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Medical Malpractice: The Racist Roots of Prejudice in Covid-19 America

Preface

This paper[1] will explore disparities in healthcare in America between black[2] and white patients from an interdisciplinary perspective. Covid-19 has produced an onslaught of information regarding infectivity, risk factors, and safety measures – and a lot of it is contradictory or conflicting. My dissatisfaction with explanations for death rates among intersectional populations prompted me to research external risk factors and their correlations with black populations, as well as denounce assumptions of biological differences made on the basis of race. I was able to gather sources on legality, nursing, history, and incarceration from professors and faculty at Villanova University with the help of my research advisor, Dr. Rebecca L. Winer of Villanova University. It was my intention to begin with an understanding of race in medical history, using sources on slavery, racism in medicine, and medical care during the Antebellum era. I used legal sources to obtain information about changes to medicine-based legislature during and after the Civil Rights Movement, referring back to historical sources to determine how legislature impacted the lives of black people, if at all. I extrapolated the information learned about historical medical care and racism to current practices, where I

[1] I would like to express my appreciation for all who have helped me in writing this paper. I would like to thank the Lepage Center for History in the Public Interest for this research fellowship and the opportunity for learning it afforded me. I also wish to acknowledge the help of Dr. Dveera Segal for her contacts, as well as Caitlin Barry, who in addition provided excellent legal articles. I am grateful for the articles and references provided by Dean Candace Centeno and Michael Campbell, and for their time as well. I would like to thank Dr. Ruth McDermott-Levy for her sources on adherence and public health. I also extend my gratitude to Father Joseph Ryan for his sources on medical and gynecological history, as well as his constructive insights on my research. Last but not least I would like to thank Dr. Rebecca Winer for her spectacular advising, support, and tireless revisions of this project. The importance of her guidance, encouragement, and recommendations cannot be overstated.

[2] I have chosen to use a lowercase 'b' in reference to black Americans, as it encompasses all ethnicities, rather than African-Americans exclusively. Villanova University's Sociology course on Race and Ethnic Relations, taught by Dr. Rory Kramer, stressed that that capitalizing the first letter creates a sentiment of 'otherness' and further alienates the black population, whereas describing a population as 'white' lacks that alienating factor and is widely accepted.

consulted medical and biological sources to explain the persistence of racial components in healthcare, often disguised as a component of biology rather than environment. When examining the impact of this medical racism on Covid-19 death rates, I looked at environmental factors as contributors, and more specifically at reports from prisons to explore how Covid-19 disproportionately affects the black and incarcerated. This paper is by no means a complete or perfect summary of sources regarding factors that inform racially distributed health disparities, but it explains the mechanism by which racism can be introduced to the healthcare community under the guise of biology, and how ultimately, that hurts the patient who is in need of care. The weight of this information should serve as a clarion call to medical professionals and students to be conscious of the difference between environment and race when assessing patients, and underscores the necessity of increased education regarding medical racism.

This paper is not a method by which to frame the black population as victims without agency. Black Americans have overcome incredibly boundaries of racism enabled by racist policy. In 2020, black Americans have increased both high school and college graduation rates, and decreased the gap between black and white unemployment rates significantly. However, these successes are the result of tireless efforts which are not mirrored by the compared white population.[3] While the black American population continues to succeed despite obvious and persistent barriers, the larger disparities continue to exist and require immediate attention.

Introduction

Medical malpractice is a tragic abuse of power. It involves several betrayals; of the healthcare professionals of the community, of the hospital, of the professionals themselves, and

[3] Beyer, Don. 2020. "The Economic State of Black America in 2020." *Joint Economic Committee*. https://www.jec.senate.gov/public/_cache/files/ecf4dbe2-810a-44f8-b3c7-14f7c5143ba6/economic-state-of-black-america-2020.pdf.

in the greatest way of course, of the patient. Patients rely on their healthcare providers to be honest, trustworthy, and to look out for their patients' best interests. In the 21st century US, ethical regulations have evolved to include concepts like informed consent, where a doctor provides all treatment options available, and assists the patient in making an informed decision concerning which treatment is personally best for them. For informed consent to work, a patient must have full autonomy, or a guardian empowered to act on their behalf. On the other side of the relationship, the healthcare provider needs to remain unbiased and disclose truthful, complete information.

It has been a long road to get to where we are, which points up how vigilant we must be to safeguard patients' rights. One of the problems has been with the science itself. When we delve into the history of science and medicine, the belief that science is beyond prejudice falls flat. The history of medicine is riddled with stories of great discoveries but also theories that modern people scoff at in disbelief. Cutting-edge scientists in the Middle Ages and antiquity believed there were four humors in balance in the human body that preserved health – and it was thought that one's complexion was tied to appearance and skin color, linked to overall health, and indicative of their characters and personalities.[4] These things might seem absurd today, but they had lasting impact throughout even the eighteenth century. The idea of morality represented by complexion fed into the scientific racism of the Enlightenment, where few sources outside of the Enlightenment thinkers themselves were considered for additional information about race and ethnicity.[5] [6]

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[4] Heng, Geraldine. 2018. *The Invention of Race in the European Middle Ages*. Cambridge Cambridge University Press. https://doi.org/10.1017/9781108381710.

[5] Whitaker, Cord J. "Black Metaphors." *University of Pennsylvania Press*. https://www.upenn.edu/pennpress/book/16035.html. Whitaker examines these persisting ideals in his book about blackness as a symbol in art and culture.

[6] Eze, E., 2009. *Race And The Enlightenment*. Malden, Mass: Blackwell.

The darker side of medical discovery, often overlooked, is the abuse of the power and trust by practitioners who sought to further their careers or hide behind the idea that abuse was ok if it advanced medical science. This is especially true when medical professionals drew their ideas from "scientific racism," a term used by Dr. Dorothy Roberts, along with "race-medicine." Those who believed in scientific racism thought that skin color was an unchanging component of human biology, despite the fact that every human body has the same structure of DNA and the same gene set available.[7] Doctors and health professionals who subscribe to these ideas are blinded by their racism to the basic scientific understanding that one's environment impacts gene expression, and therefore biological presentation – devoid of any "racial" input. Despite this biological truth, "race" is still taken into account and accepted as a component of patient information necessary for a diagnosis.[8] [9] [10] This prejudice has persisted and remains current, despite overwhelming research evidencing that race-based adjustments for medical scores like lung capacity were created based on false racist ideology and currently lead to discriminatory misdiagnoses.[11]

In America especially, the problems of racial medicine and racial biological assumptions persist; these racist ideologies were generated even before the beginning of the transatlantic slave trade,[12] which fed them, and they contribute to modern-day Covid-19 death rates.[13] In order to

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[7] Roberts, Dorothy E. 2011 "What's Wrong with Race-Based Medicine?: Genes, Drugs, and Health Disparities" *Minnesota Journal of Law, Science & Technology.* 12: 21.

[8] Pittman, Larry J. 2003. "A Thirteenth Amendment Challenge to Both Racial Disparities in Medical Treatments and Improper Physicians' Informed Consent Disclosures." *SAINT LOUIS UNIVERSITY LAW JOURNAL* 48: 61.

[9] n.a. "Henry Louis Gates Jr | Encyclopedia.Com."

[10] Roberts, Dorothy. "What's Wrong with Race-Based Medicine?" n.p.

[11] Braun, Lundy. 2015. "Race, Ethnicity and Lung Function: A Brief History." *Canadian Journal of Respiratory Therapy:*51 (4): 99–101. Accessed 8 August 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4631137/ n.p.

[12] Pittman, Larry J. "A Thirteenth Amendment Challenge." N.p.

[13] Oppel, Richard A Jr., Robert Gebeloff, K.K. Rebecca Lai, Will Wright, Mitch Smith. "The Fullest Look Yet at the Racial Inequity of Coronavirus - The New York Times. *"The New York Times.* https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html?referringSource=articleShare. N.p.

gain a full understanding of the racial disparities in today's healthcare world and the reasons why it is not surprising that race-related demonstrations and even riots might ensue during a global pandemic, a decolonization of history is required. Records of slave hospitals, experiments, and other breaches of human rights must be examined from the beginning of the slave trade up through the mass incarceration of African Americans and black people in the United States today. There is a long history of unethical experiments[14] [15] and segregated hospitals[16] that were all violations of constitutional rights protecting Americans from cruel and unusual punishment; especially in the form of terrifying and painful acts performed on the incarcerated. However, what we learn over and over again when we study this history and its ramifications today is that the constitutional rights are applied to a select number of people with certain characteristics, which change to fit whatever narrative the current power holds, but which consistently exclude people of color.

In the U.S. today, vulnerable populations are acted upon intersectionally; multiple forces of discrimination oppress one person or community to force them further down in society by reducing their access to necessities to meet their goals for themselves ("the pursuit of happiness" of the Declaration of Independence); and for societal success; education, food, healthcare, shelter. The term intersectionality which describes this situation was coined by Kimberlé Crenshaw in her 1989 paper on the topic, [17] and more recently in an interview for TIME magazine, she updated her definition,

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[14] Turda, Marius. "Review of Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present." https://www.researchgate.net/publication/275327122_Medical_Apartheid_The_Dark_History_of_Medical_Experimentation_on_Black_Americans_from_Colonial_Times_to_the_Present. N.p.

