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Understanding the Role of Race in American Medicine

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Abstract

Long running inequity in health care and outcomes in the United States stem from failure to acknowledge the underlying role of the Transatlantic slave trade as it manifests in all facets of American society and commerce. This paper focuses specifically on the American medical system and its foundations to understand the precursors to generational trends in lack of access to healthcare and poor health for Black communities. This paper uses a three-pronged approach to understand the racist cycle of inequity, highlighting the history and origins of racism in American medicine, personal accounts and statistical evidence of inequity, and community and policy initiatives that orient conversations towards change and progress. The goal of this paper is to highlight historical and ongoing barriers to healthcare access for Black folks in the United States, and to push for accountability as well as inspire immediate action for the alleviation of identifiable stressors.

Acknowledgements

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Preface

It would be fallacious to not acknowledge that Western spheres of thought, research, and influence have largely excluded Black voices for centuries. As a non-Black individual myself, in no capacity can I speak on behalf of the Black community and those most impacted by the issues outlined within this thesis. Through my research I hope to bring light to systemic and cultural issues that are often overlooked or misunderstood in the United States. Accompanying my personal scholarship in economics and science, technology, and society (STS), I aim to elevate Black voices through use of personal accounts and pull from a wealth of Black scholarship on healthcare inequity and racism. Significant cultural and systemic change necessitates acceptance of past transgressions and their perpetuation in the modern era—all of which require listening directly to the needs of those harmed. As a student, I have ample privilege and recognize that the topics of my research are the lived realities of millions of racialized folks, spanning generations.

Introduction

Over the course of the 16th through 19th centuries, an estimated ten to twelve million enslaved African folks were ripped from their homes and subjected to grueling, inhumane conditions through the Transatlantic slave trade. Generations later, the ripples of the atrocities committed within this period remain evident in even the farthest corners of the world and manifest more silently within politics, science, art, and more. The foundations of the United States, homeplace of democracy and freedom, stem from economies operating on the belief that one man can own another. It makes sense then that nearly every aspect of American culture and commerce is haunted by the lingering remnants of racial power systems that serve and protect Whiteness while both actively harming or failing to protect racialized people. In the United States, we pride ourselves on the opportunities supposedly available to all citizens yet on closer examination we fail to guarantee even the most basic right of good health to our citizens. In this nation there exists intertwining narratives of amazing medical progress and horror stories of the harm perpetuated against minority communities. Furthermore, the legacy of the Transatlantic slave trade disproportionately harms Black communities.

Race is just as relevant of a concept in every facet of our society, especially health, as it was centuries ago. It is impossible to and irresponsible to omit discussion of race while looking at the American medical system. From a critical point of view, race is a major factor contributing to access, availability, and quality of treatment. For Black Americans, the health realities are even more dismal. The three major indicators of health of a population or sub-population are infant mortality, age-adjusted death rates, and life expectancy (Baciu, Negussie, Geller, et al., 2017). In the United States, substantial racial disparities exist across these metrics, indicating long-lasting systemic issues. If you were to divide White and Black American populations into

their own nations, White America's infant mortality rate would rank 49th in the world while Black America's would be ranked 95th out of 224 nations listed by the U.S. Central Intelligence Agency's World Factbook (WHO, 2015). Epidemics of childhood obesity disproportionately impact minority communities and greatly reduce life expectancies within minority groups. Age-adjusted mortality rates capture population deaths due to all causes, especially those not due to old age. High death rates indicate that a population is facing serious threats to health as well as issues with lack of resources needed to address them. From 2007 to 2009, age-adjusted mortality rates for White Americans were around 729.1 per 100,000, while they were at 858.1 per 100,000 amongst Black Americans (WHO, 2015).

In this thesis I analyze the association between race, racism, and healthcare and health outcome inequity in the United States through illumination of the intertwining relationship between the ever changing definition of race, lived experiences, and cultural and political responses. To do so, I have pulled from several personal accounts, Black scholarship, and scientific and economic and political literature on trends in access, affordability, and quality of care. This paper sets out to bring light to a new perspective of the definition of race—and subsequently racism—that takes into account cultural and historical contexts as well as acknowledgement of underlying intent and reinforcement of existing power systems. In doing so, I draw connections between the evolving conceptualization of race and the intentional perpetuation of issues with life-altering consequences that have for too long been overlooked or misunderstood. These life-altering consequences are best understood through the most honest source—the individuals within Black communities who have been victimized by these systemic and cultural systems that are pervasive throughout the American healthcare system. Understanding the full extent of harm caused by the racialization of research and science in

medical contexts requires a humanistic and personalized understanding of how tools of bias are implemented. To round out the three-pronged approach of this paper, I have compiled several examples of both community and policy oriented initiatives that are a strong start towards alleviation and eradication of disparity in healthcare contexts. Though only a beginning, these initiatives show a growing reaction and demand for equity in health. Collective demand for change can subvert the racial tools and technologies used to harm Black folks into action that benefits low-income, marginalized, and intersectional communities who are also frequently overlooked. Given the heated political climate of the modern era in which mass media allows for the depiction and dissemination of state violence against Black Americans and the failure of the American healthcare system to adequately serve these communities in the face of a global pandemic, I hope that this paper can raise awareness to these issues and emphasize the need for immediate action.

Understanding and addressing the concept of race itself could significantly lend to efforts to alleviate the racial disparity plaguing the American medical field. There are many interactions between race and medical systems that are largely overlooked, minimized, or misunderstood. Significant social and political progress requires acknowledgement of histories of oppression as well as the way that we discuss race within medical contexts. Failure to listen to racialized voices and to recognize long-standing systemic harm has taken countless lives over the history of the United States. Though originally applied to discussion of climate change's impact on the poor, Rob Nixon's concept of slow violence aptly conveys how issues of racism in healthcare and disparities in health outcomes have been viewed. Slow violence is "a violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all" (2). The treatment of

Black Americans within the contexts of American healthcare systems is emblematic of slow violence in that it feeds off of systems of bias to create unequal health outcomes that in turn limit the opportunities available to racialized folks. The lack of opportunity in turn limits the resources available to individuals and it perpetuates the cycle of poor health, lack of opportunity, and inequality. The wheels of this cycle have been turning for generations already, and work must be done now to counteract the momentum they carry.

While this paper seeks to highlight the realities of healthcare inequity in the United States with particular focus on the Black community, it should be acknowledged that many of these experiences are far too common for many minority individuals. The focus of this paper comes from an understanding that there is no way to discuss American history without acknowledging the atrocities of the Transatlantic slave trade. American society is entirely underwritten by systems that have roots in the oppression or omission of Black voices yet there are strong trends of failure to acknowledge this reality. Examination of issues of health inequity in the United States is impossible without discussing the Black experience. Furthermore, it can be argued that policy and social change that seeks to treat the harm inflicted upon Black communities ultimately will benefit and uplift many other marginalized voices within the United States—promoting a better quality of life for all Americans. Policy that improves the lived experience of Black Americans is likely to improve the experiences of all marginalized Americans on racial/ethnic and socioeconomic lines and hopefully can act as a vessel for long-term equity or equality.

Chapter 1: Defining Race

Historically, race has been viewed as a biological term—rooted in inherent scientific differences between people. Much of this is the result of pseudoscience and ingrained racism within medical and cultural systems, discussed earlier. Modern science has shown that in fact, race is only skin deep and bears no legitimate biological significance. While there may be minor variations between individuals of different racial backgrounds, humans are remarkably similar to one another. Racial categories are social constructs developed from prevailing social perceptions—without scientific evidence to back them up. Despite modern proof that race is biologically fictional, racial taxons are still widely used in medical teaching, practice, and research. These taxons have been “medicalized” or in other terms, legitimized by medical literature as acceptable descriptors that are core to modern diagnosis and treatment of disease (Witzig, 1996). These assumptions of disease diagnoses based on race can have severe consequences for individual patients as well as lend to inaccurate inferences for populations. The attention to race as a significant biological player within medicine is not only incorrect but has tangible effects on the treatment of individuals.

Hoffman et. al's *Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and Whites* (2016) puts forth that Black Americans are systemically undertreated for pain relative to their White counterparts. The study was conducted in two parts and examined whether this racial bias is related to pseudoscientific beliefs on biological differences between Black folks and White folks. The first part of the study documented beliefs among White laypersons. The second part of the study extended these findings to White medical students and residents. Table 1 shows the percentage of White

participants in both studies endorsing various true or false beliefs about biological differences between Black and White folks.

Table 1: Percentage of White Participants Endorsing Beliefs About Biological Differences Between Blacks and Whites

Item	Study 1: Online sample (n = 92)	Study 2			
		First years (n = 63)	Second years (n = 72)	Third years (n = 59)	Residents (n = 28)
Blacks age more slowly than whites	23	21	28	12	14
Blacks' nerve endings are less sensitive than whites'	20	8	14	0	4
Black people's blood coagulates more quickly than whites'	39	29	17	3	4
Whites have larger brains than blacks	12	2	1	0	0
Whites are less susceptible to heart disease than blacks*	43	63	83	66	50
Blacks are less likely to contract spinal cord diseases*	42	46	67	56	57
Whites have a better sense of hearing compared with blacks	10	3	7	0	0
Blacks' skin is thicker than whites'	58	40	42	22	25
Blacks have denser, stronger bones than whites*	39	25	78	41	29
Blacks have a more sensitive sense of smell than whites	20	10	18	3	7
Whites have a more efficient respiratory system than blacks	16	8	3	2	4
Black couples are significantly more fertile than white couples	17	10	15	2	7
Whites are less likely to have a stroke than blacks*	29	49	63	44	46
Blacks are better at detecting movement than whites	18	14	15	5	11
Blacks have stronger immune systems than whites	14	21	15	3	4
False beliefs composite (11 items), mean (SD)	22.43 (22.93)	14.86 (19.48)	15.91 (19.34)	4.78 (9.89)	7.14 (14.50)
Range	0-100	0-81.82	0-90.91	0-54.55	0-63.64
Combined mean (SD) (medical sample only)			11.55 (17.38)		

For ease of presentation, we shortened the items; see [SI Text](#) for full items and additional information. For ease of interpretation and ease of presentation, we collapsed the scale and coded responses marked as possibly, probably, or definitely untrue as 0 and possibly, probably, or definitely true, as 1, resulting in percentages of individuals who endorsed each item. Bold entries represent the items included in the false beliefs about biological differences between blacks and whites composite.

