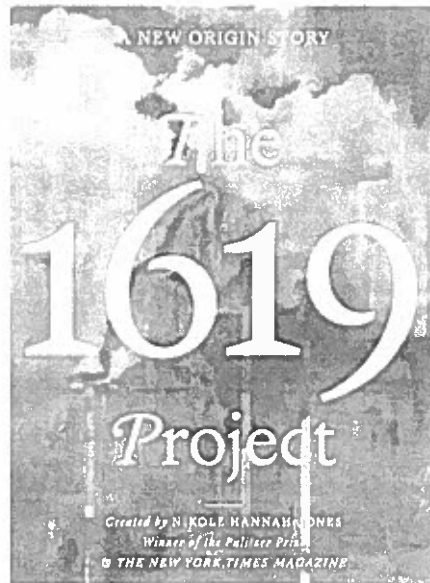




1619 Project Discussion Article Packet



1619 Project A New Origin Part 6

September 8, 2022

Race, Medicine, and Health Care

7 pm Lee Road Library

Upcoming 1619 programs

All programs IN PERSON from 7:00 pm – 8:30 pm.
Topics subject to change.

October 13, 2022

1619 Project: New Origin Part 7
Slavery, Police, and Self-Defense

November 10, 2022

1619 Project: New Origin Part 8
Race, Politics, and Progress

Please check our 1619 Discussion homepage at:
<https://heightslibrary.org/services/1619-project/>

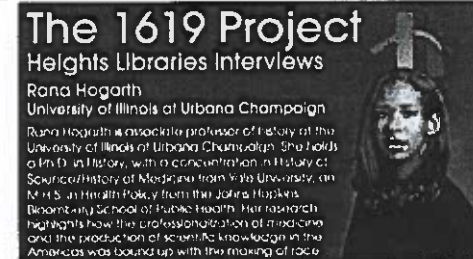
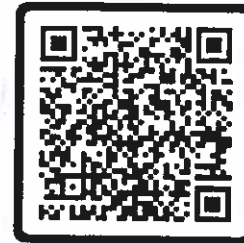
The Library's 1619 topic interviews are on Youtube
<https://www.youtube.com/hashtag/1619projectdiscussion>

Unpacking 1619 Podcast

New episode every other Wednesday

<https://heightslibrary.org/services/unpacking-1619-podcast/>

Contact: John Piche' at jpiche@heightslibrary.org

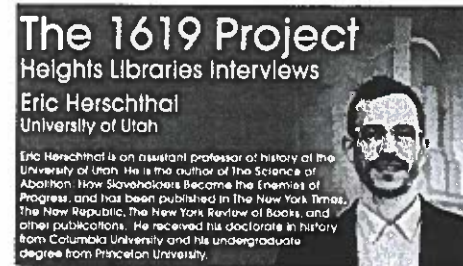


Unpacking 1619 - Slavery and Medicine with Rana Hogarth

Professor Hogarth discusses how white physicians defined blackness as a medically significant marker of difference in slave societies of the American Atlantic. And the legacy slave bodies had on the foundations of Southern Medical schools.

CHECK OUT OUR INTERVIEWS ON

YOUTUBE SLAVERY AND MEDICINE



Unpacking 1619 - Dr. Rush's Leprosy Theory of Race w



Professor Eric Herschthal examines how the medical theories of Dr. Rush informed his advocacy for the American Revolution and the end of American Slavery.

In 2002, when Susan Moore received her degree from the University of Michigan Medical School, she joined a small sorority of Black women with the MD credential after their names.¹ That year, fewer than seven hundred Black women graduated from American medical schools—out of a total of nearly sixteen thousand newly minted doctors. Several years later, Moore settled in the Indianapolis area, where she practiced family and geriatric medicine, raised her son, Henry, and cared for her parents. But in 2020, when the Covid-19 pandemic hit, years of medical training and the credentials she'd worked so hard to earn would fail to protect her from the healthcare system itself.²

On November 29, Moore tested positive for Covid-19, and soon after, she was checked in to Indiana University Health North Hospital in Carmel, a suburban city near Indianapolis.³ On December 4, she posted a video on her Facebook page that showed her lying in her hospital bed, a breathing tube inserted in her nose. Her voice halting as she struggled to catch her breath, Moore detailed disrespectful treatment by a white physician, whose name she took the time to spell out. He had rejected her plea for additional doses of an antiviral medication used to treat Covid, she said, adding in the post accompanying the video, "He did not even listen to my lungs, he didn't touch me in any way." And despite what she described as excruciating neck pain, according to her account, he told her he was uncomfortable giving her additional pain medication and tried to send her home. "I was crushed," a tearful Moore said in the video recorded on her cellphone, her eyes wide with a combination of frustration and fear. "He made me feel like I was a drug addict. And he knew I was a physician. I don't take narcotics. I was hurting."