[15] Newkirk, Vann R. II. 2016. "An Unethical Medical Study Took a Year Off the Lives of Black Men." The Atlantic. https://www.theatlantic.com/politics/archive/2016/06/tuskegee-study-medical-distrust-research/487439/. N.p.

[16] Smith, David Barton. 2005. "Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda." *Health Affairs* 24 (2): 317–24. https://doi.org/10.1377/hlthaff.24.2.317. N.p.

[17] Steinmetz, Katy. "Kimberlé Crenshaw on What Intersectionality Means Today | Time." https://time.com/5786710/kimberle-crenshaw-intersectionality/. N.p.

> It's basically a lens, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other. We tend to talk about race inequality as separate from inequality based on gender, class, sexuality or immigrant status. What's often missing is how some people are subject to all of these, and the experience is not just the sum of its parts.[18]

Vulnerable populations who are victims of intersectional discrimination include people of color, those who are poor, and those who are largely kept systematically nonautonomous by the structural policies enacted, which consistently favor more affluent whites. The nonautonomy is the entrapment of these individuals who are limited in acting on their constitutional rights due to discriminatory and racist systems and policies. These communities and individuals face challenges in satisfying basic needs – which impacts their health. Health challenges, then, become compounding factors. In terms of healthcare, racial medicine, as coined by Dr. Dorothy Roberts of the University of Pennsylvania, is responsible for the inadequate assessment of health conditions in already vulnerable populations, which in turn affects their overall ability to function within society. Roberts explains,

> By reinforcing a biological definition of race and cure for health disparities that are false, race-based medicine supports a new biopolitics of race that threatens to make health and other social inequalities even worse.[19]

Many prison inmates are people of color who already face racism and then are also isolated from general society. For these people racist medical malpractice is even more common and can be even more damaging.[20] [21] Medical malpractice within these specific communities can be seen through the lens of Covid-19 in terms of limited resources for treatment,[22] inadequate

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[18] Steinmetz, Katy. "Kimberlé Crenshaw on What Intersectionality Means Today | Time." N.p.
[19] Roberts, Dorothy. "Race Medicine." N.p.
[20] Salisbury-Afshar, Elizabeth M., Josiah D. Rich, and Eli Y. Adashi. "Vulnerable Populations: Weathering the Pandemic Storm." *American Journal of Preventive Medicine* 58 (6): 892–94. https://doi.org/10.1016/j.amepre.2020.04.002. N.p.
[21] Raifman, Matthew A., and Julia R. Raifman. "Disparities in the Population at Risk of Severe Illness From COVID-19 by Race/Ethnicity and Income." *American Journal of Preventive Medicine* 59 (1): 137–39. https://doi.org/10.1016/j.amepre.2020.04.003. N.p.
[22] Montoya-Barthelemy, Andre G., Charles D. Lee, Dave R. Cundiff, and Eric B. Smith. "COVID-19 and the Correctional Environment: The American Prison as a Focal Point for Public Health." *American Journal of Preventive Medicine* 58 (6): 888–91. https://doi.org/10.1016/j.amepre.2020.04.001. N.p.

and insufficient personal protective equipment, [23] [24] and especially lack of information.[25] These factors play into the already existing intersectional vulnerabilities of these populations to greatly increase their risk for contracting Covid-19 as well as the risk of patient mortality.[26]

By connecting the historical accounts of medical malpractice to modern day racial disparities in health care, it is possible to see how systemic racism impacts all facets of life and all people in a minority community, putting them at a higher risk for contracting disease. Additionally, dismantling this white-washed version of events combats false claims of race-based biological inferiority that have persisted for centuries and alarmingly still continue to be a part of modern medical procedure.[27] Including the idea now that people of color are more likely to contract Covid-19 because of some aspect of their biology (like their blood type).[28] This view downplays the social injustice of the position of people of color in American society, in terms of their occupations and household situations, which make them vulnerable to the disease.

Historical Accounts: The Slave Period

In order to link historical accounts of medical malpractice that resulted from or was abetted by racist ideology, I will begin by examining the historical accounts of racial medicine and black inferiority theory, as both contribute to the false idea of a consistent genetic difference

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[23] Flagg, Anna. "Jails Are Coronavirus Hotbeds. How Many People Should Be Released To Slow The Spread?" *The Marshall Project.* https://www.themarshallproject.org/2020/06/03/jails-are-coronavirus-hotbeds-how-many-people-should-be-released-to-slow-the-spread. N.p.

[24] Blakinger, Keri and Keegan Hamilton. "'I Begged Them To Let Me Die': How Federal Prisons Became Coronavirus Death Traps." *The Marshall Project*. 2020.

[25] Flagg, Anna. "Jails are Coronavirus Hotbeds." N.p.

[26] Storz, Emily "New Report: Pandemic in PA's Prisons Warns of a Looming Public Health Crisis." *DrexelNOW.* https://drexel.edu/now/archive/2020/July/Pandemic-inPAPrisons/.

[27] Smith, David Barton. "Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda."

[28] Zhao, Jiao Yan Yang, Hanping Huang, Dong Li, Dongfeng Gu. "Relationship between the ABO Blood Group and the COVID-19 Susceptibility | MedRxiv." https://www.medrxiv.org/content/10.1101/2020.03.11.20031096v2.

between black and white individuals. As early as the 1500s, there are accounts of European contact with West Africans where the latter are described as inferior due to their skin color.[29]

> After an initial curiosity with the many different shades of black skin color, English explorers and their countrymen in the late 1500s began to consider black skin color to be unclean and otherwise worse than their own complexion.[30]

This idea of complexion as related to spiritual purity can be related back to medieval medicine, where skin color and clarity was accepted as a reflection of the soul's purity.[31] Europeans then combined this rather outdated idea with the unfamiliar cultural customs and religious practices exhibited by the West Africans. Some of these practices included different foods, clothes, communications, and cosmetic "mutilations" including gum tattoos, [32] that were culturally acceptable to the West Africans, but very different from European expectations. These differences later led to the use of "savage" as a description for West Africans, and later all Africans, as a way to dehumanize them and compare them to non-sentient beings[33] like the beasts of the jungle. Pittman provides a description of these dehumanizations,

> In furtherance of the beast metaphor, Englishmen had a substantial fixation with Africans' sexual life and created many myths that accentuated and labeled Africans' sexual behavior as being "lewd, lascivious, and wanton."88 These beliefs included allegations that Africans were overly lustful and beast-like, and that African women had sex with apes.[34]

This dehumanization became widely acceptable[35] and was eventually used as a way to justify the socioeconomic inferiority of black people. During these colonial times, the groundwork for the portrayal of Africans and those of African descent in history was laid out and solidified.

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[29] Morgan, Jennifer L. "'Some Could Suckle over Their Shoulder': Male Travelers, Female Bodies, and the Gendering of Racial Ideology, 1500-1770." *The William and Mary Quarterly* 54 (1): 167–92. https://doi.org/10.2307/2953316.
[30] Pittman, Larry J. "A Thirteenth Amendment Challenge." 148.
[31] Heng, Geraldine. "The Invention of Race." 15-55.
[32] Gum tattooing, artificial pigmentation of the Wolof women, discussion with Dr. Rebecca Winer of Villanova University
[33] Morgan, Jennifer. "Some Could Suckle."
[34] Pittman, Larry J. "A Thirteenth Amendment Challenge ." 149.
[35] Whitaker, Cord J. "Black Metaphors."

After Europeans made contact with West Africans, the slave trade began with racist stereotypes underpinning it. The slave trade absolutely reinforced and exacerbated European explorer's ideas of inferiority by creating rigid social structures that trapped Africans into servitude and submission at the hands of whites and systemic efforts to completely strip Africans of autonomy and their identities. The transatlantic slave trade's inhumane conditions resulted in the death of anywhere from 20-80% of the slaves aboard the ships.[36] The 'waiting period' that followed to see if the slaves would then survive the shock of a new environment and European diseases was also largely inhumane, and little medical treatment was provided to save those who had fallen ill.[37] During the transatlantic slave trade, black inferiority theory became commonplace in medical establishments through theories such as the Great Chain of Being, where Africans were described as being derived from apes and inferior to their white counterparts. Within this theory, the use of phrenology demonstrated lesser intelligence in blacks and Native Americans, and it became acceptable to blame slaves for the diseases the acquired from their captors,[38] despite the fact that whites had immunities built up to these diseases, but Africans did not, as they had never come into contact with them before. In the same way, it was claimed that Africans introduced malaria and yellow fever to the New World,[39] which contributed to theories that dehumanized them and related them to apes or other beasts. And in this situation slavers took no responsibility for bringing these diseases to the Americas although they too were vectors themselves.

[36] Pittman, Larry J. "A Thirteenth Amendment Challenge."
[37] Hood, R. G. "The 'Slave Health Deficit:' The Case for Reparations to Bring Health Parity to African Americans." *Journal of the National Medical Association* 93 (1): 2.
[38] Hood, R. G. "The Slave Health Deficit." 3.
[39] Hood, R. G. "The Slave Health Deficit." 3.