*Items that are factual or true.

Note. From “Table 1: Percentage of white participants endorsing beliefs about biological differences between blacks and whites” by Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites* (p. 4298), 2016.

From this information, the overall study was able to conclude a couple things. Firstly, individuals with at least some medical training in the U.S. healthcare system hold and may use false beliefs about biological differences between Black and White folks. Secondly, these beliefs are used to inform medical judgment in such a way that supports pseudoscientific differences between racial groups—especially as they pertain to pain tolerance levels. Ultimately, science has shown that there are no differences in pain tolerance between Black and White individuals, and belief in the contrary leads to racist, harmful mistreatment in medical settings.

An Argument for Redefining Race

In contrast to race, ethnicity is a concept that arises from the culmination of social, linguistic, religious, and other characteristics specific to individual populations. Unlike race, ethnicity could impart key clinical clues in diagnosis. Clinicians should be well informed on the cultural history of their patients and approach patient interactions with an open mind.

Throughout this essay, I argue for the movement away from race as a scientific term and towards a cultural technology. Importantly, the definition of race is inherent to the cultural context of the era you look at. Race is an ever-evolving term reflecting contemporary power systems and histories of racism. Turning to the medical field, it is important to address how race is defined and therefore used, to understand the treatment and inequities existing that impact minority communities. Throughout this essay, I will focus on the American medical system specifically. The working definition of race used within this essay is contextualized by the Transatlantic slave trade, American racism, the deliberate testing on and torture of Black bodies, and structural issues that fail to address inequalities within the system. Looking at the history of medicine in the United States it is clear that the medical treatment of Black individuals is directly tied to the eras attitudes towards race, especially the rift between race as a scientific term, cultural term, or the mixture of the two. Failure to address how race has been used as a tool within American medicine has culminated in significant and dangerous disparities that alter the viability and trajectory of Black communities.

The Technological Function of Race

Diverging from race as a biological indicator, it can be argued that race is a cultural tool. Within the framework of Science, Technology, and Society (STS) scholarship, race can be viewed as an operator of bias.

Race as Technology (2009)

Beth Coleman's *Race as Technology* argues for the presentation of race as a concept outside of traditional biological ideologies. Coleman's definition of race is one that moves away from biological and genetic systems and towards technical agency. Technical agency is the way in which external devices help us navigate the terrain we live in. Coleman argues that as humans, we have a natural urge to use technology to navigate and understand the world around us—hence the creation of a race to help humans navigate understanding our own societies. In this formulation, race exists as if it were on par with a hammer or a mechanical instrument: denatured from its historical roots, race can then be freely engaged as a productive tool, operating as the Greek word for technology, “techné”. The main difference between techné and what we know as “technology” is that techné is about technique and application more than the tool itself (178). Tools inevitably change over time and Coleman argues for the intentional separation of race from an inherited position of abjection toward a greater expression of agency.

“In extending the function of techné to race, I create a collision of value systems. In this formulation, race exists as if it were on par with a hammer or a mechanical instrument; denaturing it from its historical roots, race can then be freely engaged as a productive tool. For the moment, let us call “race as technology” a disruptive technology that changes the terms of engagement with an all-too familiar system of representation and power.” (178)

Coleman asserts that to begin the process of transitioning race to a technological term, it must be estranged from its history as a biological “fact”. To do so, she relies on the image of a levered mechanism where race is an internal part that keeps all running smooth rather than the main engine of the system. As a tool, and again alluding to the metaphor of race as a hammer, Coleman begs to question, “in whose hand does it rest?” (179). This question is at the core of Coleman’s argument and starts conversations on the creation of race, its intentionality, and its ramifications on human society. Coleman asks,

“Is it possible to think of race as a disinterested object of our delight, as opposed to one that is overinscribed? Can race survive as something other than the remnant of a traumatic history? Race as technology tells the tale of the levered mechanism. Imagine a contraption with a spring or a handle that creates movement and diversifies articulation. Not a trap, but rather a trapdoor through which one can scoot off to greener pastures. As an object of history, race has been used as a contraption by one people to subject another. An ideological concept of race such as this carries a very practical purpose. It vividly and violently produces race-based terrorism, systems of apartheid, and demoralizing pain.” (180)

As a technology, race moves towards an aesthetic category of the human condition where mutability of identity, reach of individual agency, and conditions of culture all influence one another. As a tool, race can aid and supplement conversations or it can be used with ill will. “It can become a trap or a trapdoor” depending on the ethical choices of the user and system participants (180). Without context, race is valueless. To address the issues perpetuated by definitions and applications of race, we are forced to confront the current systems of oppression.

Sensing Race as a Ghost Variable in Science, Technology and Society (2020)

Coleman’s desire for the intentional separation of race is a crucial component in redefining what race is and how it can and should affect our power systems and society. In many ways, race acts as a ghost variable in various settings. The idea of race’s role as a Ghost Variable is explored in Karkazis and Jordan-Young’s *Sensing Race as a Ghost Variable in Science*

Technology and Society (2020). They argue that race is “submerged and disavowed,” yet wielding power (767). The use of a ghost metaphor aptly conveys the shape-shifting and lingering aspect of the concept of race. Overtime, definitions of race have fluctuated but one thing that remains the same is that the residue of these iterations continues to inform all aspects of society—whether we like it or not. Understanding the rift between race as a biological concept and cultural technology is central to efforts to free society of the ghostly chains of historical bias. Defining and coming to terms with the varying ideas of race is something that has troubled scholars across several disciplines for years.

Beyond Fact or Fiction (2013)

Amade M’Charek asserts in *Beyond Fact or Fiction: On the Materiality of Race* that the two presented narratives do not have to be mutually exclusive. Race can, and should be, viewed as both fact and fiction. Using material semiotics, M’Charek argues that objects achieve their significance in terms of their relationship—an approach that is rarely used when talking about the concept of race. The reframing of race with its cultural relationship and usage in mind supports the idea that race can and has been used throughout history and impacts society in a tangible but not necessarily justified way.

The Racial Feedback Loop

Racial inequity across all contexts is a self-reinforcing cycle. Systemic inequalities are perpetuated through notions of racial inferiority that result in tangible socioeconomic impacts. In her book, *Reproducing Racism: How Everyday Choices Lock in White Advantage*, USC Gould School of Law Professor Daria Roithmayr argues that even if all discrimination were to cease

tomorrow, racial disparities would continue due to longterm self-reinforcement. “It’s really a racial ‘rich get richer’ story,” Roithmayr says. “It’s all about the power of networks.”

For example, as the dominant racial group in the United States, White individuals in well-paying jobs refer their friends for jobs who in turn refer to their friends, and so on. These “White networks” within high-paying jobs show substantial inequity in comparison to Black and brown networks where under-employment and unemployment rates are higher due to generational and systemic barriers. The stark differences in income lead to even more stark differences in school funding and resources—creating yet another vein of inequity. Affluent neighborhoods (which frequently correspond to racial divides) are able to afford to provide their students with richer learning experiences and opportunities, which in turn results in those students achieving higher paying jobs than their Black and brown counterparts, reinforcing economic differences. “It turns out that racial inequality persists because the old clichés are true: it does take money to make money, and it really isn’t what you know but who you know. Because racial disparities now run on automatic pilot, these gaps will continue even in the absence of intentional discrimination,” Roithmayr says.

In addition to the tangible generational effects just outlined, I would argue that the defining of race implies a racial feedback loop. The way that race is defined within cultural context shapes how race is used, which in turn reinforces ideas of racial differences and definitions. This cycle contributes to a lot of the inherent cultural bias against Black folks we see in the United States today, despite the dismantling of systems of intentional racism such as that of chattel slavery, voting discrimination, and other intentionally discriminatory laws. While these institutions of racism have been dismantled, the ways that they have shaped the American psyche and understandings of race continue to present day. In turn, these definitions of race inform

unconscious or more covert racism in the modern era. Within the realm of the American medical system, this culminates in clear racial differences with life altering consequences.

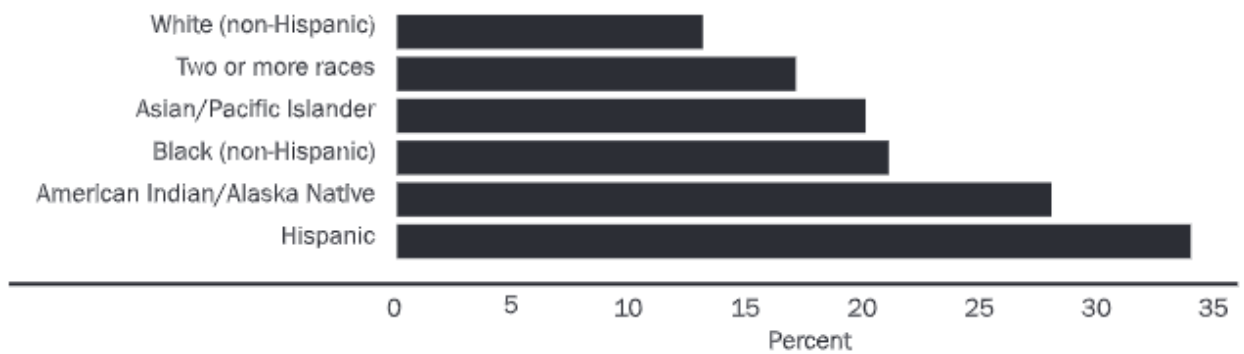
Chapter 2: The Current State of American Medicine for Black Americans

As shown before, there are clear differences in health outcomes of Black Americans in comparison to other minority groups, but the differences are especially apparent in comparison to White Americans. Across the board, Black Americans are severely limited in the choices they are able to make surrounding their health and interactions within the medical sphere. In this section, three major avenues in which Black folks are severely limited in their health opportunity are as follows: issues of payment and insurance access, geographic access, and quality access. Furthermore, this section includes some key personal testimonies on treatment of Black folks within the American medical system.

