the case. Her passion for issues around equality and discrimination do not just rest with racial concerns around Black, Asian and or Minority Ethnic alone but focus on the impact seen within podiatry as an important contributor to our medical health. She adds,

*"Its a good idea to push an idea when there is momentum behind it. I did not realise, until I read more that there are so many racial inequalities were not just related to poverty but amongst historic studies and assumptions. The debate on* eGRF *is a good example of this. When it comes to Black Lives Matter movement, we need to just say what it is. It may not be outright discrimination but it is a fact that there is a missed diagnosis through lack of experience and skewed education. This might persuade people to look more widely and educate themselves. For instance, do we need to recommend to dermatologists that they have more representative photos? What does this lack of representation feel like for Black and Asian people, does their conditions feel less worthy?”* (1)

**A crisis that started in Powderhorn Park**

That momentum follows with the sudden eruption over the issues of ***Black Lives Matter*** movement following an arrest that went viral. This was coupled with greater numbers of deaths from COVID in people of colour in the UK and more specifically the NHS.

In the UK the crisis that seemed to start in Powderhorn Park then triggered the act of pulling down Edward Colson’s statue in Bristol. We were not only dealing with the Covid-19 crisis and trying to get back to normal clinical practice, but suddenly we were addressing concerns over how whiteled society was relating to black people and their health. Slave history and statues became the narrative. Jill realises when it comes to podiatry*, “what is that angle and where does momentum lie for the foot specialist?*” She pressed for further research to be conducted.

**Skin colour merges with missed diagnosis**

Jill explains;

*"Now is the time to focus on how skin colour is not represented to clinical practice, and for this we need to consider the story of a third year medical student. His specific concern was how ill prepared he was to deal with his clinical examination when none of the medical textbooks provide illustration or discuss cirrhosis in black men. This is being highlighted in*[*UK Medical Schools*](.%20https://www.sgul.ac.uk/news/mind-the-gap-a-handbook-of-clinical-signs-on-black-and-brown-skin)*."*

A current project being run by the Royal London Hospital considers the problem in children. Dr Shaana Shanmugavaivel was interviewed on BBC Radio 4 TODAY by Mishal Hussein on 25th August. The project **'Skin deep - don't forget the bubbles'** attempts to build an atlas of conditions associated with rashes in children. The presentation varies outside redness and considers the bumps that appear in order to effect an accurate diagnosis. The concern is missed diagnosis and incorrect treatment.

Journalist Usha Lee McFarling interviewed dermatologist Dr Jenny Lester in the USA and similar attitudes emerged about the paucity of textbook pictures for skin other than white. Within the same article, Nada Elbuluk, an Associate Professor of Clinical Dermatology at the University of Southern California and the founder of a diversity and inclusion program in her department. (2).

*“It may be no surprise that a field that focuses on skin is now reckoning with skin color. In dermatology, where images are critical for diagnoses, the lack of images of darker skin poses a roadblock to proper treatment and medical education. Skin conditions that involve redness or pinkness in light skin can be subtler or harder to see in dark skin, and physicians who haven’t been adequately trained with such images are prone to misdiagnose people of color.* ‘We absolutely need a diversity of images,’ *said Elbuluk.”*

Colour relates to pigment and from a scientific viewpoint this means the density of melanin within the inferior epidermal layers. Jill picked up a medical student’s story and puts it into context.

*“I realised I did not know how to spot dermatological issues in black people. I added to that Twitter debate that we (podiatrists) have a lot of medical texts that have a white racial bias; new and historic ones. Secondly people of colour are not represented on the podium, in our university lecturers and clinical photos used in courses or conferences use examples of white people.”*

The topic is hot and in the case of resonating with an audience, it is controversial in a different sense because the subject matter is stimulating our sense of probity. There is no doubt that poor recognition of dermatology conditions can lead to delays in diagnosis e.g How does the CUBED acronym perform in darker skin colour for melanoma? (3). Observing MSK issues where inflammation is not readily recognisable as a cardinal sign, redness is less apparent. Plus, poorly described prevalence and treatment strategies of rheumatic disorders in Black and Asian groups (4).

**'Watching for patients going blue is racist, says University!'**

The advent of recognising medical training has flaws and extends to more than just skin, several British Newspapers picked this up on 18th August 2020. The quote above comes from the ***Daily Telegraph*** and below the ***Evening Standard*** (5).

*Dr Joseph Hartland, part of the team heading up the University of Bristol Medical School, has said long-established parts of the UK medical curriculum, such as teaching life-or-death clinical signs, are racist as they focus on teaching students how the signs present in white people. Speaking to the BBC, Dr Hartland put forward the example of patients turning blue if short of breath, a sign which does not apply for people with dark skin (5).*

A second year student, Malone Mukwende, at St George’s, University of London, noticed that conditions were predominantly presented on white skin.  The need to reinforce teaching clinical skills on black and brown skin was evident as he felt he had not been trained to spot a number of medical conditions. Mukwende took matters into his own hands and created a handbook **'Mind the Gap'**. The idea is to present side-by-side images showing the way diseases present differently on dark and light skin. This project has gained strong support from St George's to be released in the coming months. In a statement, the university wrote:

*“It was agreed that this was a very important issue and an essential part of decolonising the curriculum.”*

**Poor quality research**

Jill likes to push the boundary on these types of issues and is clear that we need to have that awareness about how we view colour related to pigment changes in our work as diagnosticians. Taking up the mantle as a post-graduate PhD researcher, she emphasises that there is bias around research.