Once slaves were sold, in the antebellum south, slave hospitals became a way for slaveowners to "protect" their purchases – whether the slaves wanted treatment there or not.[40] In These hospitals there was no informed consent; the slaves often did not know what procedures they were enduring, nor did they get to object to them.[41] [42] This lack of autonomy resulted in horrific accounts of restrained surgeries against the will of the patient, as recounted by Dr. James Marion Sims and other white doctors of the time. Many of the supporters of these hospitals believed and practiced racial medicine as directed by black inferiority theory, Kenny provides the example of Dr, Merrill:

> Memphis Physician Dr. A. P. Merrill's appeal to slaveholders hinged on two main arguments. First, that there were fundamental and essential—biological and physiological—differences between blacks and whites. black people allegedly manifested constitutional and pathological "peculiarities" that only trained medical experts could recognize and treat. [43]

By creating a false field of expertise in "slave medicine", white doctors and healthcare providers prevented slaves from understanding and advocating for their own bodies.[44] The slaves lacked the access to primary resources to care for themselves, and the slaveowners were told they lacked the expertise to care for their own slaves.[45] However, slaves also were able to organize and create their own forms of folk medicine to help their own community members.[46] Which included midwifery, gynecology, and obstetrics.[47] These slave practitioners often used methods and

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[40] Kenny, Stephen C. "'A Dictate of Both Interest and Mercy'? Slave Hospitals in the Antebellum South." *Journal of the History of Medicine and Allied Sciences* 65 (1): 1–47.
[41] Savitt, Todd L. "The Use of Blacks for Medical Experimentation and Demonstration in the Old South." *The Journal of Southern History* 48 (3): 331–48. https://doi.org/10.2307/2207450.
[42] Pittman, Larry J. "A Thirteenth Amendment Challenge."
[43] Kenny, Stephen. "A Dictate of Both Interest and Mercy."4.
[44] Savitt, Todd. "The Use of Blacks for Medical Experimentation."
[45] Kenny, Stephen. "A Dictate of Both Interest and Mercy."
[46] Private discussion with Dr. Rebecca Winer discussion 08/10/20
[47] Telles, Lorena Féres da Silva. 2018. "Pregnant Slaves, Workers in Labour: Amid Doctors and Masters in a Slave-Owning City (Nineteenth-Century Rio de Janeiro)." *Women's History Review* 27 (6): 924–38. https://doi.org/10.1080/09612025.2017.1336844.

materials for treatment that opposed white doctors' methodology, but their restricted access to medical text and resources led them to become creative in their treatments – sometimes ultimately leading to success.[48] These women succeeded in fighting back against the unjust treatment of slave hospitals.

For others who did not have the ability to create their own healthcare, slave hospitals typically resulted in slaves being completely at the mercy of doctors who believed they were biologically and intellectually inferior and knew they could not legally advocate for their own wellbeing.[49] The relationship between doctor and patient in a slave hospital was non-existent, in fact it became a conversation between doctor and slaveowner about the third party[50], which is more comparable to discussing a car's maintenance with the mechanic. This rendered the slave in care "medically incompetent"[51] which allowed treatment to become exploitative.

Furthermore, such slave hospitals served as spaces for unethical experimentation[52] and innovation in surgery and medical technique, pioneered by doctors such as Dr. S. Gillbert of Memphis and Dr. James Marion Sims.[53]

Dr. James Marion Sims wrote numerous personal accounts and papers about his own techniques and procedures, one of which is the 'Sims Position,' where black patients were restrained on the operating table from head to toe.[54] Dr. Sims, a very controversial historical figure, succeeded in treating vesicovaginal fistulas and pioneering gynecological treatment and receives recognition for that throughout history. Though he has received backlash from modern historians and medical professionals for the exclusive use of female slaves in his experiments,

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[48] Telles, Lorena Féres da Silva. 2018. "Pregnant Slaves, Workers in Labour."
[49] Roberts, Dorothy. "Race Medicine."
[50] Kenny, Stephen. "A Dictate of Both Interest and Mercy."
[51] Kenny, Stephen. "A Dictate of Both Interest and Mercy." 9.
[52] Turda, Marius. "Review of Medical Apartheid."
[53] Kenny, Stephen. "A Dictate of Both Interest and Mercy." 19.
[54] Kenny, Stephen. "A Dictate of Both Interest and Mercy."20

the records state he had obtained voluntary consent from the women in the study.[55] The accounts of Dr. Sims have been contested as unclear or embellished, but it has been argued that removing him from history would also remove his subjects from history, meaning their contributions as patients would be lost as well.[56] The frustrating lack of clear or verifiable sources within history creates controversy surrounding ethics within the context of human research. Sims is both a pioneer of science and a source of pain for many of his patients and their relatives, who experienced a great deal of injury as a result of his procedures. Sims' patients were not always consenting, nor were his methods always successful or ethical. His practices should be scrutinized for his failure to obtain and document informed consent, and his use of exclusively black patients.

Because Dr. Sims' procedures took place before anesthetics were widely available or used (especially on the black population), his position ensured a stable and unmoving patient, similar to the cadavers practiced upon in medical schools. Kenny describes this procedure from previous records,

> Sims's will for absolute control of an intransigent slave body, suggests that what he was about to attempt was both hazardous and required working far beyond the range of common practice. By making Sam's body "immovable" Sims had made his subject corpse-like, an anatomical object.[57]

Sims' positioning created an extreme power imbalance between doctor and patient, where he, as the practitioner, held all of the power, and the slave-patient became an object virtually without sentience.[58] Today Sims would be guilty of assault and battery at the very least for his abuse of

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[55] Vernon, Leonard F. "J. Marion Sims, MD: Why He and His Accomplishments Need to Continue to Be Recognized a Commentary and Historical Review." *Journal of the National Medical Association* 111 (4): 436–46. https://doi.org/10.1016/j.jnma.2019.02.002.
[56] Vernon, Leonard F. "J. Marion Sims, MD."
[57] Kenny, Stephen. "A Dictate of Both Interest and Mercy." 20.
[58] Kenny, Stephen. "A Dictate of Both Interest and Mercy." 20.

human research subjects.[59] Slave owners willingly gave Sims this power as they viewed their slaves' ailments as burdensome and financially threatening, and consent (and payment) was given from slaveowner to doctor without any patient consultation.

Moreover Sims was not alone, many physicians took advantage of southern blacks by testing techniques or remedies on them, "In several instances, physicians purchased blacks for the sole purpose of experimentation, in others doctors used free blacks and slaves owned by others."[60] By labeling slaves as inferior, non-autonomous, and as property, white slaveowners and doctors created a human ethics nightmare that allowed bodies to be used for whatever purpose best interested their owners, regardless of the consent or wishes of the body itself.[61] Dr. S. Gillbert advertised cancer cures in *The Mississippian* newspaper for slaves "free of charge to the owner",[62] with the fine print reading that the cures were not certain, but experimental. Other doctors established "Negro Infirmaries"[63] which claimed to cure slaves of specific diseases but actually just tested remedies on them with variable success. Dr. Sims used black women's bodies for experimental purposes when examining potential cures for vesicovaginal fistulas in the 1840s.[64] He conceived an idea for operation while treating a white woman for another ailment, and then set out to test his theories on enslaved black bodies, disguising the fact that his tests were experiments and operating repeatedly on the same black women,

> Each woman underwent up to thirty operations in quest of relief. When local physicians lost interest and ceased assisting Sims with the procedure, the persistent doctor trained the slave patients to assist him. Finally, in May 1849, Sims succeeded in overcoming all the complications that had been plaguing his procedure for four years. One by one, the Black women were cured and sent home.[65]

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[59] Richardson, L. Song. "When Human Experimentation Is Criminal." 99:47 Scholarlycommons.law.northwestern.edu.
[60] Savitt, Todd. "The Use of Blacks for Medical Experimentation." 343
[61] Roberts, Dorothy. "Race Medicine: Treating Health Inequities from Slavery to the Genomic Age with Prof. Dorothy Roberts | Center for the Study of Slavery and Justice.". https://www.brown.edu/initiatives/slavery-and-justice/prof-dorothy-roberts-race-medicine-treating-health-inequities-slavery-genomic-age.
[62] Kenny, Stephen. "A Dictate of Both Interest and Mercy." 13.
[63] Kenny, Stephen. "A Dictate of Both Interest and Mercy." 13.
[64] Savitt, Todd. "The Use of Blacks for Medical Experimentation." 345.
[65] Savitt, Todd. "The Use of Blacks for Medical Experimentation."345.

In most history books the eventual success of Sim's operation has overshadowed the horrible conditions under which he experimented. It is true that the unfree women expressed their discomfort and a desire to be cured of their incontinence and associated pain; however, Sims failed to disclose to them that his treatments were purely experimental and would not work at first pass (or until the thirtieth pass!).[66] With the additional lack of anesthetics or sanitary protocols of modern-day medicine (anesthesia was in its infancy in the 1840s and antisepsis would not be discovered until the 1860s) ,[67] these trial procedures were most likely excruciating, mortifying, and terrifying for these gynecological patients – especially as they were constrained to assist Sims as he operated on other patients with the same conditions.