Payment and Insurance Access

A driving reason for the racial differences across these three metrics boils down to issues of access. Inequity in access and racism have long gone hand in hand. While anti-discriminatory laws have been enacted to prevent racial bias from barring minority individuals from many facets of society, race still plays a distinct role in access issues. Barriers to healthcare and health insurance coverage result in poor health outcomes. Lillie-Blanton and Hoffman (2005) cites that people of color made up (per 2003 data) 34% of the U.S. population yet accounted for around 52% of the uninsured. Referring to Figure 1, over 20% of non-Hispanic Black Americans were found to be uninsured.

Figure 1: Uninsurance Rates Among Nonelderly Americans, by Race and Ethnicity (2003)



Note. From “Exhibit 1: Uninsurance Rates Among Nonelderly Americans, By Race/Ethnicity, 2003,” by Lillie-Blanton, M., & Hoffman, C., *The Role Of Health Insurance Coverage In Reducing Racial/Ethnic Disparities In Health Care* (p. 399), 2015.

Within the typical American model of health insurance, individuals are typically covered under their employer with a private insurance plan. Historically, public insurance plans like that of Medicare and Medicaid that especially benefit minority groups and may help equalize opportunities for care. However, these options have been severely limited in scope and funding.

Americans of racial/ethnic minorities are less likely to have employer-sponsored coverage (see Table X). While nearly 70% of White Americans are covered through an employer-sponsored health plan, less than 50% of Black Americans had access to this coverage in 2003. The lower rate of insurance among Black Americans can be explained in part by lower-wage jobs in which insurance coverage is either unavailable or unaffordable. Many Black Americans without employer-provided coverage have earnings just too high to be eligible for public options but not high enough to take advantage of subsidies under marketplace prices, leaving them in the “coverage gap” (Bittker, 2020).

Table 2: Health Insurance Coverage Among Nonelderly Americans, by Race/Ethnicity/Source of Coverage (2003)

Race/ethnicity	Millions of people	Source of coverage (%)				
		Employer-sponsored	Private nongroup	Medicaid	Other public ^a	Uninsured
White only (non-Hispanic)	165.9	69.7	6.4	8.7	2.3	12.9
Black only (non-Hispanic)	32.0	48.8	2.7	24.6	2.9	21.0
Hispanic	38.2	40.6	2.7	20.9	1.4	34.3
Asian/Pacific Islander	11.2	62.3	6.8	9.0	1.4	20.4
American Indian/Alaska Native only	1.5	38.2	3.9	24.9	5.0	28.0
Two or more races	3.9	54.5	4.5	21.0	3.3	16.7

From “Exhibit 3: Health Insurance Coverage Among Nonelderly Americans, By Race/Ethnicity And Source of Coverage, 2003,” by Lillie-Blanton, M., & Hoffman, C., *The Role Of Health Insurance Coverage In Reducing Racial/Ethnic Disparities In Health Care* (p. 400), 2015.

Overall, uninsured Black folks are on average poorer than uninsured White folks. In 2003, three quarters of uninsured Black and Hispanic Americans had incomes below 200% of the federal poverty level, in comparison to 56% of White Americans (Lillie-Blanton and Hoffman, 2005). Employment rates are also an important factor to consider with only 56% of uninsured Black folks coming from families with at least one full-time worker.

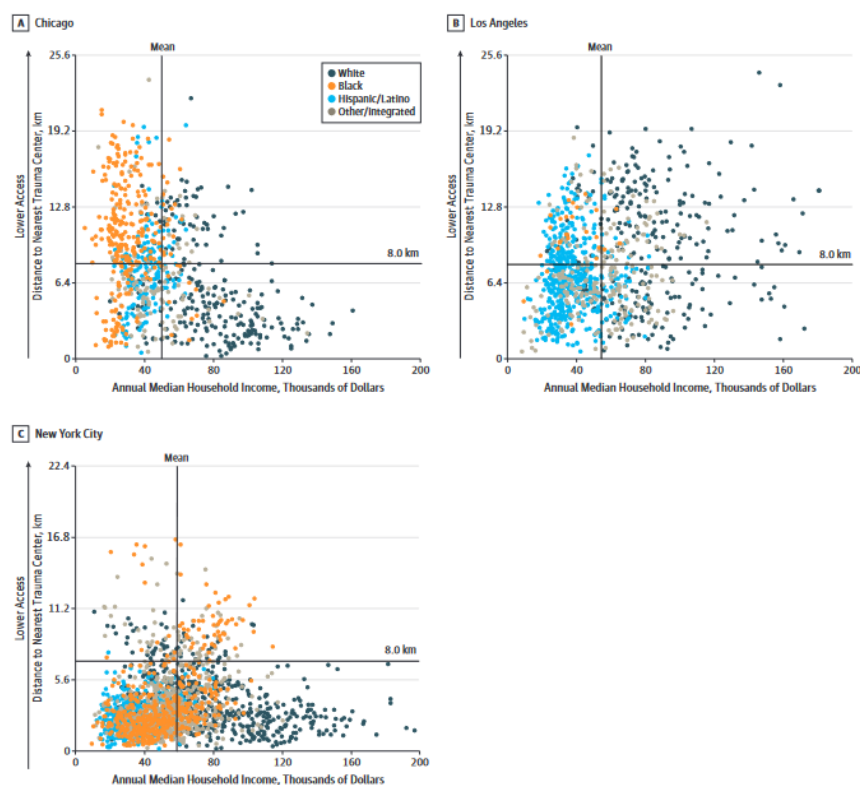
Recent proposals to expand insurance coverage for minority individuals focus on a combination of public and private-sector approaches. The final section of this paper highlights the merits of policy initiatives and the expansion of public programs which have been shown to be the most effective approaches to expanding health insurance coverage across the board. From a broader sense, it is imperative that these discrepancies in insurance and payment access are addressed immediately to allow for access to life-saving medical infrastructure.

Geographic Access

Another component of inequity in healthcare is access to healthcare. Many studies have shown that there are marked differences in access to various forms of healthcare by community.

Tung et al.'s *Race/Ethnicity and Geographic Access to Urban Trauma Care* (2019) highlights the racial and ethnic differences in access to trauma care in the three largest U.S. cities: Chicago, Los Angeles, and New York City. Notably, all three of these cities have historically large Black populations, making them optimal locations to understand racial variation in access to care. The study defines a trauma desert as a “travel distance greater than 8.0 km to the nearest adult level I or level II trauma center” (1). To examine racial and ethnic differences, the study used census tracts classified into racial/ethnic composition categories (based on patterns of racial segregation) and poverty categories. The study found that Black majority census tracts were the only racial and ethnic groups that appeared to be associated with disparities in geographic access to trauma centers. Looking at Figure 2, it is evident that across all three cities, majority Black census tracts were the ones more commonly found in trauma deserts.

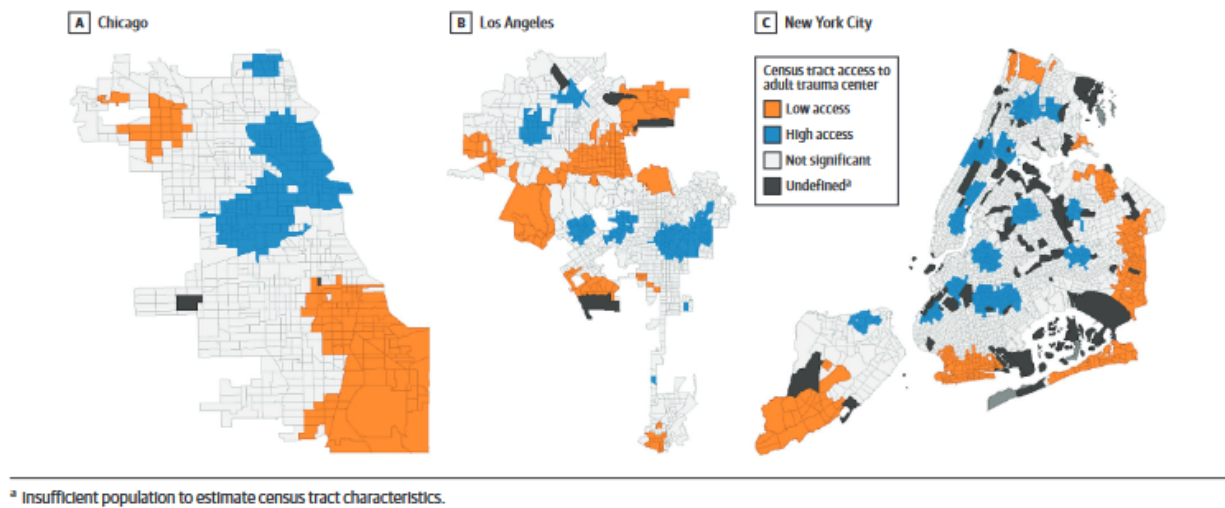
Figure 2: Census Tracts by Racial/Ethnic Composition, Median Annual Household Income, and Travel Distance to Nearest Adult Level I or II Trauma Center in Chicago, Illinois; Los Angeles, California; and New York City, New York, in 2015



Note. From “Figure 1: Census Tracts by Racial/Ethnic Composition, Median Annual Household Income, and Travel Distance to Nearest Adult Level I or II Trauma Center in Chicago, Illinois; Los Angeles, California; and New York City, New York, in 2015,” by Tung, E. L., Hampton, D. A., Kolak, M., Rogers, S. O., Yang, J. P., & Peek, M. E., *The Race/Ethnicity and Geographic Access to Urban Trauma Care* (p. 6), 2019.

