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ACHIEVING HEALTH EQUITY: The Intersectionality of Racism and Health Disparities

Racism as a Public Health Threat

Racism, both overt and systemic, poses a significant threat to public health and health equity. The intersectionality of racism and health care disparities is well-documented and reflected in the historical and current health outcomes of racial and ethnic minorities. Achieving health equity requires acknowledging and addressing these disparities at every level, from individual care to the broader structure of the health care system, including increasing representation within the health care workforce. This move may significantly improve patient outcomes. The recognition of racism as a public health threat by major health organizations and the existence of legal protections such as Title VI are steps towards ensuring health equity, but there remains much work to be done.

The declaration by the [Centers for Disease Control and Prevention \(CDC\)](#)¹¹, and the [American Medical Association \(AMA\)](#)¹² that racism is a public health threat represents a significant shift in the way these institutions are addressing health inequities.

The CDC's declaration in April 2021 that racism is a "serious public health threat" highlighted how racism directly and indirectly affects the health of individuals and communities by creating unequal access to social and economic opportunities based on race. The CDC emphasized that these disparities contribute to a wide range of health inequities, including higher occurrences of chronic illnesses, lower life expectancy, and higher rates of infant mortality among racial and ethnic minority groups.

The disparities in health care today mirror those of the past, reinforcing a systemic pattern of bias and unequal treatment. Until recently, tests to detect early kidney disease relied on a blood test that included a correction

for people of African descent. We know that there is no basis for this correction that resulted in a delay in diagnosis. In addition, research from the [NIH's National Human Genome Research Institute](#)⁴ has revealed that, people of sub-Saharan African descent more often carry a genetic change that results in chronic kidney disease that can be detected early by screening the urine for protein. Revised evidence-based guidelines for screening for kidney disease include [the urine test and the non-corrected blood test](#). For too long, these types of variations have often been ignored, leading to misdiagnosis and inappropriate treatment plans for Black patients, resulting in poorer health outcomes.

The AMA, for its part, approved a new policy in November 2020 recognizing racism as a public health threat. This policy encourages AMA's branches to take actions to combat racism, from advocating for health equity to supporting research into the health impacts of racism.

A Long and Lingering History of Racism in Health Care and Science

These declarations represent an acknowledgment that racism, whether structural, institutional, or interpersonal, has a profound impact on the health outcomes of racial and ethnic minorities. They reflect a growing consensus in the medical community that combating health disparities requires directly addressing the ways that racism shapes health care and health outcomes. By labeling racism as a public health threat, these organizations are indicating their commitment to confronting and mitigating these issues at a systemic level.

[Alondra Nelson](#), a renowned sociologist, former President of the Social Science Research Council and first woman and first African American Deputy Director for Science and Society in the White House Office of Science and Technology Policy, has done extensive work exploring the intersection of race, science, and health. When Nelson speaks of the "history of medical apartheid" and the "ongoing exploitation of Black bodies," she's referring to the long, often hidden, history of racialized medical practices and experimentation on Black people.

The term "[medical apartheid](#)"¹⁴ as outlined in Harriet A. Washington's book [Medical Apartheid - The Dark History of Medical Experimentation of Black Americans from Colonial Times to the Present](#) refers to the systematic and institutionalized discrimination in health care that disproportionately affects Black people, both in terms of access to care and the quality of care received. This concept is rooted in the historical segregation of health care facilities in the United States, where Black patients were often given substandard care in inferior facilities. While these overtly segregated practices are no longer legal, the legacy of this discrimination continues to permeate health care systems, leading to persistent disparities in health outcomes.

Nelson's reference to the "ongoing exploitation of Black bodies" draws attention to the disturbing history of medical research and experimentation on Black people without their consent. Notable instances include the infamous Tuskegee Study of Untreated Syphilis in the Negro Male (informally referred to as the Tuskegee experiment or the Tuskegee syphilis study), where Black men were intentionally left untreated for syphilis to study the progression of the disease. Another is the case of Henrietta Lacks, a Black woman whose cancer cells were taken without her knowledge or consent and used to create the immortal HeLa cell line, a cornerstone of modern medical research.