The racist belief in the inferiority of slaves' physical, mental, and moral health was used to support the acceptability of slaveowners making medical decisions for them, as well as the interest in slave markets and the return on investment expected by slaveowners from their property. Eventually the practice of experimentation carried over to become a segue for novice doctors and surgeons to practice and hone their clinical skills on these patients. Enslaved people were societally insignificant, and therefore produced less pressure for unskilled doctors to perform. Enslaved bodies became useful for medical schools for cadaver labs and other anatomical objectifications. [6869]

Historical Accounts: Medical Colleges

[66] Savitt, Todd. "The Use of Blacks for Medical Experimentation."
[67] Vernon, Leonard F. "J. Marion Sims, MD."
[68] Sappol, Michael. *A Traffic of Dead Bodies: Anatomy and Embodied Social Identity in Nineteenth Century America*. PRINCETON; OXFORD: Princeton University Press, 2002. Accessed August 27, 2020. doi:10.2307/j.ctv36zrh7.
[69] Smith, David Barton. "Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda."

The majority of cadavers used for anatomical research in the antebellum south were the bodies of the enslaved, “medical archaeological excavations in the 1990s confirmed post mortem racism and the disproportionate use of slave corpses in the teaching of anatomy”[70] at the Medical College of Georgia. Additionally at the Medical College of South Carolina, a slave-specific infirmary was erected for the faculty, students, and members of the Medical Society to use for experimentation purposes.[71] Black bodies and patients were widely accepted in medical institutions for teaching purposes because they were less important than white patients. A student doctor could perform treatment on a black patient in order to perfect their techniques without significant repercussions if a mistake was made, compared to a white patient.[72] As Todd Savitt explains medical schools advertised the use of black bodies as a way to broaden the scope of their students’ learning,

> Students at the school saw not only "all the common diseases of the climate" but also a variety of operative procedures, owing to the presence of a slave population "peculiarly liable to surgical diseases requiring operations for their relief."" The medical college continued to use black patients for surgical demonstrations throughout the antebellum years[73]

Slave populations produced ‘peculiar’ conditions because of their work and housing conditions, as well as the food and hygienic amenities available to them.[74] Meaning that medically, slave bodies and conditions were considered to be something completely unrelated to white or even human health. Their inclusion in ‘colored wards’ of medical schools enabled students to receive a broader education, but also served to further ideas of biological racial differences and racial medicine, which was falsely researched and used in practice during the antebellum south.[75] Slave

[70] Kenny, Stephen. “A Dictate of Both Interest and Mercy.” 16.
[71] Kenny, Stephen. “A Dictate of Both Interest and Mercy.”17.
[72] Savitt, Todd. “The Use of Blacks for Medical Experimentation.” 335.
[73] Savitt, Todd. “The Use of Blacks for Medical Experimentation.” 335.
[74] Kenny, Stephen. “A Dictate of Both Interest and Mercy.” 16.
[75] Roberts, Dorothy. “Race Medicine.”

bodies were also valued by white medical students because their powerlessness made them virtually disposable people – if mistakes were made, it was only a financial loss for the slaveowner, which would be repaid by the college, there were no other negative ramifications for the medical student.

The use of black bodies in teaching medicine also resulted from religious and cultural burial practices of the time. Excavating or mutilating a body after death was widely considered both sinful and disrespectful to the body and the family of the corpse. Respecting human dignity meant not disturbing the bodies of the deceased. Thus, cadavers were in very short supply for medical students.[76] [77] Black freedmen and slaves had access to religious institutions, especially in an urban context, such as within Philadelphia. Despite active involvement in their church congregations, and the ability to be legally married and baptized there, blacks were excluded from burial within their congregational churchyards.[78] Instead of the churchyard, black bodies were interred in Philadelphia's Potter's Field, which served as the final resting places for both paupers and criminals as well.[79] This space was unsupervised by church or city officials, and therefore open to the potential for graverobbing and "body snatching" for activities such as human dissection in medical schools[80].

> Defined as the practice of illicitly disinterring or stealing corpses from a gravesite, body snatching was a means through which anatomists could acquire bodies in bulk without having to wait or to go through established channels, for example, waiting for an execution to occur and then acquiring the body from the city prison.[81]

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[76] Sappol, Michael. *A Traffic of Dead Bodies: Anatomy and Embodied Social Identity in Nineteenth Century America*.

[77] Marshall, Jubilee. 2020. "Race, Death, And Public Health In Early Philadelphia, 1750–1793." *Pennsylvania History: A Journal of Mid-Atlantic Studies* 87 (2): 364–89.

[78] Marshall, Jubilee. "Race, Death, and Public Health." 368.

[79] Marshall, Jubilee. "Race, Death, and Public Health." 371.

[80] Sappol, Michael. *A Traffic of Dead Bodies: Anatomy and Embodied Social Identity in Nineteenth Century America*. 44-73. Specifically discussing the Doctor's Riots of 1788 in New York City details how laypeople reacted with mob violence after rumors spread regarding the illegal exhumation and dissection of a white woman's body juxtaposed with the refusal to believe or act in advocacy for black bodies suffering the same fate.

[81] Marshall, Jubilee. "Race, Death, and Public Health." 373.

Those involved in the commerce in these bodies (the cadaver trade) justified their actions in the communal disrespect for these dead because they lead lives of crime and were thus considered morally undeserving of a peaceful burial or afterlife. That black people were lumped with this group shows how low their social status was. The lack of legal protection surrounding Potter's Field prevented body snatchers from being held accountable. It was difficult for freedmen to get authority to respond to body snatching, since, Jubilee Marshall argues, societal attitudes suggested that "free black residents were a drain on society, unable to support themselves and destined to end up in jail or the alms-house."[82] The white perspective of the socially, physically, and moral inferior black body permitted body snatchers and graverobbers to get away with disrespectful acts[83] that caused distress and grief to the families and friends of the departed, who were unable to find the resources to protect their deceased from being objectified and mutilated by white hands even after death. However, the black community was able to organize and stand guard over the Field in 1787, eventually raising enough money to purchase their own cemetery – we must not discount their ability to organize and succeed in the face of discrimination and blatant, racist disrespect.[84]

Furthermore, human dissections were illegal in many states during the antebellum era, but slavery allowed them to continue in places and under circumstances that were hard for authorities to control.[85] The dehumanization of slaves and black freedmen as well as the disregard for their moral capabilities and religious capacities allowed for them to be labeled as both savage and uncivilized in the north and south the antebellum era.[86] This made black corpses targets for cadaver labs, especially as they were limited in access to burial grounds for

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[82] Marshall, Jubilee. "Race, Death, and Public Health." 381.
[83] Sappol, Michael. *A Traffic of Dead Bodies: Anatomy and Embodied Social Identity in NineteenthCentury America*.
[84] Marshall, Jubilee. "Race, Death, and Public Health." 377.
[85] Savitt, Todd. "The Use of Blacks for Medical Experimentation." 337.
[86] Pittman, Larry J. "A Thirteenth Amendment Challenge."

their departed.[87] When black cadavers appeared on lab tables, it was much less likely that there would be an inquiry by authorities, friends, or family members.[88] In 1828 a correspondent to the Milledgeville, *Georgia Statesman and Patriot* endorsed a proposal before the state legislature that permitted local authorities to release the corpses of black felons to medical societies for dissections,

> The bodies of colored persons, whose execution is necessary to public security, may, we think, be with equity appropriated for the benefit of a science on which so many lives depend, while the measure would in a great degree secure the sepulchral repose of those who go down into the grave amidst the lamentations of friends and the reverence of society.[89]

White people feared that their deceased loved ones would fall victim to body snatching –this law gave them peace of mind. Even white felons were buried respectfully according to religious burial rites, but black felons according to this proposal did not need to be accorded that basic respect.

This history has not been forgotten among American blacks; the fear in the black community of medical schools and healthcare field carried over into the period of Reconstruction. During this time whites continued to exercise control over freedmen through ideas and practices of 'night-doctors,' who stole, killed, and dissected blacks.[90] This history is not regularly taught in American school and ignorance about it makes medical professionals see any reluctance to consult white doctors as simply irrational, which creates backlash in the medical community that black patients are 'difficult,'[91] which contributes to a vicious cycle between doctor and patient to be discussed later.

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[87] Marshall, Jubilee. "Race, Death, and Public Health."
[88] Savitt, Todd. "The Use of Blacks for Medical Experimentation." 337.
[89] Savitt, Todd. "The Use of Blacks for Medical Experimentation." 339.
[90] Savitt, Todd. "The Use of Blacks for Medical Experimentation." 340.
[91] Savitt, Todd. "The Use of Blacks for Medical Experimentation." 340.