Many of the Black majority census tracts with low geographic access to trauma centers consist of historically Black neighborhoods, meaning that these issues are generational. For example, the South Side of Chicago has been majority Black occupied since the early 1900s. Given this, it is possible that the stark racial disparities in access reflect economic and social policies of the mid-twentieth century—a period of significant racial segregation in healthcare. Looking at a spatial depiction of trauma center access across the three cities shown in Figure 2 yields interesting observations about the three cities' various reactions to racial disparities.

Figure 2: Univariate Local Indicators of Spatial Association Cluster Maps of Census Tracts in Chicago, Illinois; Los Angeles, California; and New York City, New York, by Relative Travel Distance to Nearest Adult Level I or II Trauma Center, 2015



Note. From “Figure 2: Univariate Local Indicators of Spatial Association Cluster Maps of Census Tracts in Chicago, Illinois; Los Angeles, California; and New York City, New York, by Relative Travel Distance to Nearest Adult Level I or II Trauma Center, 2015,” by Tung, E. L., Hampton, D. A., Kolak, M., Rogers, S. O., Yang, J. P., & Peek, M. E., *The Race/Ethnicity and Geographic Access to Urban Trauma Care* (p. 8), 2019.

As shown in the previous figure, New York City had smaller trauma access disparities. This may be due to the city’s unique public healthcare system and safety net. NYC Health and Hospital Corporation operates a municipal healthcare system with 11 acute-care hospitals and 6 trauma centers across the city. In Chicago and Los Angeles, the public healthcare system is much more centralized, limiting geographic access to public medical facilities. While disparities still exist in New York City, it acts as a model for future efforts to expand distribution to address racial equity.

Quality Access

Even after surmounting issues of payment/insurance and geographic access to healthcare, Black Americans still face a significant barrier to healthcare by quality. The quality of treatment

given to Black patients is subject to institutional and provider perception and biases. In general, ethnic and racial minorities have been shown to generally receive poorer quality care, especially when it comes to mental health treatment (Harris, Edlund, and Larson, 2005). Furthermore, Black folks are more likely to experience greater psychological distress than White Americans (Barrio et. al, 2003). Medical settings are far too often plagued with instances of racism and microaggression.

A microaggression is defined as “a comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group (such as a racial minority)” and can have serious consequences when allowed to persist in medical spaces (Merriam-Webster Dictionary). Microaggression can manifest in one of two ways: interpersonal and environmental (Karlsen and Nazroo, 2002). Interpersonal microaggression can then be broken down into microassaults, microinsults, and microinvalidations. Microassaults are categorized as the conscious degradation of people based on bigoted views—most closely resembling overt, traditional bigotry. On the other hand, microinsults and microinvalidations are subconscious, meaning that the perpetrators are often unaware of the offensive nature of their behavior. Microinsults are common and often hidden as a compliment (e.g., *Wow! You speak surprisingly well!*) whereas microinvalidations seek to uphold White supremacy by invalidating the merit of minority individuals.

Recognizing and addressing the ways that these forms of bias exist in medical settings is extremely imperative in conversation on how to minimize racial discrepancies in healthcare. Part of this comes from a need to acknowledge the lived experiences of others outside of one’s own world view. One of the best ways to fully understand the depth of current issues within the

American medical system is to go straight to the source and those most affected by long running traditions of racism in the medical sphere.

Personal Accounts

A 2020 nationally representative cross-sectional survey study found that 21% of the 2,137 U.S. adult respondents reported that they have experienced discrimination in the healthcare system. 72% of those who had experienced discrimination reported experiencing it more than once. In fact, racial/ethnic discrimination was the most frequently reported type of discrimination experiences (Nong et. al, 2020). Lack of respect for Black voices and avoidance of Black stories is a major contributor for the continuation of practices of bias in the medical system. Black individuals are far too often belittled, disrespected, and ignored when they speak out about the mistreatment they face on a daily basis. Below are several accounts (some edited for brevity) that highlight the frequency and commonplace nature of bias in medical settings. These stories represent just a small sub-sample of stories, and do not take into account the numerous other stories that go untold and unreported. Sharing stories like these is a huge step in acknowledging systemic harm and taking action.

Background: While getting ready for bed, Angela Anderson noticed an immediate and very localized pain in the right side of her chest and back, ushering her to visit the nearest urgent care facility the next morning. After waiting an hour to be seen, she was informed that she would have to go to another urgent care facility with the proper staff to read a chest x-ray if she needed one. At the second location, she was immediately greeted with frustration and hostility from the staff. Throughout her stay, the staff was snappy, slow, and seemingly neglected proper inductive process. The following are excerpts of Anderson's account and opinions on the matter.

“[The nurse] brutally jabbed the swab into my nose so far that it caused me to yell out and cry...I have had several Covid tests and never even flinched... Her response to me [was] ‘you just need to learn how to relax.’”

“The lack of care was so negligent that my husband reached out to the clinical director of the urgent care group to report how we had been treated. Two days later, the director made arrangements for me to be seen by a third urgent care facility. Less than one hour after I arrived, I was immediately sent to the ER where I had a CT scan, echocardiogram, and full blood work done. The ER doctor informed me that I had a pulmonary embolism in the lower lobe of my right lung, pneumonia, and an infarction in my right lung, which resulted in that part of my lung tissue dying. The first two facilities had sent me away in critical condition.”

“I couldn't help but think, if this could happen to me and my husband [who is a M.D.] this could happen to anyone. I thought about the numerous people of color whose symptoms have been ignored or minimized. Healthcare disparities are real and far more common than we think. We have to talk about this because lives are at stake.”

Anderson concludes her account by highlighting that for women of color, there are far more odds stacked against them just to get proper care. Patients must navigate through “bias, negligence, and minimization” of a patient’s experience. This reality necessitates action and the promotion of Black and brown women’s voices. Anderson adds that “there are still people who do not believe that stories like mine and many others exist,” and that we need to train providers who are culturally competent and committed to providing thorough care to all people.

Background: Famed American tennis player Serena Williams shares an account of the traumatic birth of her daughter, Alexis Olympia, and subsequent complications. Despite her fame and wealth, Williams was still subjected to mistreatment and minimization of her history of pulmonary embolisms. The following are excerpts of Williams’s account and opinions on the matter from her 2018 Vogue profile.

“Though she had an enviably easy pregnancy, what followed was the greatest medical ordeal of a life that has been punctuated by them. Olympia was born by emergency C-section after her heart rate dove dangerously low during contractions. The surgery went off without a hitch; Alexis cut the cord, and the wailing newborn fell silent the moment she was laid on her mother’s chest. ‘That was an amazing feeling,’ Serena remembers. ‘And then everything went bad.’

“The next day, while recovering in the hospital, Serena suddenly felt short of breath. Because of her history of blood clots, and because she was off her daily anticoagulant

regimen due to the recent surgery, she immediately assumed she was having another pulmonary embolism. (Serena lives in fear of blood clots.) She walked out of the hospital room so her mother wouldn't worry and told the nearest nurse, between gasps, that she needed a CT scan with contrast and IV heparin (a blood thinner) right away. The nurse thought her pain medicine might be making her confused. But Serena insisted, and soon enough a doctor was performing an ultrasound of her legs. 'I was like, a Doppler? I told you, I need a CT scan and a heparin drip,' she remembers telling the team. The ultrasound revealed nothing, so they sent her for the CT, and sure enough, several small blood clots had settled in her lungs. Minutes later she was on the drip. 'I was like, listen to Dr. Williams!'"

Despite her fame and influence, Williams still had to fight to be taken seriously by her attending medical staff—who really should've had access to her medical record of pulmonary embolisms and should have taken it seriously to begin with. The staff's hesitancy and quickness to attribute her desires to confusion brought about by pain medicine resulted in the prolongation of debilitating pain on William's part. Thankfully, she was adamant about the severity of the issue and the underlying cause which ultimately led to the medical staff taking her concerns seriously and confirming her concerns. Unfortunately, this isn't always the outcome for Black women.

Even Black medical professionals are not exempt from bias in the medical sphere. Serafini et al. (2020) showed that physicians of color are more likely to experience significant racism while providing health care in their workplace and feel very unsupported by their institutions when these instances of racism occur. Of the 71 survey participants, 23.3% reported having had patients refuse their care specifically due to their race/ethnicity. Microaggressions like this were not significantly correlated with compassion fatigue or burnout, but were positively correlated with a measure of secondary traumatic stress. Physicians whose first language was not English reported significantly more instances of racism in the workplace than those whose first language was English. The purpose of the study was to show that medical institutions seeking more equitable working conditions should intentionally include diversity and

inclusion conversations within their training as well as create hiring practices that promote diverse and welcoming workforces.

Chapter 3: History of American Medicine for Black Americans

The previously discussed issues of racial disparities in access and quality of care did not develop overnight. They are the results of generations of compiling racism and bias within the United States. To understand how these issues came to be requires critical examination of the history of the country as pertains to the medical treatment of Black folks and subsequent issues of mistrust in the system that further dissuades individuals from seeking medical care. The following sections act as an introduction and overview of how American medical history has generated these issues in the long-run, but cannot account for all of the specific historical instances.

