You’re walking down life’s road, society’s foot is on your throat, every which way you turn you can’t get from under that foot. And you reach a fork in the road and you can either lie down and die, or insist upon your life.

Odetta Holmes

Who was Ms Odetta Holmes? She was an opera singer, skilled guitarist, queen of US folk music, and a recipient of the National Medal of the Arts and Humanities. Her work embodied social activism and was recognized as the voice of the civil rights movement. Ms Holmes was a Black woman who sang about Black culture and the atrocities experienced by Black individuals in the past and her present-day United States. She also expressed how she was personally discriminated against for her physical appearance and race. Her songs included spirituals that evoked agonizing pain as well as hope for change. She described how structural racism impacts minoritized people, ultimately leading to death. Ms Holmes’ work provided warnings for society’s future if intentional systemic changes were not made. Ms Holmes died from heart disease in her seventies.

Ms Odetta Holmes’ legacy provides a valuable lesson for clinicians and scientists. As members of society, we as clinicians and scientists are not immune to systemic racism and may often contribute to it. Ms Holmes’ work provides insight to the everyday lives of many Black individuals and demonstrates where our focus should be if we desire equity, which is addressing systemic inequality.

In JAMA Network Open, Cascino et al sought to address a question of equity in the delivery of life-saving advanced heart failure therapies, left ventricular assist devices (LVAD).

In a population that includes patients similar to those Ms Holmes sang about, Cascino et al evaluated whether Black race and female gender compared with White race and male gender were associated with LVAD implantation and 1-year survival following LVAD among patients hospitalized with systolic heart failure. Using the 100% Medicare Fee-For-Service administrative claims data, investigators eliminated uninsurance as a contributing barrier to racial and gender differences in care for US residents. Investigators used a machine learning technique, synthetic minority oversampling (SMOTE), to create a simulation of patients with similar propensity (probable need) for LVAD across Black and White race groups to increase accuracy of models. They adjusted for age, LVAD propensity, hospital fixed effects, and social determinants of health, including patient proximity to LVAD centers, neighborhood social deprivation index, and presence of Medicare Part D Low Income Subsidy (income less than 150% of federal poverty level). Ultimately, this study demonstrated that Black patients and women were less likely than White patients and men to receive LVAD implantation, which could not be fully attributed to social determinants of health. Survival following LVAD was similar across race and gender.

Post hoc analyses were performed to understand how LVAD propensity was associated with outcomes. LVAD propensity of less than 0.52 was associated with lower receipt of LVAD for Black patients vs White patients and higher survival for Black patients vs White patients. In contrast, across all LVAD propensities, women were less likely to receive LVAD than men, and survival was similar by gender. When patients by race and gender were algorithmically similar, clinical care was less likely to be offered to Black patients and women.

The article by Cascino et al adds to substantial literature indicating that factors beyond social determinants of health and comorbidities contribute to persistent racial, gender, and intersectional cardiovascular disparities. Major contributors that cannot be easily evaluated using administrative

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claims data are social bias and structural racism. Studies examining the clinical decision-making process for the allocation of therapies such as LVAD have demonstrated the presence of systemic discrimination. Urgent investigation is needed to demonstrate effective strategies for producing systematic equitable clinical decision-making.

There are practical steps to reduce the impact of structural racism on patient care immediately. Listen to patients. Actively listen to people like Ms Odetta Holmes. Avoid mislabeling patients with subjective assessments, such as difficult, noncompliant, angry, and substance abuser. Instead, gain insight for patient decision-making. Establish rapport, inquire and write about the reasons for their decisions, and develop a plan with the patient. Consider obtaining longitudinal evidence-based bias reduction and antiracism training. Become partners in care with your patients and community leaders. Collectively identify community needs and academic, corporation, and community resources to provide to patients as needed.

Ms Holmes died from heart disease in her seventies. Could she have lived a longer and higher-quality of life? Do you believe that the current US health system structure provides equitable access to care irrespective of an individual’s race or gender? Consider not avoiding the topic of race and implications of racism; rather, learn from Ms Odetta Holmes. Listen to her ministry of music. Focus on how you can address systemic racism in your daily life.

ARTICLE INFORMATION
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