Black medical schools went some way to addressing this problem educating black students, which was crucial given the previous racist medical practices and climate. But in 1910 the Flexner report was released to improve and modernize medical education, by way of producing fewer, better trained professionals, which impeded this advancement. As Ann Steinecke and Charles Terrell argue The Flexner report promoted "the limited education of the African American doctor as a service to his own race, but also for the larger purpose of protecting whites from the African American's potential to spread disease."[92] This idea, of course is completely racially biased and suggests that black people do not warrant decent medical care in and of themselves but simply so that they will not transmit diseases to whites. The Flexner model for reform described a different mission for black and white medical schools; white schools were focused on improving and creating innovative techniques, while black schools were being educated to contain their (incorrectly) presumed biological inferiority to within their own race.[93] Despite the different purposes, each school was expected to demonstrate the same institutional resources.[94] The minimum for resources of course was that of a white school, many of which had alumni donors and other forms of endowment that black schools lacked. This financial requirement resulted in the closure of all but two African American medical schools, Howard and Meharry.[95] This severely limited opportunities for blacks to seek medical education, and limited the availability of medical professionals for black patients. Black patients now either had to pay to see a white doctor, who no doubt treated them as almost a

[92] Steinecke, Ann, and Charles Terrell. "Progress for Whose Future? The Impact of the Flexner Report on Medical Education for Racial and Ethnic Minority Physicians in the United States." *Academic Medicine* 85: 2 (2010): 236–245. https://doi.org/10.1097/ACM.0b013e3181c885be. 180.
[93] Steinecke, Ann, and Charles Terrell. "Progress for Whose Future?" 238.
[94] Steinecke, Ann, and Charles Terrell. "Progress for Whose Future?" 238.
[95] Steinecke, Ann, and Charles Terrell. "Progress for Whose Future?" 238,

separate species due to the curriculum including racial medical theories[96] or forgo treatment if a black doctor was unavailable.

Doctors were supported and reinforced in their methods of treatment by cultural values that additionally dehumanized black bodies and treated black people as nonautonomous beings. These practices extended beyond life as black corpses were also abused within medical schools and unprotected by religious or city officials. After the Civil Rights movement, actions of desegregation were initiated throughout many hospitals and healthcare facilities, but medical racism persisted beyond these measures in the treatment of patients as well as the further experimentation that occurred.

Historical Accounts: Post Civil Rights Movement

From the late 1940s on through the 1960s the Civil Rights Movement began the slow process of desegregation throughout American institutions. Harsh reactions to the Movement, included de facto segregation and those opposed sometimes voted with their feet as 'white flight' occurred. De facto segregation is that of which occurs due to socioeconomic, cultural, or political disparities, despite legal requirements of desegregation.[97] Systemic racism and racial inferiority theories contributed to both socioeconomic and cultural differences between black and white Americans during this period. Black Americans were limited in their ability to get jobs and to secure housing due to redlining,[98] and often to go to the best schools due to transportation and distance. White Americans' participation in 'white flight,' or moving to the suburbs where it was

[96] Savitt, Todd. "The Use of Blacks for Medical Experimentation."
[97] "De Facto Segregation | Definition of De Facto Segregation at Dictionary.Com." \
[98] Gross, Terry. "A 'Forgotten History' Of How The U.S. Government Segregated America." *NPR.Org.* https://www.npr.org/2017/05/03/526655831/a-forgotten-history-of-how-the-u-s-government-segregated-america.

unlikely black Americans could afford to live, in part because of biased mortgage insurances[99] , created another component of de facto segregation: geographical placement.

Hospitals and medical institutions also participated in de facto segregation creating barriers between black and white patients. The elimination of separate but unequal hospitals or colored wards for black patients was a slow and uneven process. In Mississippi, the threat of losing federal resources (about two fifths of the University Medical Center's budget) prompted the elimination of signs separating white and colored facilities.[100] Hospitals had to choose between solvency through compliance to legislature or bankruptcy which motivated the desegregation of staff, patient facilities, and waiting rooms far more than political opinion did.[101] However, hospitals, blood supplies, and room assignments all remained quietly segregated under the guise of "patient's choice" (often actually doctor choosing for patient – not autonomy) until the Office of Equal Health Opportunity inspected and threatened to remove funding.[102] The reluctance of medical institutions to participate in desegregation is a physical manifestation of the persistence of racial medicine. By refusing autonomy to black patients, hospital administrators, doctors, and other healthcare professionals continued to send a message of their beliefs that black people were not capable of being as healthy or as cognitively coherent as their white counterparts. Doctors often disguised this racism by framing it as a financial concern for the patient, whether or not they expressed financial need.[103] An example of this loss of autonomy is described by Larry Pittman regarding the forced sterilizations of black women,

> White physicians became involved in this sterilization effort for the purpose of extinguishing the African-American race by taking away African-American women's ability to procreate. Therefore, even when some African-American women had the

[99] Gross, Terry. "A Forgotten History."
[100] Smith, David Barton. "Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda." 317.
[101] Smith, David Barton. "Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda." 317.
[102] Smith, David Barton. "Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda." 321.
[103] Roberts, Dorothy. "Race Medicine."

> financial resources to pay for their medical treatments, some white physicians refused to treat their pregnancies unless the women consented to sterilization.[104]

By forcing sterilization on patients, physicians dehumanized black women and insinuated that their ability to reproduce should lie at the hands of a white (often male) doctor. Their sterilization was promoted by racial medicine, here in the area of "eugenics", and black inferiority theory that suggested black reproduction was inferior to whites. This Social Darwinist ideology is also an example of intersectionality in a vulnerable population, where black woman is at two crossroads of inferiority, and is thus more at risk for oppression than a black man, or a white woman.[105] Professor Dorothy Roberts analyzed this eugenics experiment and explained that speaking about racial inequalities in biological terms makes the inequalities seem natural, rather than systemic, allowing them to be invisibly applied throughout history.[106] Assuming that all medicine is objective, just because it is medical science, gives physicians and researchers a platform for inhumanity and racial control disguised as science, which can increase and perpetuate racial disparities.

As seen in the antebellum south, experimentation persisted beyond the Civil Rights Movement. Experimentation and the withholding of informed consent for human research subjects continued to disproportionately affect black Americans, which in many cases understandably contributes to distrust in healthcare professionals today.[107] In many cases, these racist procedures and experiments occurred within populations of black prisoners, who had limited autonomy in their constitutional freedoms as both incarcerated people and black people. From 1965 to 1980, white physicians used black prisoners to test drugs and pharmaceutical

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[104] Pittman, Larry J. "A Thirteenth Amendment Challenge." 158.
[105] Williams, Kimberlé Crenshaw. "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color". In: Martha Albertson Fine-man, Rixanne Mykitiuk, Eds. *The Public Nature of Private Violence*. (New York:Routledge, 1994), p. 93-118.
[106] Roberts, Dorothy. "Race Medicine."
[107] Savitt, Todd. "The Use of Blacks for Medical Experimentation."

products for a multitude of diseases, including polio, hepatitis, tuberculosis, typhoid, malaria, and cancer.[108] In many cases, they performed burn, radiation, and other toxic substance tests on black prisoners body parts, occasionally their entire bodies. The knowledge gained from these horrific trials was primarily used to treat white patients.[109] In a prison population, many inmates can be coerced into agreeing to treatment with incentives like commissary payment, increased privileges, or shortened sentences, which may or may not be empty promises by researchers who are trying to get study participants. In these vulnerable populations, incentives must be fair, and consent must be obtained freely.[110] Those who are incarcerated have considerably limited ability to walk away or refuse treatment from a researcher, who may return as often as he likes and ask as many times as he needs to until the inmate agrees, regardless of actual interest in the study.

In 1972 twenty-two African American women were treated with an unapproved 'super-coil' procedure, which resulted in the need for emergency hysterectomies, and consequent sterility.[111] Potential incentives given to these women may have targeted them as a vulnerable population of both women and black people. Additionally, a lack of informed consent including all precautions, side-effects, and potential damages of the procedure may have been withheld by a doctor who was more concerned with piloting his newest surgical innovation.

Perhaps the most well-known experiment from this period is the Tuskegee Study of Untreated Syphilis in the Negro Male, which began in 1932 and lasted 40 years until 1972 when

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[108] Pittman, Larry J. "A Thirteenth Amendment Challenge." See also Byrd and Clayton. See also Angela Davis, Women, Race and Class 221. 1981.

[110] "The Belmont Report." 2010.

[111] Pittman, Larry J. "A Thirteenth Amendment Challenge." 159. Pittman cites Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African-American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 202-04 (1996)).

public outrage shut it down.[112] The study followed 600 rural black men in Alabama with syphilis throughout their lives while refusing to treat them for decades after a cure had been found.[113] This study resulted in the formation of the Belmont Report, which created guidelines and regulations for human research subjects, including definitive regulations of informed consent.[114]

The multitude of experiments done on black people with or without their knowledge or consent is a tangible expression in our society that black lives are worth less, thus it is safer to experiment on a black person's body as replaceable compared to white bodies. This is another extension of the combination of black inferiority theory and racial medicine which was exacerbated by the slave system and slave hospitals, which pioneered many of the ideas of race-medicine. The Tuskegee Study in particular had generational effects on the trust black patients have in their healthcare providers, many people alive today remember when the story broke about it in the news. Follow up studies with relatives of those 600 black men show generational scarring from being forced to choose between participating in an unethical medical system or forgoing healthcare all together.[115] The establishment of the Belmont Report[116] helped to protect vulnerable populations from experimentation, but failed to give those who suffered long-term complications from their traumatic experiences their lives back. Just as racist attitudes from slave hospitals carried on after the Civil Rights Movement, medical disparities still exist among healthcare today, which often targets populations of intersectionality. After the court settlement regarding the Tuskegee study, a collective $10 million was given to those who suffered and their

[112] Newkirk, Vann R. II. "An Unethical Medical Study."
[113] Newkirk, Vann R. II. "An Unethical Medical Study."
[114] "The Belmont Report." 2010.
[115] Newkirk, Vann R. II. "An Unethical Medical Study."
[116] "The Belmont Report." 2010.

families.[117] That is a step in the right direction, but the situation with Covid-19 today shows we still have a long way to go.