Racism in the Origins of American Medicine

Current realities of racism in the American medical system are symptoms of long running traditions. Several historical practices within organized medicine have perpetuated inadequate care for Black patients including limitations on the influence of Black physicians, promotion of pseudoscientific differences, and unscientific, unethical, and unjust medical research and clinical disparities. The way that medicine is understood in the United States is a consequence of inhumane treatment of Black folk in the name of scientific discovery. Furthermore, the way that medicine is underwritten by pseudoscience and the inclusion of blatant racism in medical texts and conversations.

Signer of the Declaration of Independence and “Father of American Psychiatry,” Doctor Benjamin Rush defined “negritude” as a mild form of leprosy that could only be cured by becoming White. Ironically Rush would become a cofounder of America’s first antislavery

society after observing the mental health degradation of enslaved folks in the West Indies.

Despite his opinions against slavery, the terminology used to depict Black folks and his work on the mental condition of enslaved folks was used to potentiate the cruel treatment of slaves.

Another example is that of Robley Dunglison's *Human Physiology Volume II*, an eminent medical textbook used across countless American medical schools in the 17th century. In the section titled "4. Of the Varieties of Mankind," beginning on page 587, he breaks down categories in which "the great human family may be divided" (587). From the beginning of this section, Dunglison's work operates on notions of eurocentrism and racial inferiority.

On the "Caucasian Race," Dunglison explains:

The Caucasian race is chiefly distinguished by the elegant form of the head, which approximates to a perfect oval. It is also remarkable for variations in the shades of complexion and the colour of the hair. From this variety, the most civilized nations have sprung. The name Caucasian was given to it from the group of mountains between the Caspian and the Black Sea, –tradition seeming to refer to the origin of this race to that part of Asia. Even at the present day, the peculiar characteristics of the races are found in the highest perfection amongst the people who dwell in the vicinity of Mount Caucasus, –the Georgians and Circassians, –who are esteemed the handsomest natives of the earth. (591)

In contrast, on the "Ethiopian Race," Dunglison has the following to say:

The Negro, African, Ethiopian, or Black man of Gmelin occupies a less extensive surface of the globe, embracing the country of Africa which extends from the southern side of Mount Atlas to the Cape of Good Hope. This race is evidently of a less perfect organization than the last and has some characteristics, which approximate it more to the monkey kind. The forehead is flattened and retiring; the skull is smaller, and holds from four to nine ounces of water less than that of the European. On the other hand, the face, which contains the organs of sense, is more developed, and projects more like a snout. The lips are large; the cheek bones prominent; the temporal fossae hollower; the muscles of mastication stronger; and the facial angle is smaller; –the head of the negro, in this respect, holding a middle place between the Caucasian and the orang-outang. The nose is expanded; the hair short and woolly, very black and frizzled. Skin black. (598)

Dunlison's understanding of the differences between races is underwritten by the reality of the Transatlantic slave trade. He even notes that "in almost all situations in which he is found, it is in a state of slavery and degradation, and no inference can be deduced regarding his original *grundkraft*— as the Germans call it— or intellectual capability" (598).

From a modern lens, it's easy to see the absurdity of Dunlison's take on racial differences as well as recognize the inherent racism. While medical textbooks have moved away from the flagrant racism and pseudoscientific claims presented by Dunlison, his textbook was integral to the formation of the American medical system. For decades, this textbook was used in most American medical schools to train the next generation of physicians, surgeons, and more—leaving an everlasting imprint of false hierarchies of races during the formative years of medicine in the United States.

Outside of false claims on the nature of Black folks and their relation to White folks, Black bodies have been subjected to physical violation and unethical testing regimes for the sake of "advancement" within the American medical system. Over the period of 1945 to 1849, American physician and "Father of Gynecology," Dr. James Marion Sims used female slaves as research subjects to help develop a surgical treatment for vesico-vaginal fistula (VVF). VVF is caused by obstructed labor and results in the tearing of the region between the bladder and the vagina. Women with VVF suffer from incontinence and continuously leak urine. Prior to the 19th century, women with VVF were ostracized from society due to their medical issues. Despite his noble cause to help women suffering with this affliction, Sims's research relied on non-consensual and invasive testing on enslaved women, brought to him by their masters (Ojanuga, 29). The enslaved women that were tested on had no claims to decision-making about their bodies or any other aspect of their lives. The first operation Sims conducted was on an

enslaved woman named Lucy. Lucy was operated on without anesthetics, experienced extreme humiliation, and nearly lost her life to the excruciating procedure after it failed. Despite this, Sims continued his testing on several other enslaved women until eventually perfecting the surgical procedure on June 21, 1849.

After this point, many White women came to Sims to treat their VVF. While Sims's perfection of the surgical practice was a huge advancement in gynecology and has benefitted generations of women, historian Diana E. Axelson points out in *Women as victims of medical experimentation: J Marion Sims's surgery on slave-women* (1985) that "Sims failed utterly to recognise his patients as autonomous persons and his own personal drive for success cannot be minimised, especially as a balance to the enormous amount of praise accorded Sims for his work and for subsequent applications of the technique developed in Montgomery and elsewhere" (10). Going off of Axelson's point, the unethical testing on Black folks is commonly accompanied by some sort of discussion on the societal cost-benefit analysis of the injustice committed. The atrocities committed within the systemic framework of the American medical system are often juxtaposed with the long-term advancement of science and benefit towards greater society. It is important to note that Western society is White dominated society. The ends of research are far too often used to justify the means used to derive them—even if the means is the torture and murder of countless Black folks.

It would be a disservice to assume that instances of testing on Black bodies is far in the past. The infamous Tuskegee Study of Untreated Syphilis in the Negro Male (common known as the Tuskegee Syphilis Study) serves as a prime example of the willingness to intentionally harm Black communities for the benefit of the "greater good". In 1932, the U.S. Public Health Service (USPHS) began a study to record the natural history of syphilis in conjunction with the Tuskegee

Institute. The study initially involved 600 Black men, 399 with syphilis and 201 who did not have the disease (CDC). The participants were told by researchers that they were being treated for “bad blood,” a local term used to describe several ailments ranging from syphilis to fatigue. In return for participation, participants received free medical exams, meals, and burial insurance. However, participants were not given correct information on the nature of the study, violating informed consent.

By 1943, penicillin was the widely available common treatment choice for syphilis, yet the participants of the study were not offered this treatment so that researchers could examine the natural progression of syphilis—in essence willingly condemning these men and their families to suffering and death for the sake of science. It wasn't until 1972 when the Associated Press (AP) released a story about the study that people started to address the unethical nature of the study. In response to the AP story, the Assistant Secretary for Health and Scientific Affairs appointed an Ad Hoc Advisory Panel to review the study. The panel concluded in the *Final Report of the Tuskegee Syphilis Study Ad Hoc Advisory Panel* (1973) that “in retrospect, the Public Health Service Study of Untreated Syphilis in the Male Negro in Macon County, Alabama, was ethically unjustified,” and that “its results are disproportionately meager compared with known risks to human subjects involved” (7,8).

While it may be easy to write off the Tuskegee Syphilis Study as a moment in history, the reality is that the wounds created by the study are still fresh in the minds of the children, grandchildren, and great grandchildren of the study's participants. The lessons of the study have taught folks to be wary of placing blind faith in the American medical system, leading to significant rates of mistrust in American Medicine.

Mistrust in American Medicine

While there are many factors contributing to the major differences in health outcomes between Black and non-Black Americans, one factor that should be explored and addressed are racial differences in trust in the American Healthcare system. Generations of trauma arising from the Transatlantic slave trade, unlawful testing on Black folks, and the continuous deligitimization of the issues of Black patients has culminated in large populations of Americans doubting that the medical institutions will care for them properly.

Dwayne T. Brandon and team's *The legacy of Tuskegee and trust in medical care: is Tuskegee responsible for race differences in mistrust of medical care?* outlines a telephone survey conducted by his team on 277 Black adults and 101 White adults aged 18 through 93 in Baltimore, Maryland. Participants responded to questions regarding mistrust in medical care, including a series of questions regarding the Tuskegee syphilis study. The study found that there were no major differences in knowledge of or about the Tuskegee syphilis study across racial groups. While this specific study was unable to conclude if knowledge of the Tuskegee syphilis study is a legitimate predictor of trust in medical care overall, the study found a significant difference in medical care mistrust across racial lines. Racial differences in mistrust likely stem from broader and repetitive historical instances and personal experiences with racism and disrespect in personal medical encounters.

Contrasting Brandon et. al (2005), Marcella Alsan and Marianna Wanamaker's *Tuskegee and the Health of Black Men* found significantly lower utilization of both outpatient and inpatient medical services by older Black men in closer geographic proximity to Macon County, Alabama—where the initial syphilis study was conducted. The effects on utilization of medical

services were particularly heightened among less educated and lower income men, demonstrating the compounding effects of socioeconomic status. Reduction in healthcare utilization paralleled evidence of the significant increase in the probability that older Black men died before the age of 75. In short, when Black folks do not feel safe within medical systems—owing to horrific histories of mistreatment—they are less likely to utilize existing healthcare infrastructure. Stories of these atrocities are passed down through oral histories and manifest generational trauma.

Dr. Katrina Armstrong's *Prior Experiences of Racial Discrimination and Racial Differences in Health Care System Distrust* (2014) seeks to identify specific contributing factors to this mistrust. Using a phone survey, Armstrong's team surveyed 762 Black-identifying Americans and 1,267 White-identifying Americans, living within the 40 U.S. Metropolitan Statistical Areas (MSAs). The survey included scales on distrust, personal experience with discrimination, access to care, sociodemographic characteristics, and the isolation index (used to identify the level of racial residential segregation within cities).