*“Research data is often biased for various reasons. Firstly, the leadership it falls under: researchers in the UK are more likely to be male, white and middle class. Secondly, research sampling is often not representative. For instance, UK epidemiological studies that include the foot are located in Keele (CASF), Southampton (Chingford) and Halifax (Calderdale cohort) These cohorts are not representative of larger UK cities where there is higher prevalence of Black, Asian and ethnic minorities (average is 15 %) these errors can lead to assumptions that certain conditions. So, do we need to focus on studies from other countries. The Framlingham (USA) work provides a good ethnic mix in the data. This work helps translate into practice the presenting features of pathology when a patient sits in front of you. Of course, if you have not seen enough representative cases it is easy to misunderstand the implications. The disparity of foot conditions may well appear differently with people with different melanin and densities. In my experience recruiting to research studies, people who volunteer are generally well educated, white and privileged.  Even in large urban cities, people of colour who volunteer in less representative numbers. This leads to the question why is poor representation in studies and leadership is not highlighted. My only conclusion is systemic racism and a culture of exclusion. Research shows that in the UK one in four people will be of colour in 20 years’ time and this will be much higher in urban cities. How are we preparing ourselves and our students for this future? And how we can avoid bias."*

We had a brief discussion and agreed about the importance of the transition from research and gathering evidence to the implementation of information that patient and clinicians can benefit.

*“I am passionate about closing the clinical academic gap. As I reflect on the black lives matter movement, I want us to be upfront about our narratives and what the education racism perpetuates, which is unfortunate.  It’s not that people don’t want to know about race and melanin bias, it’s just not been highlighted in the literature and the absence is a problem in itself.”*

She admitted that she had approached me, as a fellow author, because of a need to recognise sensitivity and integrity.

*“There’s a lot of backlash around Black Lives Matter because it’s about people and changing realities. I think as clinicians we need to honest about our culture and read more. A discussion in a narrative form, like this, is ideal as it can be descriptive and we can highlight honest observations. I cannot recall one picture of a black or Asian persons’ foot in any podiatry text books. Plus, there is limited representation within senior levels of our profession (University and NHS managers), despite good levels of diversity.”*

**A balance of understanding knowns versus the unknowns**

It was clear from our 30-minute discussion that there are still a good number of unknowns.

*“We need to have conversations. Representation is lacking in our particular field (*podiatry*). It is really about where are the holes in our knowledge and where are the barriers. We all have bias and prejudices and it’s about awareness and reading more. Once we accept we are conditioned by the society we all live in, we can challenge this. I reflected on the book; Why I no longer speak to white people about race, and this talks about this in detail (I strongly recommend it).  Racism is not new so why haven’t we achieved a fair society, perhaps the problem is not the outspoken but the silent bystander. This in turn causes stagnation in attitude and a barrier to progression."*

I asked her,

*“Do you think it comes down to our background therefore and social economic position and upbringing together without education and where we live that forms the backdrop of Brexit that has created a division of intolerance?*

She replied,

*“We have a class based system in the UK and the white working class, especially males who have significant health inequalities, I worked in Salford for around 3 years, where there was high depravity and high smoking levels which was predominantly white. The thought of privilege in this living and working environment is hard to comprehend. The system does not affect white males as much as black males. Yet there is evidence that educational and work opportunities that are more challenging of people of colour.*

*For instance, downgrading in schools is common in black boys, which can be removed by anonymous marking.* *And an English sounding name which is more likely to get an interview. Both stand out as examples* (6,7).

**Throwing down the gauntlet**

We discussed skin wounds as in surgical scars and puckering of scars. She then asked me has the experience with higher proportions in feet of melanin been a factor in your practice and associated with the difficulty of dealing with people of colour and their management?

As a podiatrist one cannot help feel that her deep thoughts are also challenges, both to the readership, the profession and possibly even me. Could I add to the narrative and what about others she called specialist leaders?

I gave some thought to our discussion. While doubtless there are podiatrists who could answer some of these questions, I decided that this topic was hot enough for some further reflective thought from my own key board. I set about writing two further reflective articles entitled ‘Living in a Melting Pot’ and ‘Were we Trained with Colour in Mind?’

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First Published 2009. ISBN 978 1 84712 645 0

All hyperlinks were checked at the time of submission 27-08-2020

This article was produced following an interview between Jill Halstead-Rastrick and David R Tollafield for Busypencilcase Reflective Communications on 26th June 2020