Current Day Inequalities: Persisting Racist Attitudes

The framework of modern-day systemic racism is based off of the de facto segregation that ensued after the Civil Rights Movement. These disparities of health are truly the result of many other areas of inequity including housing, transportation, income, occupation, and insurance, and this list is by no means exhaustive. In conjunction with black Americans have less access to the best primary care providers and hospitals, physicians treating blacks are less likely to be board certified, resulting in difficulty with referrals for specialist work or additional treatment.[118] Because they lack the credibility that a board certified physician would, they may experience a more difficult time getting the referrals their patients need for specialists or specific treatments. These findings are mirrored in studies that analyze disparities according to geographic placement as well.[119] On average, black patients receive less pain medication, less intensive care for pneumonia, and more c-section deliveries.[120] Throughout multiple medical institutions, findings are consistent that black patients receive less overall care and less cutting-edge care than whites.

Black patients experience discrimination in diagnoses as well, and furthermore studies have shown that "physicians report personal perceptions of less affluent or less well-educated patients that are more negative than their perceptions of other patients"[121] and these populations

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[117] "Tuskegee Study - Frequently Asked Questions – CDC
[118] Bach, Peter B., "Racial Disparities and Site of Care." *Ethnicity and Disease.* (2005). 31-32. https://pubmed.ncbi.nlm.nih.gov/15822835/
[119] Bach, Peter B., "Racial Disparities and Site of Care" 31.
[120] Pittman, Larry J. "A Thirteenth Amendment Challenge." 138.
[121] Pittman, Larry J. "A Thirteenth Amendment Challenge." 136.

described are disproportionately represented by black patients.[122] Due to these perceptions, medical professionals may be less likely to fully discuss the benefits of certain treatments, or fully disclose treatment options if they presume their lower socioeconomic patients may not be interested in paying for certain treatment options or may not understand the options. This is an oversight on their part and violates the rules of informed consent, which mandate complete disclosure of all possible treatment options and effects.

It has also been described that different care sites may exhibit different qualities of care to black patients, Peter Bach references the Chandra and Skinner article on myocardial infarction as an example of inequity in care,

> 50% of black care occurred in a subset of hospitals in which only 14% of non-blacks received care, and also cited a related study showing that the quality of the myocardial infarction care was lower at the hospitals where Blacks were more likely to go.[123]

This difference in care quality based on location may have a relationship to the geographical distribution of housing prices and therefore black residents. If a site is located in a lower income (and therefore disproportionately black) neighborhood, the study suggests that site may have lower quality of myocardial infarction care in particular. Other research has documented "difficulties in communication about cardiac testing between physicians and patients of lower socioeconomic status.,"[124] which again may be related to incorrect presumptions a physician makes about finances or patient interest.

Healthcare insurance coverage also plays a role in patient care. David Barton Smith concluded that "patients who were covered by the Medicaid program or had no insurance were

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[122] Boyd, Rhea W., Edwin G. Lindo, Lachelle D. Weeks, Monica R. McLemore. "On Racism: A New Standard For Publishing On Racial Health Inequities | Health Affairs." 2020. https://www.healthaffairs.org/do/10.1377/hblog20200630.939347/full/.

[123] Bach, Peter B., "Racial Disparities and Site of Care" 32. Citing Chandra A, Skinner J. Geography and Racial Health Disparities. Cambridge, Mass: National Bureau of Economic Research; 2003. NBER Working Papers No. w9513

[124] Pittman, Larry J. "A Thirteenth Amendment Challenge." 136.

three times are likely to be discharged against medical advice (AMA),"[125] insinuating that finances create value for a patient and help determine their treatment outcomes. Smith elaborates,

> Urban community hospitals located in areas with the most serious problems of social disorganization (e.g., crime, drug addiction, unemployment) had the highest rates [of discharge]. AMA rates do not appear to be simply a function of the disease and the nature of its treatment. Males, Medicaid patients, and patients identified as self-paying were more likely to be discharged AMA, independent of diagnosis.[126]

If a patient's condition worsens after discharge AMA, they are likely to require additional hospitalization, which means an increased cost for care. If they have insurance, the company might also refuse to pay these costs. The finding that these discharge rates persisted in these populations independent of diagnosis clarifies that the discharges were made based on financial capability of the patient.[127] While this may be a factor for hospitals that operate on a budget, it is a disgrace that healthcare professionals would discharge a patient before reaching their treatment outcomes due to finances or lack of insurance coverage. It also allows for de facto segregation to persist; the low-income population Bach references from the Chandra and Skinner research is disproportionately black, and therefore the populations of people without medical insurance or supported by Medicaid are also disproportionately black.[128] Doctors and hospitals are denying black patients full treatment on the basis of their finances, which reduces their humanity to being a monetary value to the hospital, and obliterates their autonomy to make their own financial decisions as coherent individual members of society.

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[125] Smith, D B, and J L Telles. 1991. "Discharges against Medical Advice at Regional Acute Care Hospitals." *American Journal of Public Health* 81 (2): 212–15. https://doi.org/10.2105/AJPH.81.2.212. 212.
[126] Smith, David Barton. "Discharges Against Medical Advice." 213.
[127] Smith, David Barton. "Discharges Against Medical Advice."
[128] Bach, Peter B., "Racial Disparities and Site of Care" 32.

Race medicine is a factor for black patients receiving lower quality and volume of care in medical institutions. Misconceptions and incorrect methodologies, such as accounting for race in spirometry measures (test to assess lung function by measuring air inhaled),[129] allows for the persistence of the belief that black patients have biological differences from whites. Lundy Braun evaluates the historical differences in spirometry measures as well as their modern-day applications, and how that increases healthcare disparities by making it harder for black patients to obtain healthcare related to lung function,

> Alternatively, they [The American Thoracic Society] recommend correction factors. In the United States (US), spirometers use either correction factors of 10% to 15% for individuals labelled 'black' and 4% to 6% for people labelled 'Asian', or population-specific standards, usually those derived from the third US-based National Health and Nutrition Examination Survey for 'Caucasians', African Americans and Hispanics.[130]

Within these measurements is the misconception that race is both linked to biological capability as well as the incorrect assumption that a racial-identity is straightforward.[131] Speaking about inequalities in biological terms contributes to this ideology of inferiority in the black population.[132] For example, studies showing a majority of hypertension patients to be black are taken out of context and treated as if that means there is a specific gene unique to black people that is responsible for this majority.[133] This is a falsified way of approaching scientific studies in which the context of the sample is completely removed. There is a large interplay between genetics and the environment; meaning that hypertension may be more likely due to genetics, but the reason it truly occurs in an individual is actually the result of that individual's

[129] Braun, Lundy. "Race Ethnicity and Lung Function."
[130] Braun, Lundy. "Race Ethnicity and Lung Function."
[131] Braun, Lundy. "Race Ethnicity and Lung Function."
[132] Roberts, Dorothy. "Race Medicine."
[133] Roberts, Dorothy. "What's Wrong with Race-Based Medicine?"

environment – stress, food deserts (lack of easy and cheap access to fruits and vegetables in the poorest neighborhoods[134]), and substandard primary care.

Within the educational system as well, racist ideologies of biological inferiority remain a component of teaching methodology. Medical students are trained to observe race as a component of the patient profile and an informing factor of a patient's condition. Blinding an assessor will eliminate this bias – seen in a case study of a female patient who had cystic fibrosis.[135] Radiographs of her condition at ages 4 and 6 were diagnosed as pneumonia, and she was only correctly diagnosed with cystic fibrosis at age 8 when the assessor did not know who the patient was, what her "race" was. This anecdote explains the function of racial bias and race-medicine in practice. Incorrectly assuming that diseases like cystic fibrosis are limited to a white person's DNA results in the unnecessary suffering of patients from misdiagnosis.[136] American literary critic, film-maker and public intellectual Henry Louis Gates[137] also experienced a similar bias after he sustained a leg injury,

> He stood me on my feet and insisted that I walk. When I tried, the joint ripped apart and I fell to the floor. It hurt like nothing I'd ever known. The doctor shook his head…'there's not a thing wrong with that child. The problem's psychosomatic. Your son's an overachiever.'[138]

Gates remarked that the doctor's diagnoses of him as an overachiever was an insult to his natural capacity – the doctors misdiagnosis was rooted in his (the doctor's) belief that young black Gates did not have the natural ability to be a doctor, and thus was destined for failure. Gates however, rose above the racism he experienced to become a national figure in the U.S.