Measures of healthcare access were derived from the National Health Interview Survey (NHIS) and included current health insurance coverage, having a personal doctor, going without needed medical care in the past 12 months because of cost, and being contacted by a collection agency because of medical bills in the past 12 months. Sociodemographic characteristics include race, ethnicity, educational level, and income and were assessed using items from the NHIS. Racial residential segregation is used to capture different dimensions of segregation including the degree to which the minority group members come into contact with same-group members. It is hypothesized that segregation influences distrust by concentrating disadvantage and reducing interactions between racial groups.

Looking at the characteristics of study respondents shown in Table 3, Black respondents were more likely to be male, younger, less educated, single, lower income, and with more comorbidities than their White counterparts. These individuals also reported having greater barriers to access to healthcare—including the lack of health insurance, personal physician, cost barriers, and debt collection. 80% of Black respondents reported having experienced racial discrimination in a medical context at least once in comparison to 34% of White individuals.

Table 3: Participant Characteristics

	Overall N=2,179	African American N=762	White N=1,267	p-value
Male (%)	35.4	37.0	32.2	0.03
Age(%)				
18–30	2.8	3.2	1.9	<0.001
31–40	6.8	8.1	5.3	
41–50	24.2	29.8	19.3	
51–60	29.4	31.2	29.0	
61–70	20.6	18.7	22.9	
>70	16.1	9.1	21.6	
Education (%)				
High school or less	39.8	49.0	32.8	<0.001
Some college	29.1	29.7	29.2	
College or higher	30.8	21.0	37.9	
Partner (%)	58.5	48.7	63.6	<0.001
Annual Household Income (%)				
<\$20,000	19.8	25.9	15.0	<0.001
\$20,000–\$40,000	21.9	28.5	17.7	
\$40,001–\$60,000	19.5	18.9	19.6	
\$60,001–\$100,000	18.9	15.5	22.3	
>\$100,000	11.7	4.6	16.5	
Unknown	8.2	6.7	9.0	
Comorbidity (%)				
None	38.5	36.4	38.8	0.52
One	31.7	32.3	31.5	
Two or more	29.8	31.4	29.7	
Has health insurance (%)	87.3	84.9	90.7	<0.001
Has a personal physician (%)	83.9	81.8	87.7	<0.001
Unable to get medical care because of cost (%)	12.5	15.2	9.6	<0.001
Contacted by collection agency for medical bills (%)	19.9	29.0	14.0	<0.001
Racial discrimination				
Mean	1.93	3.73	0.84	<0.001
No discrimination (0) (%)	47.4	20.0	66.0	<0.001
Moderate discrimination (1–2) (%)	21.1	20.2	21.6	
High discrimination (3+) (%)	31.5	59.8	12.5	
Racial residential segregation (isolation index)	0.58	0.60	0.57	<0.001
Health care system distrust				
Mean	27.3	27.9	26.9	0.002

	Overall N=2,179	African American N=762	White N=1,267	p-value
High distrust (%)	22.8	28.0	19.8	<0.001
Mean values distrust	16.0	16.6	15.7	<0.001
High values distrust (%)	22.2	27.7	18.7	<0.001
Mean competence distrust	11.3	11.3	11.2	0.51
High competence distrust (%)	17.8	17.9	18.4	0.80

* High distrust = top quartile of distrust score

Note. From *Prior Experiences of Racial Discrimination and Racial Differences in Health Care System Distrust* by Armstrong, K., Putt, M., Halbert, C. H., Grande, D., Schwartz, J. S., Liao, K., Marcus, N., Demeter, M. B., & Shea, J. A., 2013.

Across the board, Black Americans had higher levels of “Healthcare System Distrust” (HCSD) and greater experiences of discrimination. After adjusting for sociodemographic characteristics, the study revealed that healthcare access and residential segregation had little effect on the association between identifying as Black and overall HCSD.

Despite the previous findings, the underlying reasons for some of the results are still hard to pin down. In summary, the study states that "higher HCSD among African Americans is explained by a greater burden of experiences of racial discrimination than Whites,” but the reasons for higher distrust amongst White respondents (adjusting for experiences of racial discrimination) are not known. Overall, what is clear is that efforts to eliminate existing racial discrimination and barriers to care are needed to restore trust in the American medical system. When Black folks do not feel welcomed or are actively not accommodated in medical systems, it leads to tangible health outcome differentials and decreases the viability of Black communities and Black liberation.

Chapter 4: Action Going Forward

After recognizing the histories of racism that have shaped American medical systems, the question then becomes, “what can we do about it?” There are several avenues of approach that have developed over the past couple decades including community-led intervention and major policy change. While there is no definitive correct way to approach these issues, viable solutions likely exist in the intersection of community and policy action, as well as cultural and historical acceptance of wrongdoings and the systems role in their development and perpetuation. In short, it is important that as a collective, Americans need to hold our systems, politicians, and each other accountable and work together towards long-term solutions. This section explores a small handful of examples of community and policy initiatives that have been extremely fruitful in their impact on increasing health opportunities for Black folks. These efforts are great reference points for future action and the push for Black liberation both in medical and non-medical contexts.

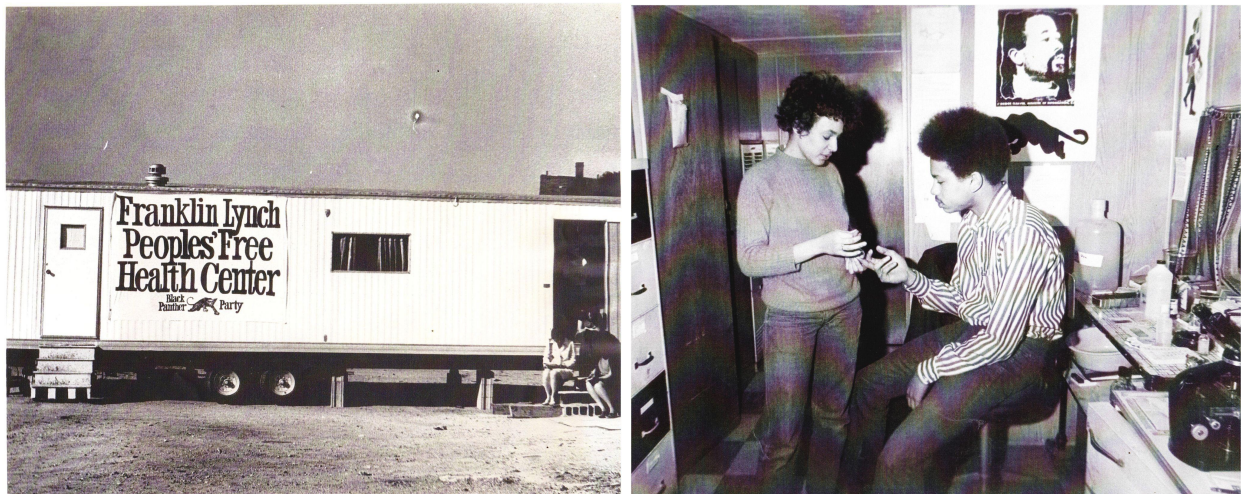
Community Initiatives

Given a lack of historical support for minority groups, many communities have had to take their own health and protection into their own hands. Amid the turmoil of the civil rights movement, the Black Panther Party (BPP) established its own free medical clinics to help serve the Black community that was largely ignored by existing American medical systems. The BPP strongly believed that achieving health for all demanded a more just and equitable world (Bassett, 2016). From the start, the BPP were champions of health as a human right: first for the

liberation of Black folks and later more broadly for the poor. In 1970 their first guiding document, the *Ten Point Program* (1966), was edited to call for leadership to establish free clinics. The document was updated again in 1972 to include a clear sixth point, “we want completely free health care for all Black and oppressed people.” To promote a model in which such a work might work, the BPP opened 13 free health clinics across the United States.

These clinics primarily provided first aid, basic childhood vaccinations, and screenings for several diseases including sickle cell anemia. The BPP’s work with sickle cell anemia was particularly important because it addressed a neglected genetic disease. For years, research and screening into the disease had been largely ignored or underfunded since the vast majority of those impacted came from African descent. Treatment was even more limited.

Images: The Black Panther Party’s Franklin Lynch Peoples’ Free Health Center, Boston, MA [left] and Mary T. Bassett demonstrating a finger stick for sickle cell screening [right] (1970)



Despite the positive public health impact of these clinics, they were often harassed by city health inspectors, subjected to police raids, and struggled to find consistent volunteers to keep up with the needs of the community.

In Alondra Nelson's *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination*, argues that the BPP's focus on providing healthcare was practical and ideological, and stemmed from understanding health as a basic human right within the contexts of genetics and the politics of health and race. The BPP's Nelson continues to show through her research and personal insight that current issues of poverty, discrimination, and access to medical care remain hauntingly similar to the very issues that the activism of the BPP sought to eradicate in the late 1960's.

The BPP was eventually disbanded in 1982. Though the official party came to an end then, it popularized a set of beliefs that identified health as a social justice issue for Black Americans and has influenced public health to this day. Aspects of the party and the blending of science and community engagement can be seen resonating today under the banner of the Black Lives Matter movement.

