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Healthcare: A Universal Human Right or White Privilege?

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Abstract

It is an undeniable fact that racism has been present in the United States since the beginning of the European colonization of the nation. Structural racism and implicit biases are the modern reality of the African American experience, reflecting years of direct racial targeting, mistreatment and discrimination. Today, there are many examples of deeply rooted racial discrepancies, de facto segregation, and modern acts of colonization. Perhaps one of the most troubling disparities present between African Americans and white Americans is the alarming difference in their experiences with healthcare. After a long history of medical torture, mistreatment, and a denial of basic human rights, there exists an ingrained distrust of the medical field, accompanied by racially charged treatment differences, and the misunderstanding of different medical needs in diverse societies, leading to major health inequalities among African Americans and white Americans.

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It is an undeniable fact that racism has been present in the United States since the beginning of the European colonization of the nation. Structural racism and implicit biases are the modern reality of the African American experience, reflecting years of direct racial targeting, mistreatment and discrimination. Today, there are many examples of deeply rooted racial discrepancies, de facto segregation, and modern acts of colonization. Perhaps one of the most troubling disparities present between African Americans and white Americans is the alarming difference in their experiences with healthcare. After a long history of medical torture, mistreatment, and a denial of basic human rights, there exists an ingrained distrust of the medical field, accompanied by racially charged treatment differences, and the misunderstanding of different medical needs in diverse societies, leading to major health inequalities among African Americans and white Americans. Without drastic changes in the medical field and public policy, African Americans will continue to be “second- class health citizens” (Byrd & Clayton, 1992).

There is a long history of racism in the medical field, which has led to a general distrust of medical institutions by the African American population. There are several distinct examples that are accountable for the mistrust of the medical field that continues to negatively impact African Americans. One of the most identifiable examples of horrific treatment of African Americans in the medical field is the reoccurring mistreatment of female reproductive rights. Perhaps most notably was James Marion Sims, a gynecologist in the 1800s, who operated on female slaves in an attempt to perfect his surgical techniques. Sims performed surgical experimentation on several female slaves, who were brought to him by their owners, without the use of

anesthesia, which was new to the medical field at this time (“J. Marion Sims,” 2019). Not only were these procedures conducted without consent, but Sims functions as a prime example of the common belief that African Americans do not feel as much pain as white people (Hoffman, Trawalter, Axt, & Oliver, 2016). Sims’ eventually perfected his techniques and was sought out by white women for his operations. Noticeably, Sims used slaves as his so called ‘lab rats’ before performing surgeries on white women, which contributes to a horrifying legacy of the treatment of African Americans, and particularly African American women. In addition to Sims’ experiments, there a history of the neglect of female reproductive rights as seen by forced sterilization. For eugenic purposes, African American women were given forced hysterectomies, either without being told, or being asked under the influence of medications which hindered their cognitive abilities. Byrd and Clayton (1992) identify a term “Mississippi appendectomies,” which explains that when African American women were receiving treatment on their appendix or an appendectomy, it was common that they received a hysterectomy or another sterilization surgery, preventing them from having children and further reproducing. While reproductive rights and gender equality have been fought for by women for many years, the issues at hand are starkly different. For white women, the fight is about access to contraception, abortion, and the right to choose what to do with their bodies. For African American women, who face significantly higher maternal deaths and infant mortality rates, the fight is about their ability to give a healthy birth and survive it (Byrd & Clayton, 1992). Whether used for experimentation or eugenic purposes, African American women have historically been denied basic reproductive and healthcare needs.

Another identifiable case of exploitation of African Americans in the medical field is the Tuskegee syphilis experiment, conducted on poor, African American men for 40 years, beginning in 1932. Now noted as one of the most unethical medical studies in the United States, the Tuskegee Study was meant to observe the effects of untreated syphilis (Reverby, 2009). None of the men, however, were told they had syphilis, and none were treated with penicillin after it was discovered as an effective treatment for the disease. These men were in fact denied a basic right to proper medical treatment. Additionally, men in the study were told they were being treated for 'bad blood,' which was a term commonly used to describe several ailments including syphilis, anemia, and fatigue (Reverby, 2009). During this time, 'bad blood,' was one of the highest causes of death among the southern, African American population, depicting the lack of proper health care, which caused the community to umbrella many different illnesses into one term. The damage of the Tuskegee experiment was and is colossal; not only did it engrain a mistrust for the healthcare treatment in African Americans, but it is also responsible for the fear of participating in medical trials and experiments that are ethical and could potentially be extremely beneficial for the African American population.