These examples reflect a systemic issue in which the bodily autonomy and rights of Black individuals have often been compromised for the sake of medical advancement. This history has not only left deep scars on the Black community but also contributes to the ongoing mistrust and fear of medical institutions among Black people, further exacerbating health disparities.

Understanding and acknowledging this history of exploitation and discrimination is a crucial step in addressing health disparities and achieving health equity.¹³ This involves not only recognizing past wrongs but also working actively to ensure that current health care practices are equitable and just, and that Black individuals are not unduly burdened or exploited by the health care system.

The unethical and exploitative history of medical experimentation on Black people in the U.S. is deeply troubling. Here are several more examples beyond the infamous Tuskegee syphilis study and the Henrietta Lacks case:

1. [J. Marion Sims](#):⁸ Often hailed as the “father of modern gynecology,” Sims conducted a series of experimental surgeries on enslaved Black women without anesthesia in the mid-19th century. These women, Anarcha, Betsey, and Lucy, were subjected to repeated, inhumane, excruciatingly painful surgeries as Sims attempted to treat vesicovaginal fistula, a tear between the bladder wall and vagina, a complication of childbirth.
2. [The Mississippi Appendectomy](#):² In the mid-20th century, it was discovered that hundreds of Black women were being sterilized without their consent in the South, in a procedure colloquially termed the “Mississippi Appendectomy.” The practice was so widespread that civil rights activist Fannie Lou Hamer, herself was a victim.
3. [The Holmesburg Prison Experiments](#):¹ From 1951 to 1974, dermatologist Albert Kligman conducted a range of experiments on the inmates of Holmesburg Prison, a large number of whom were Black. The experiments ranged from testing the effects of Agent Orange to pharmaceutical trials for Johnson & Johnson. The inmates were not adequately informed about the experiments, and reports suggest they were exposed to harmful conditions and substances.
4. [The Baltimore Lead Paint Study](#):¹⁸ In the 1990s, a research study in Baltimore deliberately exposed Black children to lead paint to assess its harmful effects. The landlords of the buildings were told not to remove the lead paint, and the families were not informed about the high levels of lead to which their children were being exposed.

These examples reflect a historical pattern of unethical medical practices that involved a disproportionate number of Black subjects, often without their knowledge or consent. The long-term health consequences of these experiments, along with the violation of basic human rights and medical ethics, have contributed significantly to the mistrust of the health care system among many in the Black community. [The Kaiser Family Foundation’s Timeline of Policies and Events](#)⁹ illustrates the impact that health disparities had on policy throughout history. Understanding and confronting these horrific episodes from the past are critical steps in ensuring the rights and dignity of all individuals in medical research and health care are respected.

Intersectionality Between Racism and Health Care Disparities

The concept of intersectionality sheds light on the complex relationship between racism and health care disparities. [The seminal Institute of Medicine \(IOM\) \(note: IOM was renamed the National Academy of Medicine in 2015\) report “Unequal Treatment”¹⁵](#) demonstrates the disturbing fact that racial and ethnic minorities often receive inferior quality health care even when factors like socio-economic status and insurance coverage are equal. This unjust discrepancy in health care quality reflects systemic biases entrenched within our health care system, contributing to a vicious cycle of poor health outcomes for racial and ethnic minorities.

Several erroneous and harmful beliefs about Black people, rooted in historical racism, have infiltrated the medical profession. Despite lacking any scientific basis, these misconceptions continue to persist and affect medical practices and patient outcomes. [Here are some of the most prevalent ones](#):¹⁷

1. **Belief in Biological Racial Differences:** Some practitioners still hold the misguided belief that Black people are biologically different from other races in ways that impact health. For example, an erroneous belief persists that Black people have thicker skin or a higher pain threshold than white people. This fallacy can lead to inadequate pain management for Black patients.
2. **Misconceptions About Disease Prevalence:** There are stereotypes that certain diseases or conditions are more prevalent in Black people due to genetics, rather than considering the impact of socioeconomic factors, access to health care, and other structural inequities. An example is the misconception that Black people are inherently more likely to develop hypertension, whereas a growing body of evidence suggests that racial disparities in hypertension rates are largely due to social determinants of health.