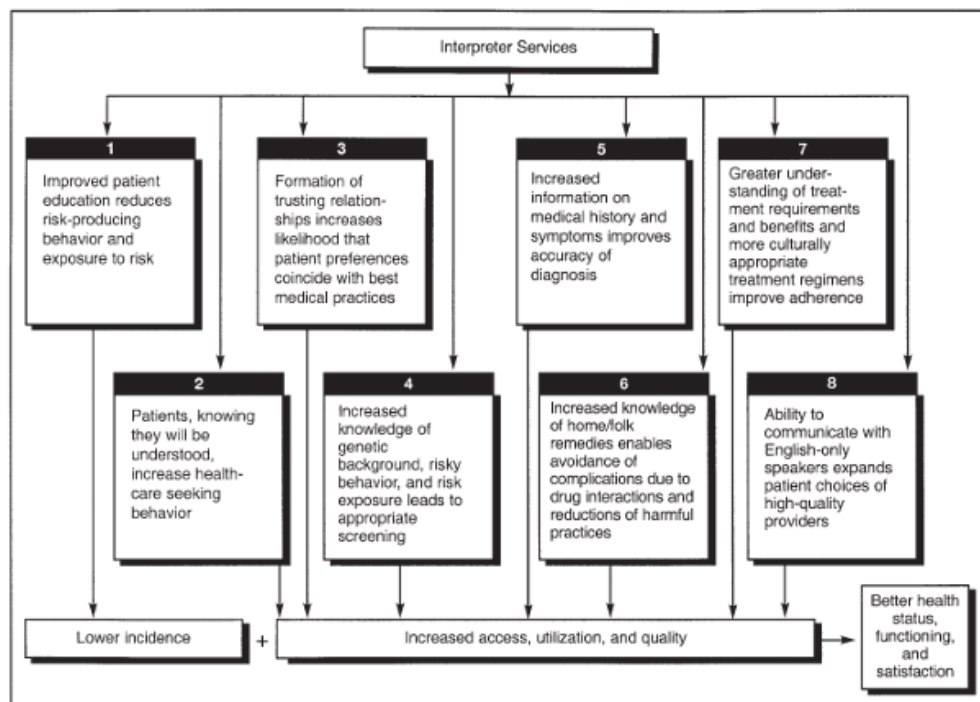
Policy Initiatives

In addition to community intervention, significant change to alleviate racial disparities in healthcare requires systemic change, on both institutional and governmental levels. Black medical liberation is impossible without the proper infrastructure and due processes to sustain accountability within medical frameworks.

In recent years, "cultural competency" has emerged as a potential strategy in conversations on addressing inequity in healthcare. Implementation of cultural competency initiatives benefits minority groups as well as caters to the specific needs of immigrant populations. Betancourt et. al (2003) defines cultural competency as the process of

“understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system... and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations” (297). Furthermore, the framework of cultural competence includes organizational, structural, and clinical interventions. Speaking first to organizational and interventions, both the leadership and workforce within healthcare delivery systems must be diverse and representative of patient populations. Structural interventions need to ensure that the processes of care within healthcare delivery systems guarantee full access to quality care for all patients—including but not limited to interpreter services and development of culturally/linguistically appropriate health education material. Lastly, clinical interventions help to enhance provider knowledge of the relationships between sociocultural factors and health beliefs and behaviors to equip them with the tools needed to deliver quality care.

Figure 3: Conceptual Models of How Interpreter Services Could Reduce Health Disparities



Brach and Faserirector (2000) affirms the findings of Betancourt et. al (2003) while expanding on the need for intersectional efforts between policy and community action, putting forth nine clear interventions to achieve cultural competency. The nine interventions are summarized as follows:

1. **Interpreter Services**– All Americans, regardless of linguistic differences, should be provided a reliable way to communicate with their healthcare providers. Interestingly, Brach and Faserirector advocate for both formal solutions (on-site professional interpreters, ad hoc interpreters) and informal solutions (friends/family, other patients in the clinic).
2. **Recruitment and Retention**– Deliberate staffing choices can benefit minority patients. Due to shared cultural beliefs and common language, minority staff members play an important role in improving patient-provider communication. Recruitment and retention of staff who can fill these responsibilities is invaluable to medical settings. Strategies for increasing staff diversity and encouraging minority folks to apply include setting up minority residency/fellowship programs, hiring minority search firms, adapting personnel policy to create welcoming work environments, mentorship programs, subcontracting with minority healthcare providers, tying executive compensation to minority hiring success, affirmative action programs, reviewing of human resource practices and compensation of all staff, and tracking minority staff satisfaction (Chang and Fortier, 1998; B. R. Williams, 1997).
3. **Training**– Cultural competency training programs aim to increase cultural awareness and knowledge to improve the skills of staff as pertains to patient-staff interactions. Training programs can be implemented within medical institutions such as hospitals, clinics, or part of undergraduate or graduate schooling.
4. **Coordinating with Traditional Healers**– The merits of cultural healing practices and traditional healers is often dismissed by Western medical professionals. However, coordinating with traditional healers minimizes the risks of complications due to patients undergoing incompatible therapies on either side. Additionally, understanding the medical culture that patients come from can aid in developing concordant treatments to increase patient trust and adherence to recommendations.
5. **Use of Community Health Workers**– Pivoting healthcare to focus on individuals and small communities through the use of community health workers helps to establish more personal and trusting relationships with healthcare and thereby promotes the use of healthcare infrastructure by previously marginalized groups. Community health workers bring in individuals who had not previously sought care, provide cultural linkages, overcome distrust, and contribute to clinician-patient communication, increasing the likelihood of patient follow-up and providing cost-effective health services to isolated

communities (Goicoechea-Balbona, 1997; Riddick, 1998; Witmer et al., 1995; Zablocki, 1998).

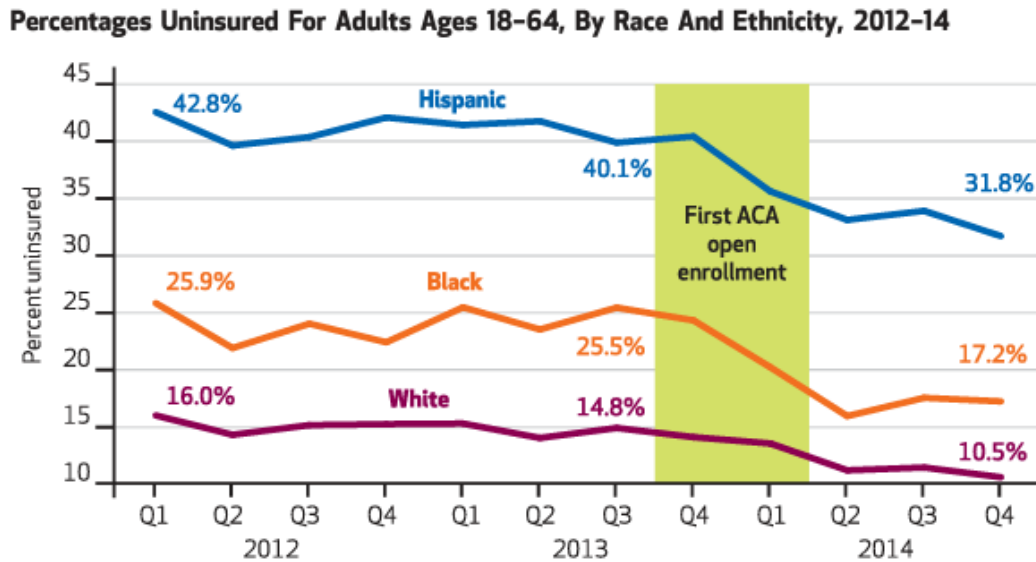
6. **Culturally Competent Health Promotion**– Health promotion seeks to encourage good health through healthy behaviors and risk reduction, early detection and treatment, and proper care of chronic or acute diseases (Kok et. al, 1997). Additionally, public culturally competent information campaigns can help to inform marginalized communities of potential health risks and interventions that they can take.
7. **Including Family and/or Community Members**– While patient autonomy is a core principle of healthcare in the United States, different cultures have varying views on the involvement of family members and decision making. Recognition of this and adapting of healthcare schemes to maintain patient rights and also include family if requested, could help many individuals adapt to and utilize American healthcare infrastructures.
8. **Immersion Into Another Culture**– Immersion programs for staff working with specific cultural groups can help to develop sensitivity and skills when working with other cultures. St. Clair and McKenry (1990) found that immersion programs enable participants to overcome their ethnocentrism, increase their cultural awareness, and integrate cultural beliefs into their healthcare practices.
9. **Administrative and Organizational Accommodations**– Administrative and organizational decisions such as clinic location, hours of operation, network membership, physical environments, and written materials can all influence utilization of healthcare. These institutions should also take into consideration travel distances and availability of public transportation to and from their locations. Intentional decision making in regard to these aspects can result in more comfortable and accessible experiences for minority and low-income populations.

Outside of community action, major policy movements have taken place to try and alleviate the aforementioned issues of access. One example of healthcare policy that has gained a lot of political traction in the past couple decades is that of the Affordable Care Act (ACA). On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act into law. The ACA aims to expand healthcare coverage in lower-income communities across the country. Below is a brief summary of the major topics of reform/expansion by the ACA, provided by the Kaiser Family Foundations (KFF) non-profit.

- 1. Individual Mandate**
- 2. Employer Requirements**
- 3. Expansion of Public Programs**
- 4. Premium and Cost-Sharing Subsidies to Individuals**
- 5. Premium Subsidies to Employers**
- 6. Tax Changes Related to Health Insurance or Financing Health Reform**
- 7. Health Insurance Exchanges**
- 8. Benefit Design**
- 9. State Role**
- 10. Improving Quality/Health System Performance**
- 11. Prevention/Wellness**
- 12. Long-Term Care**
- 13. Other Investment**

While the ACA expands coverage and healthcare opportunities for all low-income Americans, it should be noted that the expansion of the ACA would drastically improve healthcare opportunities for Black and Hispanic groups. The creation of the ACA has been a pivotal moment in the development of new health coverage options that significantly narrowed, but has not eliminated, racial disparities in health coverage. There are many benefits that come with the expansion of the ACA including: improved chronic disease management, access to community health centers, the diversification of healthcare workforces and strengthening of cultural competency, and addressing health disparities in general. McMorrow et al. (2015) pulled early release data from the 2014 National Health Interview Survey (NHIS) to show that uninsurance rates for Hispanic adults (both citizen and non-citizen) had dropped from 40.1% in the third quarter of 2013 to 31.8% by the fourth quarter of 2014. Within the same period, non-Hispanic Black adults saw a decline in uninsurance rates from 25.5% to 17.2%. Even non-Hispanic White adults saw a decline from 14.8% to 10.5%.