Byrd and Clayton (1992) discuss two short periods of progressive health reform in which changes in the healthcare systems provided hope for African Americans and their access to adequate treatment. The first period of healthcare reform came during the Reconstruction period after the Civil War. Due to an alarmingly high death rate of African Americans, Congress passed legislation, out of fear, to open hospitals, schools, clinics, and soup kitchens. This legislation also led to the opening of black medical schools and hospitals, however systematic racism and mistreatment of African

Americans continued. Minuscule societal changes were made and poverty levels, the lack of healthcare, and proper sanitation continued to separate available and adequate healthcare for African Americans. African American doctors made great strides during this period, however the power of white medical professionals continued, and African Americans did not have rights to public accommodations. This time period represents the continuation of the “slave health deficit,” and functions as an example of deeply rooted, systemic racism (Byrd & Clayton, 1992, p. 195). The second period of reconstruction for African American healthcare occurred during the Civil Rights Era, when mainstream healthcare was made available to the black population, as segregated facilities were outlawed. Medicare and Medicaid legislation aided African Americans and other oppressed groups, however progress in African American healthcare stopped increasing in the 1970s (Byrd & Clayton, 1992). This era also consisted of misconceptions about mental health. It was a general belief that African Americans were devoid of their culture and history and would struggle in society. White doctors did not think African Americans could ‘handle’ their freedom and used schizophrenia to depict African Americans as violent and paranoid (Williams, 2017). Both of these periods of health reform were short lived, representing the inadequate response for long- term healthcare equality.

It is evident that African Americans have been mistreated directly, through unethical experimentation and procedures, and indirectly, through systemic racism and segregation in the healthcare field. Distrust of the medical field has alarming consequences and continues to be an issue for the African American population. Prostate cancer, for example, is the most common cancer for men in the United States,

and while African American men are more likely to get prostate cancer, they are twice as likely to die from it. This statistic may be a result of the underrepresentation of African American men in prostate cancer research and medical trials, which is largely a result of the mistrust of medical trials and the healthcare system in general (Cohen, 2018). Cohen (2018) discusses study results, which indicates that genomic testing is a promising approach to understanding cancer and its treatment, yet African American men are generally unaware of this type of research and are weary of participating. Additionally, this study indicates that participants mentioned the Tuskegee syphilis study and explained their hesitance of participating in medical research (Cohen, 2018). For endometrial cancer trials, studies indicate that for every white female, there are .04 African American females enrolled, which results in cancer treatments that work for a majority white population, while there are potentially more effective treatments for African American women (Furneaux, 2019). Medical professionals acknowledge the validity of African American distrusts towards their field yet explain that in order to better diagnose and treat conditions, there needs to be a more diverse representation in clinical research (Cohen, 2018). Linking disease to race and genetics can be troubling due to a history of history and scientific racism; however, there is a link between certain populations and diseases, and it is crucial that those who are predisposed to diseases and illness are receiving the best and most informed care. This care, however, is not possible if patients are not being properly treated and if discriminatory actions are still present in the medical field. Furthermore, African Americans are not only weary of medical trials, but are also less likely to seek treatment or be compliant with suggested treatment as a result of medical mistrust (Furneaux, 2019). A history of mistreatment

and distrust contributes to the narrative, as African Americans can be reluctant to receive proper medical treatment.

In addition to general mistrust of the medical field, there are many distinct examples in which African Americans are still treated and diagnosed differently than white Americans. While there are certainly diseases and illnesses that effect different racial groups, there are racial disparities between proper treatment, accurate treatment, and pain assessment. In a 2016 study, Hoffman, Trawalter, Axt, and Oliver discuss the systematic undertreatment of African Americans. Research indicates that the black body is perceived as stronger than the white body, and therefore pain is underestimated. Thus, African Americans are less likely to receive pain medications or are prescribed pain medications at a lower quantity than white patients. Also concerning is the position of African Americans in the United States opioid crisis, as white Americans are often over prescribed pain medications and opioids, while African Americans are generally under prescribed pain medications and opioids (Hoffman et al., 2016). Inadequate treatment is a reality for many African Americans. African American women with health insurance and access to proper healthcare often receive less aggressive care for endometrial cancer and are less likely to receive an early biopsy compared to white women. Additionally, black women are less likely to receive surgery for endometrial cancer and are less likely to receive chemotherapy (Furneaux, 2019). Furthermore, African American women are less likely to be tested for hereditary breast cancer, are four time more likely to die from a pregnancy related death than white women, and in general are more likely to die from breast, prostate, and stomach cancer (Furneaux, 2019). Bridges (n.d.) discusses a National Academy of Medicine report that

indicates minority groups are less likely to receive the same cardiac care, kidney care, treatment for stroke, cancer, or AIDS as white people. These results also indicated that lesser treatment was not a result of accessibility, but rather a result of race or ethnicity. Additionally, African American patients are more likely to be prematurely discharged after major surgeries, receive older and cheaper treatments, are more likely to receive undesirable treatments like amputation, and bipolar disorder is more likely to be treated with antipsychotics, which are proven to be ineffective with negative, long- tern effects (Bridges, n.d.). Implicit biases, resulting from years of institutionalized and systemic racism, are to blame for healthcare disparities among African Americans and white Americans.