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[134] "USDA ERS - Food Access Research Atlas."
[135] Roberts, Dorothy. "What's Wrong with Race-Based Medicine?"
[136] Roberts, Dorothy. "Race Medicine."
[137] n.a. "Henry Louis Gates Jr | Encyclopedia.Com."
[138] Gates, Henry Louis Jr. "About Men; A Giant Step." 9 Dec 1990. *The New York Times*. https://www.nytimes.com/1990/12/09/magazine/about-men-a-giant-step.html

today and professor at Harvard University.[139] Medical professionals must take racially distributed disparities into account; access to food, facilities, hygiene, finances, and transportation to work and healthcare facilities are all disproportionately distributed along lines of race and socioeconomic class. However, that does not excuse nor evidence a genetic or biological difference between the health of two patients of different races. Additionally, it has been proven that disease or medical conditions do not apply specifically to one race over another, but are transmitted biologically from human to human – thus it is more than possible for a black patient to have cystic fibrosis. This theory is additionally flawed in modern medicine, Americans are interrelated across what is considered to be "racial" lines. When intermarriage was illegal the existence of rape and sexual slavery has meant that black Americans have white ancestors and white Americans have black relatives.[140] Today, the idea that a family tree is exclusively white people or black people without any mixing is absurd – which denounces the medical theories that require race as a component of measurement.[141]

In 2020, the medical world has been grappling with the rapid and devastating spread of Covid-19 and the effects it has on life as we know it. Reports and death tolls provide only a small component of information surrounding transmission rates and populations affected. Racial disparities about Covid-19 range from the purely racist (the misconception that only Asian-Americans could receive or transmit the virus) to socioeconomic discrimination, as the transmission rates are higher in poorer classes.

Covid-19 Transmission and Racial Disparities: Underlying Health Conditions

[139] n.a. "Henry Louis Gates Jr | Encyclopedia.Com."
[140] Norton, Mary Beth. 2018. "Jefferson's Three Daughters — Two Free, One Enslaved." *The New York Times*, January 26, 2018, sec. Books. https://www.nytimes.com/2018/01/26/books/review/jeffersons-daughters-catherine-kerrison.html.
[141] Braun, Lundy. "Race Ethnicity and Lung Function."

One of the main factors that increases the mortality rate with Covid-19 is the presence of underlying health conditions. One sign of a severe case of Covid-19 is blood clotting, which may cause death by stroke.[142] Those who are more likely to have blood clots then are at a greater risk for death when infected by Covid-19. A 2016 study found that blood type can be associated with stroke factors, and that AB blood types, which increase risk, may mediate some of the excess stroke risk seen in blacks in the US.[143] This is not to say that only black people have this gene, or that only black people with this gene are at risk for strokes – it is a relationship between the risk for development presented by the genetic makeup and the environmental factors that contribute to the disease. In fact, the study concluded that the association of AB blood type and stroke was stronger in patients who had diabetes. Blood type and stroke are related independent of external factors, including race. A news article from the New York Times stated that the two factors of blood type and diabetes do put blacks at risk for stroke, therefore increasing the danger that Covid-19 imposes to them, then inferred that this caused black people to be more affected by Covid-19. This insinuates a racially-based genetic relationship to the transmission of the disease.[144] Other studies conclude that blood type and Covid-19 infection may be related; blood group A was associated with a higher risk of infection than non-A blood groups.[145] [146] The New York Times article was later updated to announce that blood type was less of a risk factor than originally believed, after the associations were found to be relatively weak and do not result in

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[142] Rabin, Roni Caryn. 2020. "Coronavirus May Pose a New Risk to Younger Patients: Strokes." *The New York Times*, sec. Health. https://www.nytimes.com/2020/05/14/health/coronavirus-strokes.html.

[143] Zakai, Neil A., Suzanne E. Judd, Kristine Alexander, Leslie A. McClure, Brett M Kissela, George Howard, and Mary Cushman. "ABO Blood Type and Stroke Risk: The REasons for Geographic and Racial Differences in Stroke (REGARDS) Study." *Journal of Thrombosis and Haemostasis : JTH* 12 (4): 564–70. https://doi.org/10.1111/jth.12507.

[144] Zimmer, Carl. 2020. "Genes May Leave Some People More Vulnerable to Severe Covid-19." *The New York Times*, sec. Health. https://www.nytimes.com/2020/06/03/health/coronavirus-blood-type-genetics.html.

[145] Zhao, Jiao Yan Yang. "Relationship between ABO Blood Group and Covid-19."

[146] Ellinghaus, David, Frauke Degenhardt, Luis Bujanda, Maria Buti, Agustín Albillos, Pietro Invernizzi, Javier Fernández, et al. 2020. "Genomewide Association Study of Severe Covid-19 with Respiratory Failure." *New England Journal of Medicine* 0 (0): null. https://doi.org/10.1056/NEJMoa2020283.

infection on their own.[147] This article exemplifies the invisible race medicine that exists in medical practice today, disguised by biological terminology and evidence, incorrectly attributed to a racial group rather that the environmental factors they face as a cohort due to systemic racism.

In the end the truth in the disproportionate number of black patients affected lies in their environments, not their blood types. According to Matthew Raifmain's article determining disparities in at risk populations, anyone who lives in a low-income household is more likely to have underlying health conditions, compounded by structural inequities with access to medical insurance, wealth, and income volatility[148] which puts black, American Indian, and poor people more at risk than whites or those in higher-income households.[149] Within these environments as well, exposure is more likely – poorer populations are more likely to be essential workers, in industries that have remained open throughout the pandemic, which greatly increases the number of people they come into contact with, and therefore the probability of contracting Covid-19. These populations are also more likely to live in crowded and multigenerational homes that additionally elevates exposure[150] due to the number of people in a small space and the potential for multiple job-holders as essential workers in different locations to be living in the same home. Since black households are more likely to be poor as well as affected by system racism – they are more affected by risk factors than a population who is black and affluent or white and poor.[151]

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[147] Williamson, Elizabeth J., Alex J. Walker, Krishnan Bhaskaran, Seb Bacon, Chris Bates, Caroline E. Morton, Helen J. Curtis, et al. 2020. "OpenSAFELY: Factors Associated with COVID-19 Death in 17 Million Patients." *Nature*, 1–11. https://doi.org/10.1038/s41586-020-2521-4.

[148] Raifman, Matthew A. "Disparities in the Population at Risk."

[149] Janes, Chelsea. "Hispanic, Black Children at Higher Risk of Coronavirus-Related Hospitalization, CDC Finds." *Washington Post*. https://www.washingtonpost.com/health/2020/08/07/hispanic-black-children-higher-risk-coronavirus-related-hospitalization-cdc-finds/.

[150] Raifman, Matthew A. "Disparities in the Population at Risk."

[151] Janes, Chelsea. "Hispanic, Black Children at Higher risk."

Including these socioeconomic disparities from an intersectional perspective when mandating measures that decrease risk of infection would serve to reduce deaths in these populations and overall. Additionally, rationing resources based on intersectional inequalities would serve to reduce mortality of Covid-19 by focusing on these more vulnerable populations who must choose between working to feed their families or quarantining for their own safety. For example, once a stable vaccine is released, extra measures should be taken to ensure these populations receive the vaccine. Implementing policies that adjust for the extra risks that intersectional and vulnerable populations face would help slow transmission by limiting their contact with others, as well as go some way to addressing the systemic racism people in this group face in general at this time of pandemic. Some positive steps are being taken in this direction. Currently, there are free testing centers organized in predominantly black communities by black doctors to help provide adequate resources to vulnerable populations.[152] I would like to propose that medical institutions and healthcare providers help them in whatever ways we can. I want to see us express our solidarity and support.

Covid-19 Transmission and Racial Disparities: The Incarcerated

Another vulnerable and intersectional population affected disproportionately by Covid-19 is the population of the incarcerated, "In the Philadelphia jail system, the infection rate of inmates is 14.75 per 1,000—a higher infection rate than any Philadelphia neighborhood."[153] Any analysis of the public health situation for his population brings up compliance and adherence as important components of race medicine, autonomy, and of the current culture developing around

[152] "Pa. Coronavirus Recovery: Free COVID-19 Testing in Strawberry Mansion."
[153] Geffen, Benjamin. Griffin, Ebony. McKenzie, Mimi. "Philadelphia Federal Detention Center Detainees File Class Action Lawsuit Demanding Protection from COVID-19 | The Public Interest Law Center." https://www.pubintlaw.org/cases-and-projects/philadelphia-federal-detention-center-detainees-file-class-action-lawsuit-demanding-protection-from-Covid-19/.

Covid-19. The culmination of underlying health risks, inadequate protective measures, and lack of information collides with the intersectional vulnerable populations of poor, underserved, black individuals in the prison system of the US. The Universal Declaration of Human Rights states that all humans deserve medical care, necessary social services and security of livelihood in situations out of one's control[154] but Pennsylvania state prisons have failed the incarcerated in all these areas. There are not adequate testing procedures within Pennsylvania prisons for neither detainees nor staff, and prison administrations have failed to provide sufficient or adequate personal protective equipment.[155] Detainees are responsible for disinfecting surfaces, but are often not given the proper equipment to do so.