Figure 4: Percentages Uninsured for Adults Ages 18-64, by Race and Ethnicity (2012-14)

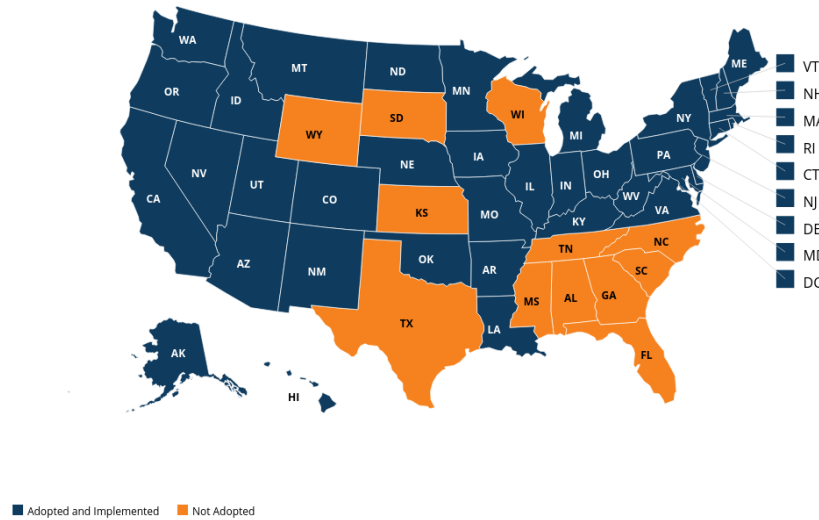


Note. From “Exhibit 1: Percentages Uninsured For Adults Ages 18–64, By Race And Ethnicity, 2012–14,” by McMorrow, S., Long, S. K., Kenney, G. M., & Anderson, N., *Uninsurance Disparities Have Narrowed For Black And Hispanic Adults Under The Affordable Care Act* (p. 1774), 2015.

Several components of the ACA were expected to contribute to coverage gains for all racial and ethnic groups. Across the board, the policy under the ACA expanded who would be eligible for financial assistance under Medicaid.

Two notable limiting factors in the reduction of racial and ethnic disparities under the ACA are the 2012 Supreme Court ruling in *National Federation of Independent Business v. Sebelius* that made Medicaid expansion optional for the states. As a result, only 28 states and D.C. implemented the expansion as of July 2015. To date, only 11 more states have adopted the expansion, bringing the total count up to 39 states and D.C..

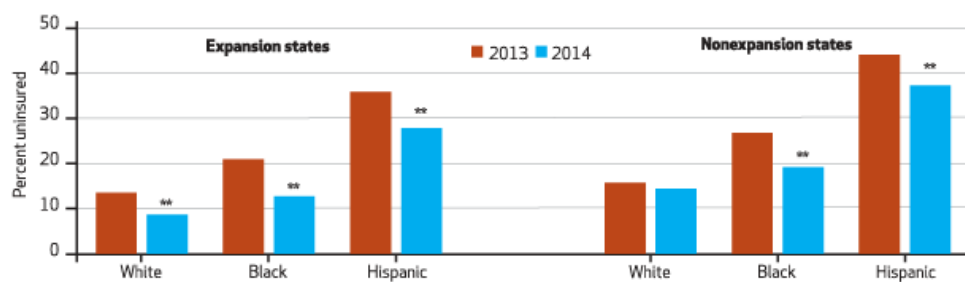
Figure 5: Status of State Action on the Medicaid Expansion Decision (2022)



Note. From “Status of State Medicaid Expansion Decisions: Interactive Map” by The Kaiser Family Foundation, 2022.

In states where Medicaid was not expanded, there are large racial coverage gaps due to the ineligibility of individuals with incomes below the federal poverty level to receive subsidies. The uneven implementation of Medicaid expansion disproportionately impacts Black populations.

Figure 6: Percentages Uninsured for Adults Ages 18-64, by Race and Ethnicity and by States’ Medicaid Expansion Status (2013-14)



Note. From “Exhibit 3: Percentages Uninsured For Adults Ages 18–64, By Race And Ethnicity And By States’ Medicaid Expansion Status, 2013–14,” by McMorow, S., Long, S. K., Kenney, G. M., & Anderson, N., *Uninsurance Disparities Have Narrowed For Black And Hispanic Adults Under The Affordable Care Act* (p. 1776), 2015.

The study found that approximately 1.4 million more Black folks were expected to be uninsured than if all states had adopted the Medicaid expansion. In 2017, coverage gains began reversing

and rates of insurance decreased for three consecutive years. Uninsured rates increased for Hispanic, Black, and White people between 2016 and 2019. These coverage losses likely reflected a range of policy changes made by the Trump administration that contributed to reduced access to and enrollment in coverage. As of 2019, non-elderly Black individuals are still more likely to not have health insurance coverage in comparison to their White counterparts (Artiga, 2021).

The results of the expansion of the ACA so far demonstrate the need to expand across all states. Clemans-Cope et al. (2014) projects that the expansion of the ACA to all states would reduce the Black-White disparity in the uninsurance rate to 2.6 percentage points. Furthermore, targeted education, outreach, and Medicaid enrollment efforts are particularly important in addressing racial and ethnic disparities in health insurance access.

Conclusion

The three-pronged approach to conversations on racial healthcare inequity within the United States put forth in this thesis highlights the racialization and technification on race and racism, personal impact and humanization of conversations going forward, and the subversion of race through community and political action that would benefit Black and non-Black Americans alike. Previous conversations surrounding these topics have primarily relied on either the economic and statistically defined inequity or personal testimony. Combining academic and humanistic perspectives allows for more nuanced conversations on the direct impact of cultural and systemic contributors to bias that has spanned generations. Immediate and long-term reform must be made to put an end to the generational genocide that continues to disadvantage and even claim an immeasurable amount of lives. Black liberation and the state of the American medical system are deeply intertwined. As Americans, we cannot afford to be ignorant to these issues and must demand systemic change from our legislative bodies as well as cultural change from our peers. This paper focuses on the state of the American healthcare system as the right to life is the most fundamental right a person has. Existing structures fail to guarantee these rights for all Americans which only widens gaps between Black and White Americans.

Going back to Beth Coleman's idea of race as a technology, it is imperative that society reclaim race as a tool of progress over one of oppression. History has highlighted the power of race as a social concept—particularly seen as a vessel for systemic oppression and bias against marginalized groups—but there is hope that society can move away from this definition into a celebration of cultural diversity and a concept that is used to drive progress. For this to be possible, I believe that history and current realities need to be understood through an academic and humanistic cross section that relies on acknowledgement of issues, empathy and the desire to

help, and the willingness to accept ownership of past transgressions while moving forward in a positive direction.

In the United States, issues of racial injustice particularly in the criminal justice system and police brutality have brought concepts of race to the forefront of the media, forcing the American people to address the unequal living conditions and treatment of Black persons in the United States. Organizations like Black Lives Matter (BLM) are pushing individuals and lawmakers alike to address their own biases and the systemic limits imposed upon Black communities across the United States. The violence against Black folks must be put to a stop immediately. While the days of chattel slavery are far behind, it stands that Black liberation has not been achieved and is stifled by failure to make sustansive social and political change. Medical liberation is one of many facets of society that needs to be addressed, and I would argue that it is one of the more pressing issues. Access to fair, safe, and affordable healthcare should be a guarantee for all American citizens, regardless of race or ethnicity. Failure to provide this drives generational health issues along with mistrust in the medical system. The right to life is written into the values of American society and needs to be protected for all citizens.

In the paper, I argue for the support of community and policy initiatives to achieve Black medical liberation. Models like that of the BPP clinics serve to show the power of community initiatives. Western centrism places humanitarian aid as something foreign and distant—relegated to non-profits and non-governmental organizations in faraway countries, but the United States has as much demand for community health projects and initiatives that expand access for low-income and otherwise marginalized individuals who are not being accommodated under current private and public options. Especially in an era of COVID-19 and vaccine proliferation,

the merits of community oriented health pop-ups and initiatives has been shown to bring ample values to communities across the nation.

However, the burden of minimizing the impacts of systemic racism in medicine cannot be laid on the public alone. Substantial change is also required within lawmaking bodies. Public options like that of Medicare and Medicaid need to be expanded across all states to provide necessary primary and specialized care options for those in poverty or within the aforementioned coverage gap. Lawmakers in states that have been refused to expand coverage under the ACA need to be held accountable for limiting the health of their constituents. Health is a basic human right, and existing systems that fail to address racial differences in health access are either racist in design or uphold cycles of generational harm.

Regardless of your personal identity and role in society, I urge you to use the information presented in this paper as a jumping off point into your own critical analysis of personal and system issues with the American medical field. One paper alone cannot summarize generations worth of violence and racism, nor can it capture the lived reality of Black Americans. One thing that is clear is that Black liberation requires guaranteed medical equality and freedom. I urge you to pay special attention to and to uplift the voices of Black scholars, community activists, and individuals who share their experiences and have been calling for change for decades and to use your voting power to support legislation that address the key faults within the American medical system as are highlighted throughout this paper.

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