Healthcare gaps between African Americans and white Americans are often moderated by socioeconomic status including housing, education level, income, and other factors. However, implicit bias, which is often unintentional, needs to be addressed in medical schools and in all medical professionals. Parallel to this, race should be properly considered in medical assessments. In a 2011 focus group study, Snipes, Sellers, Tafawa, Cooper, Fields and Bonham identify three main themes, determining that African American physicians differ in their opinions on the importance of race for a proper medical assessment as compared to white physicians. While both African American and white physicians agree that the most important component of a medical assessment for decision- making is medical health history and symptoms, African American physicians report that patient race is relevant for treatment decision-making, while white physicians report that patient race is not relevant (Snipes et al., 2011). One African American physician in the study pointed out that it is important to

acknowledge race immediately because “[doctors] need to often be more aggressive… and use different standards… than [one] would for the general white population,” which may be a result of less treatment- seeking tendencies among the African American population (Snipes et al., 2011, p. 6). African American physicians also indicated that race factors into treatment options, as diseases like hypertension, diabetes, and kidney problems are more severe for African Americans. Again, genetic differences between groups are important to acknowledge, however it is crucial to distinguish medical facts from implicit biases in these cases. Impacts of internalized colonialism are also observed in this study. Not all of the white physicians considered socio- cultural context, while all of the African American physicians identified several examples of the relevance of using race as a guide for social context. The African American physicians discussed the importance of understanding patient’s beliefs, health history, socioeconomic status, access in regard to healthcare, and financial ability in regard to payment for medications. Additionally, the African American physicians mentioned understanding a patient’s beliefs on how seriously they take disease management and how at- home treatments may influence their willingness to take prescriptions (Snipes et al., 2011). White physicians did not acknowledge socio- cultural components of medical treatment to the same extent as their African American colleagues, which was probably not purposeful, but provides context that it is common for white Americans to not consider how race, cultural, and social aspects affect minority groups in many settings.

In order to transform healthcare to eliminate racial disparities, doctors must be the first to change their methods. Healthcare professionals enter the workforce with the purpose of aiding the sick and preventing disease. Therefore, it is crucial that doctors

account for marginalized groups and treat patients with the same vigor, respect, and dignity. Implicit bias is often not purposeful, but it is harmful. These biases, however, can be eliminated with thoughtful purpose to aim to change these biases and act more fairly. African American patients rely heavily on African American health providers to provide effective and correct care (Byrd & Clayton, 1992). There is also a need for more African American researchers, who may be transformative in building trust in clinical trials (Cohen, 2018). By reducing biases and increasing trust in the medical field, healthcare disparities can begin to diminish.

In general, healthcare disparities between African Americans and white Americans are affected by public policies in a wide range of contexts, which perpetuates the issue and fails to address implicit bias. Socioeconomic status is a strong predictor of healthcare across racial groups. The American healthcare system is inherently two-tiered by providing those with private health insurance exceptional care, and less adequate care to those without private insurance. There tends to be large disparities between socioeconomic groups and racial groups (Williams & Jackson, 2005). For example, those with low SES are more likely to smoke than those with high SES, independent of their race or ethnicity. Homicide rates, however, differ largely among African American men and white men who have the *same* level of education. Homicide rates for African American men with some college education is eleven times higher than that of white men with the same amount of education (Williams & Jackson, 2005). Income and housing also differ between African Americans and white Americans in the same SES groups. Poor African Americans generally live in much worse conditions than poor white Americans, and middle- class African Americans live in worse conditions

than poor Latino and Asian groups (Williams & Jackson, 2005). Housing has a large impact on quality of life, and can determine the quality of a public education, access to medical care based on location, and a generally safe and inhabitable environment. The healthcare system is fundamentally commercialized and focuses on the monetization of healthcare by means of unnecessarily expensive testing methods and that pharmaceutical companies are entrepreneurial and exploitative in nature (Byrd & Clayton, 1992). Changes in health policy and medical care can assist those with low socioeconomic status, yet racial discrepancies need to be addressed directly. Healthcare providers must work on their implicit biases, and African American medical professionals can contribute to the conversation and aid their colleagues. The healthcare itself can be delivered by medical professionals more strategically by acknowledging a deep- rooted mistrust of the healthcare system by African Americans and thoroughly conducting medical practices, reviewing treatment options with the patient, and explaining the importance of that treatment. Public policy changes cannot be made without addressing biases within the medical field professionals itself and the way treatment is delivered.

Throughout history, there is an obvious neglect of the basic human rights that African Americans deserve. While the racism faced today is much less explicit than it was in the past, internalized sentiments regarding African Americans continue to deny African Americans of the same rights as white Americans. Society is responsible for cutting ties with racial inequality, and medical professionals are responsible for reshaping the way they care for all Americans. Until implicit biases are corrected,

African Americans will continue to doubt the power of medicine and receive less adequate treatment than white Americans.

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