Racism IS a public health crisis, but it's not new

by Kimberly Adams, advocate and law school graduate, and Marie Curry, managing attorney

This year’s Black History Month theme is Black Health and Wellness, which seems fitting in the middle of a pandemic that is adversely affecting people of color at a higher rate than white people.

Even without COVID-19, race disparities in health have been a persistent problem, with states and local leaders across the nation offering reports and declarations in recent years on racism as a public health crisis.

To make sense of all this, it’s important to understand the origins of racism in health, and how it continues to play out today.

Note: The following reading includes a discussion of the harsh treatment experienced by Black individuals in healthcare. Some of this content may be disturbing. For those who wish to avoid potentially traumatizing content, pick up the text at “The sea of health disparities that exists today is wide and deep…”

One of the earliest examples we can point to is Dr. James Sims, who experimented medical procedures on enslaved Black women and children without anesthesia or their consent for decades in the 1800s. Many suffered horrific complications or died. And yet not only were his actions legal -- he only needed consent of the slaves’ owners, not the individuals themselves -- but he was lauded as a pioneering researcher and was named as the president of the American Medical Association in 1876.

Perhaps a better known event is the Tuskegee Syphilis Study, which was sanctioned and paid for by the United States Public Health Service. Run from 1932 to 1972, the study followed roughly 600 Black men to monitor the disease progression of syphilis. The men were recruited with the promise of care to combat the disease, but were treated with nothing more than aspirin and placebos, despite the fact that Penicillin became the main treatment for the disease by the mid 1940s. The men participating in the study suffered debilitating complications, blindness, insanity, and death, and passed the disease onto their wives and their children through birth.

During the same period of time, the U.S. saw the rise of the eugenics movement, a now largely discredited field of study that promoted the notion that a society could breed “undesirable” characteristics out of its population. From the first forced sterilization law in 1907 in Indiana, until Oregon performed its last legally forced sterilization in 1981, doctors surgically sterilized a documented 64,000 Americans (although researchers generally agree that the actual number is likely much higher), for characteristics that included mental illness and being poor -- all without patients’ consent and within the purview of the law. These practices targeted poor people, people with disabilities, and people of color. Even as recently as 2020, we have seen claims of forced hysterectomies carried out against unauthorized immigrants at detention facilities.

For communities of color, these experiences form the historic basis of their trust, or lack thereof, in the medical community. And that foundation forms a throughline that we see playing out today, particularly in health disparities among Black Americans.

But these aren’t just problems of the past. In 2016, a study was released showing that half of white medical students believe fallacies such as Black people have thicker skin than white people and therefore don’t feel as much pain. Serena Williams’ near-miss in childbirth illustrates how requests for care can be brushed aside, if you don’t have the right person taking your concerns seriously.

These incidences show -- and data backs up -- that Black people are less likely to get both the medication and testing they need to be healthy. And when we don’t feel listened to by medical professionals, what do we do? We don’t file complaints. We don’t try to find another doctor. We stop going.

On top of this, consider the added complexity of so-called race-neutral policies that ultimately have a disparate impact on communities of color. A recent example of this is flavoring in cigarettes. While the FDA outlawed most flavoring in cigarette products, they made an exception for menthol flavoring, which research shows is preferred by and prevalent among African American and other minority smokers.

None of this even speaks directly to the toxic stress that has plagued Black communities for generations, caused in part by the examples listed above, but also by the terror African Americans have faced over generations, from slavery, to lynchings and race riots, to Jim Crow, to current conditions of disparate treatment by the police and justice system.

The sea of health disparities that exists today is wide and deep. Black women today are still 41 percent more likely to die from breast cancer than white women, although the disease is not significantly more prevalent in one race or another. Infant mortality rates are more than two times higher for Black babies than for white babies, and Black women are three times more likely to die from pregnancy-related complications than white women. Black men on average die four years earlier than white men and are 75 percent less likely to have health insurance than white men.

So, where does this leave us?

There are some good things happening in the realm of race and health. More people of color are covered by health insurance than in the previous few decades. Researchers are finding that Black patients receive more effective care when seeing Black doctors, for both men and women. And the most recent class of first-time medical students is increasingly diverse.

Here’s more good news: the disparate outcomes that have existed for generations are within our power and purview to change.

First, we must acknowledge our tragic history and understand that racism in healthcare isn’t just a thing of the past. Second, we must accept that these truths have a very real impact on both the quality and the longevity of people’s lives. And lastly, we must celebrate the resiliency and strength of the people who have survived, thrived, and fought to change things for the better.

Once we do that, we can begin to repair the broken trust that perpetuates these divides. Once we do that, we will be better positioned to put in place more thoughtful policy and practices that work to counteract the generations of damage. Once we do that, the Black people in our country can heal -- mentally, emotionally, and physically.

This article is part of Legal Aid's "Big Ideas" series.

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