Not only are the prisoners underinformed about how Covid-19 spreads due to a lack of access to the outside world, they have no autonomy and therefore little ability to protect themselves,[156] despite the fact that they desire to be adherent to measures which would limit the transmission of Covid-19 throughout the prison. Medical compliance has been a topic of interest within the concept of public health and safety, especially during Covid-19 as CDC guidelines have begun to evolve based on the available knowledge of the disease. Compliance defined refers to the idea that an individual, rather than an entire population, is refusing to follow medical advice.[157] While some populations during the pandemic have openly refused to wear masks and follow guidelines, generally, Americans understand and follow the guidelines posted by the CDC regarding social distancing and other protective measures. The issue of adherence becomes more important after examining the rationale for a population who does not follow a prescribed plan. The impacts that may prevent a population from following medical guidelines may include

[154] Salisbury-Afshar, Elizabeth. "Vulnerable Populations."
[155] Geffen, Benjamin. "Philadelphia Federal Detention Center."
[156] Geffen, Benjamin. "Philadelphia Federal Detention Center."
[157] Private discussion with Professor Ruth McDermott-Levy of Villanova University's School of Nursing.

income, trust, access, and understanding of the guidelines themselves.[158] Accounting for systemic reasons that prevent individuals and entire populations from receiving healthcare may alleviate disparities in life for these populations while also increasing medical compliance and adherence alike.

In the incarcerated population, the issues of compliance and adherence become convoluted, because prisoners lack the same amount of individual freedoms that the general population has. While their restricted freedoms are a component of the consequences of their prison sentence, it should not extend to their personal health and wellbeing. Prison is a place for people to correct their behavior and learn to follow the laws – they serve one sentence that accounts for whatever they did wrong, and then they return to society. Prison should not be a place where people are dehumanized and devalued to the point of absolute nonautonomy; where even personal health is a privilege they are treated as if they not deserve. Covid-19 has laid bare many disparities in healthcare and quality of life, and the prison system is one of the places where those disparities hit hardest, especially for black detainees.

Before the pandemic hit, prisoners already had a high prevalence of chronic disease and mental health illness, combined with a chronically underfunded health system and medical copays that take up a large part of a prisoner's income – all of which may contribute to undiagnosed or maltreated diseases.[159] In addition, a large segment of prisoners are elderly, 23.3% of the total population of the incarcerated in Pennsylvania are over 50 years old.[160] These factors all make prisoners more susceptible to Covid-19 and increase their risk of patient

[158] Private discussion with Professor Ruth McDermott-Levy of Villanova University's School of Nursing.
[159] Montoya-Barthelemy, Andre. "Covid-19 and the Correctional Environment."
[160] Storz, Emily "New Report: Pandemic in PA's Prisons Warns of a Looming Public Health Crisis."

mortality this in and of itself is unethical. Furthermore, however, if we are thinking about society as a whole these prisoners are more of a risk to public health than public safety at this point.

The overcrowding of cells, poor ventilation, and restricted availability of items like soap, cleaning supplies, and hand sanitizer create poor personal hygiene practice and may contribute to the virus spread not only within jails and prisons but beyond them.[161] Prisoners who do not have the money to spend on personal hygiene products are more susceptible to infection, and the lack of funds may contribute to their reluctance to visit medical staff to get tested. Additionally, those who are infected are shown in "photos and videos of sick men in bunk beds just two feet apart,"[162] with no hope for distancing despite the Department of Corrections pandemic response plan that affirms social distancing measures were to be enacted. From the organization The Marshall Report, which relays information from prisons to the general public, Keri Blakinger reports,

> Federal officials have allegedly tried to conceal the extent of the outbreak by limiting testing—so that they didn't have to report positive cases—and refusing to recognize one staff death. As of Tuesday, they had completed testing on less than 13 percent of prisoners in BOP-run facilities.[163]

By refusing to acknowledge the cases that are occurring and refusing tests to people who need the, a falsification of data and a misrepresentation of the sample is created which ultimately causes death in the inmate population. Regardless of whether or not prisoners want to be tested – they lack the autonomy to receive healthcare that should be given to them as a component of their Human Rights.

The income prisoners receive is from their labor done within the prison – and their wages are determined by those in charge, who also set the prices at the commissary for necessary

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[161] Montoya-Barthelemy, Andre. "Covid-19 and the Correctional Environment."
[162] Blakinger, "I Begged Them."
[163] Blakinger, "I Begged Them."

hygiene items. This is an exploitation of the 13th Amendment loophole[164], which outlaws involuntary servitude except as punishment for criminal behavior. This loophole currently allows criminal neglect by the administration of corrections facilities. These even continue to operate their factories, paying workers between 23 cents and $1.15 an hour to create masks, however workers were not provided with PPE while they worked.[165]

The sickening irony in the operation of factories during a pandemic to create personal protective equipment for other individuals especially highlights the dehumanization of this intersectional population. the majority of those prisoners are black men, which is just further evidence to support facilities in enforcing working conditions despite raising concern over a pandemic. These prisoners have no autonomy in that they cannot afford to refuse to work – they must choose between affording personal hygiene products or isolating themselves in their dormitories and staying out of the factories. In light of this pandemic, if the punishment prevents its subjects from receiving necessary and human rights (such as personal hygiene products and the means for protecting oneself from contact with another inmate), This is no longer a punishment acceptable under constitutional standards – it becomes cruel and unusual. Releasing detainees from incarceration on parole or with a shortened sentence are both needed not to mention subsidized grants to all prisoners of the PPE and sanitary items they require.

The health systems within prisons are also chronically understaffed as announced by reports of a shortage of doctors and nurses in 2016,[166] and resources are limited, even for elderly populations of prisoners and detainees with chronic health conditions.[167] This lack of resources presents an additional danger in light of a pandemic – prisoners may not be able to access

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[164] Pittman, Larry J. "A Thirteenth Amendment Challenge."
[165] Blakinger, "I Begged Them."
[166] Blakinger, "I Begged Them."
[167] Montoya-Barthelemy, Andre. "Covid-19 and the Correctional Environment."

necessary tests or resources to manage symptoms of Covid-19, and those with chronic health conditions may lose access to necessary medications they required before the pandemic hit that are necessary for their health maintenance due to the added stress of the pandemic within the prison healthcare resources. Not only does this increase the risk of transmission of Covid-19, it increases the likelihood of death from chronic health conditions like diabetes or hypertension within detainees.

The US prison system to me is emblematic of the harm done to individuals oppressed by intersectionality during this pandemic. The prison population includes those with underlying health conditions, those who are racial minorities (and predominately black), those who are poor, those lacking in access to decent healthcare, and those who ultimately have no autonomy. These factors all contribute to the prisoner's susceptibility to Covid-19 and the increasing mortality rates seen in prisons due to Covid-19.

Conclusion

The pandemic has exacerbated the inadequacies in the prison healthcare system, pushing it over the edge and causing a failure to provide complete healthcare for the prison patients – regardless of whether or not those incarcerated have Covid-19. Social distancing and personal protection have been overlooked by staff and largely ignored. Despite prisoners' desires to remain safe during the pandemic, they are without adequate resources that allow them to access personal protection via equipment, space, or even fresh air. The prisoners' lack of autonomy and inability to be adherent to pandemic guidelines mirrors the post-Civil Rights hospitals' use of certain beds or refusals for blood transfusions for colored patients, masked as an autonomous patient choice. The Department of Corrections' refusal to test for Covid-19 is a repeat of de facto

segregation in hospitals and race medicine, where doctors failed to disclose complete information about diseases or treatment based on the presumption that their patient would not be able to afford it. The mandate of factories within prisons to remain open without any sort of safety regulation is a breach of the 13th Amendment and a direct correlation to slavery, where prisoners must work to access basic human necessities like personal hygiene products and avoid being punished by corrections officers. Race medicine and black inferiority ideologies have persisted since the first European contact with West Africans in the 1500s. and today still appear in perniciously inaccurate biological studies with inaccurate racial attributions.

The loss of human autonomy seen in the American prison system, especially during the global pandemic of Covid-19 highlights these inequities that have persisted and continues to devalue the lives of majority black prisoners as less-than-human. This dehumanization creates a space for a group of primarily white people to observe and make decisions for intersectional populations – as a prison guard would for a detainee. They strips these populations of their human rights and constitutional rights by rendering them nonautonomous and in many cases, incorrectly addressing them as incoherent. For researchers studying the links between race and public health – proposing a solution is even more important than describing the problem, and producing a specific rigor for research regarding race is of the utmost importance.[168] The issues surrounding racial and intersectional disparities in healthcare are widely studied and have become a huge topic for discussion in popular media outlets as well as classrooms and colleges in America. In addition to increasing methods of educating the general population about these disparities, however, there needs to be an established way to eliminate these disparities, starting with the healthcare field and moving through prison reform. Calling out the racist ideologies still

[168] Boyd, Rhea W. "On Racism."

at work in justifying the oppression of people of color in this country in the area of medicine is an important start.

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