3. **Stereotypes About Compliance and Behavior:** Some health care providers may hold biased views about Black patients being non-compliant with treatment plans, less health-conscious, or more likely to engage in unhealthy behaviors. These stereotypes can influence the quality of care provided, as well as the interpersonal dynamics between health care providers and patients.
4. **Racialized Views on Drug Use:** Black patients are sometimes stereotyped as being more likely to misuse drugs, leading to under-treatment of pain and reluctance to prescribe necessary medication. For instance, studies have shown that Black patients are less likely to be prescribed opioids for pain management.

Unfortunately, the COVID-19 pandemic only confirmed the disparities in health care and health care delivery. Those disparities were key factors resulting in poor outcomes and death for people of color, according to Dr. Camara Phyllis Jones, MD, MPH, [people were not dying because of their race, but because of racism](#)⁷. Black, Brown and Indigenous people were at a higher risk because of higher exposure as a result of poverty, making up most of our country's frontline workers, and lower protections due to lack of access to proper Personal Protective Equipment (PPE). These facts were exposed by [Camara Phyllis Jones, MD, MPH, PhD](#), past President of the American Public Health Association, Senior Fellow at Satcher Health Leadership Institute Morehouse School of Medicine, former Medical Officer at the Centers for Disease Control and Prevention. Dr. Jones' findings were supported by a [Brookings Institute Report](#)¹⁶ which reported that in the early phases of the Covid-19 epidemic, Black people died at a rate 3.6 times that of White people. The role that racism played in health care delivery was exemplified in [the case of Dr. Susan Moore, an African American physician who was hospitalized after contracting Covid-19](#)⁵. She famously recorded and posted the disparities in health care delivery that she received. She was not seen or heard, her pleas for help and pain medication were ignored, the doctors never listened to her lungs, she was made to feel like a drug addict and sent home and less than 3 weeks later she was dead at the age of 52 which was reported in USA Today and numerous news outlets.

The Shared Responsibility, Ensuring Equitable Health care For All

These harmful beliefs contribute to disparities in health care outcomes between Black and White patients. Addressing these misconceptions is a crucial step in combating racism in health care and achieving health equity. Medical education and training need to place a stronger emphasis on cultural competency, implicit bias awareness, and the social determinants of health to dispel these myths and improve patient care.

Enhancing Health Outcomes: The Impact of Physician-Patient Racial Concordance

[Emerging research indicates that Black patients tend to have improved health outcomes when treated by Black doctors.](#)³ One striking study published by the [National Bureau of Economic Research](#)⁶ found that Black doctors could reduce the Black-White male cardiovascular mortality gap by 19% and decrease the overall Black-White male life expectancy gap by 8%. These findings underscore the urgent need for strategies to boost diversity within the health care workforce, providing an actionable means to mitigate some aspects of health disparities.

Title VI: A Legal Safeguard Against Discrimination

[Title VI of the Civil Rights Act of 1964](#)¹⁰ plays a crucial role in the fight against racism and discrimination in the health care system. It prohibits discrimination based on race, color, or national origin in programs or activities receiving federal financial assistance, creating a protective legal framework to challenge discriminatory practices.

Racism, in both its overt and systemic manifestations, poses a critical threat to public health and health equity. The intersectionality of racism and health care disparities, mirrored in historical and contemporary health outcomes for racial and ethnic minorities, requires a multi-pronged approach for redressal. This includes enhancing representation within the health care workforce, addressing systemic biases, and leveraging existing legal protections like Title VI. While the recognition of racism as a public health threat by key health organizations marks a significant step forward, the journey towards achieving health equity demands sustained and concerted efforts.

Addressing these inequities is a shared responsibility. It requires us to revise our existing practices and challenge the systemic bias in health care delivery. To achieve health equity, we must move beyond merely identifying these issues and take active steps towards change. This involves anti-racist training for health care providers, revisiting diagnostic protocols to account for racial differences, diversifying the health care workforce, and enacting policies that ensure equitable health care for all.

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ENDNOTES

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