

## LETTER TO THE EDITOR

## General correspondence

### Descriptive epidemiology must not perpetuate deficit discourse and mask systemic racism

We thank Rajamohan *et al.* for highlighting the important issue of heart failure (HF) in Central Australia.<sup>1</sup>

Understanding the epidemiology of HF is important for improving prevention and management. However, we are deeply concerned by the research question and framing, methods and language of this study. As Indigenous and non-Indigenous researchers reflecting on our own roles, we are concerned that descriptive epidemiology can perpetuate harmful, disempowering discourse and disregard colonisation and systemic racism as the key drivers of health inequities. Examples of these risks appear in Rajamohan *et al.*

First, the paper does not provide evidence that the research question was self-determined by the community, or that the study protocol was underpinned by negotiated agreement and meaningful engagement with Aboriginal and Torres Strait Islander peoples.<sup>2</sup> ‘Characterising’ and comparing Indigenous and non-Indigenous Australians experiencing HF sustains deficit discourse, which serves to marginalise Aboriginal and Torres Strait Islander world-views and strengths.<sup>3</sup>

Second, the authors included Aboriginal and/or Torres Strait Islander status as a covariate in Cox regression analyses to conclude that ‘(e)ven after accounting for their greater rate of comorbidities, Indigenous ethnicity remained a strong, independent predictor of mortality in patients with HF in multivariate models’.<sup>1</sup> Such analyses and reporting disregard the socially constructed nature of ethnicity and race and perpetuate damaging narratives of individual deficiency.<sup>4,5</sup> An opportunity to highlight contributing causes such as systemic racism and discrimination in healthcare has been missed.<sup>6</sup>

Third, there are several problematic language choices in the paper. The placement of intergenerational trauma in quotation marks and the suggestion that it is merely

‘felt’ implies scepticism of a recognised phenomenon with far-ranging impacts on wellbeing.<sup>1,7–9</sup>

The authors suggest that there is a ‘complex interplay’ between Aboriginal and Torres Strait Islander status and other barriers to healthcare.<sup>1</sup> The language of ‘complexity’ has been criticised by Māori scholars as a colonial instrument to divert attention from the ‘direct and urgent causative role that colonisation plays’ in the determinants of health for Indigenous peoples.<sup>4</sup>

We acknowledge that research does not occur in isolation. These methods, framing and language permeate medical training, health systems and research paradigms. Changing this context is a collective responsibility.

All research involving Aboriginal and Torres Strait Islander peoples should be conducted in accordance with guidelines from the National Health and Medical Research Council, the Australian Institute of Aboriginal and Torres Strait Islander Studies and the CONSolidated critERia for strengthening the reporting of health research involving Indigenous Peoples (CONSIDER) statement.<sup>10</sup> We recommend strengths-based analytical approaches to counter deficit discourse in this publication and all others.<sup>11</sup> Finally, we urge all researchers to acknowledge, articulate and reflect on the ongoing impacts of colonisation on Aboriginal and Torres Strait Islander peoples and to consider the role of research in alleviating – or conversely perpetuating – these harms.<sup>12</sup>

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