Then, looking directly into the camera, her voice shaking with rage, Moore offered this scathing indictment of the American medical system, which had betrayed her: "I put forth and I maintain if I was white, I wouldn't have to go through that. This is how Black people get killed."⁴

Moore died two weeks later at age fifty-two. In her assessment of the U.S. healthcare system, she was correct on two counts. First, as a Black American, she was more likely to contract Covid-19 than a white American; and second, she was more likely to die from the disease. Around the time of her death, the Centers for Disease Control and Prevention released data showing that Black Americans were 1.4 times more likely than white ones to contract the virus, 3.2 times more likely to be hospitalized, and 2.8 times more likely to die.

Black Americans disproportionately contracted Covid-19 because of the many ways America's history of racial violence and inequality is baked into the institutions and structures of our society.⁵ Black Americans are more likely to work in low-wage jobs and to live in segregated, crowded, polluted neighborhoods that lack adequate healthcare facilities and transportation; they are far less likely than white Americans to live near safe outdoor spaces and have access to healthful and affordable food.⁶ These factors, the social determinants of health, have long had an outsized influence on health outcomes, and they help explain the racial disparities that were an immediate feature of the pandemic in the United States. The environment itself has been shown to worsen Covid-19 outcomes for Black Americans. In April 2020, as the pandemic surged, researchers from the Harvard T.H. Chan School of Public Health conducted a study that linked long-term exposure to dirty air to higher risk of death from the virus.⁷

This dangerous connection between air pollution and respiratory illness was not lost on those scientists and policy makers who have long known that African Americans shoulder a disproportionate burden of exposure to the nation's polluted environments. These social determinants more commonly impact poor communities. But racial health inequality transcends class, and even well-educated Black people with access to healthcare—like Susan Moore—are more vulnerable to a number of serious diseases. For one, they are affected by the stress of coping with racism embedded in day-to-day life, which can lead to a kind of premature aging. Arline T. Geronimus, a professor at the University of Michigan School of Public Health, does research in this area; she coined the term "weathering" to explain how high-effort coping in the face of continuous racial insults exacts a physical price on the bodies of Black Americans.⁸

What's more, as revealed by Dr. Moore's tragic death, even when Black

people go to a medical facility for treatment and care, they can still be subject to racism's dehumanizing effects. The medical establishment has a long history of mistreating Black patients, either by failing to take their suffering seriously or by dismissing their concerns. This often comes up in the context of pain management. The physician who ignored Dr. Moore's distress and denied her pain relief was more than an isolated bad apple; the problem of minimizing Black pain has been well documented in scientific literature. A 2013 review of studies examining racial disparities in pain management published in the *American Medical Association Journal of Ethics* found that Black and Hispanic people—from children with adenoidectomies and tonsillectomies to elders in hospice care—received inadequate treatment for pain, especially as compared with their white counterparts.⁹

Why would this be the case? For centuries, white physicians and scientists went to great lengths to prove that Black bodies were biologically and physiologically different from white bodies.¹⁰ To be clear, "different" almost always meant inferior. These physicians and scientists used their expertise and even empirical data to insist that enslaved Africans were "fit" for slavery and that the institution was not immoral or cruel, as many proclaimed.¹¹ Over time, their theories became incorporated into and normalized in medical practice, and this racializing of medicine did not end after slavery. Two persistent physiological falsehoods—that Black people were impervious to pain and that they had weak lungs that could be strengthened through hard work—have wormed their way into the scientific consensus, and can still be seen in modern-day medical education and practice. A study of 222 white medical students and residents published in the *Proceedings of the National Academy of Sciences* in 2016 showed that half of the students and residents endorsed at least one false idea about biological differences between Black people and white people, including that Black people's nerve endings are less sensitive than those of white people.¹² When asked to imagine how much pain white or Black patients experienced in hypothetical situations, the medical students and residents who held more false beliefs were more likely to maintain that Black people felt less pain, and thus they were less likely to recommend appropriate treatment.

This is how Black people get killed.

The Covid-19 pandemic has made it clear that by several measures, the health status of Black Americans is on par with that of people living in far poorer nations, and that at every stage of life Black Americans have poorer health outcomes than white Americans and even, in most cases, than other ethnic groups. Racial health disparities show up at the beginning of life and

cut lives short at the end. Black babies are more than twice as likely as white babies to die at birth or in the first year of life—a racial gap that adds up to thousands of lost lives every year.¹³ African American adults of all ages have elevated rates of conditions such as diabetes and hypertension that among white people are found more commonly at older ages.

In the first half of 2020, owing to the pandemic, the Black-white gap in life expectancy increased to six years, from four in 2019.¹⁴

This inequality when it comes to the health of Black people's bodies is rooted in false ideas about racial differences, developed and spread during slavery, and long challenged by Black medical practitioners and scholars, that still inform the way medical treatment is administered in America.¹⁵ To understand the racial divide in the health of our nation that was stripped bare by Covid-19, we must examine the roots of these myths.

In the 1787 manual *A Treatise on Tropical Diseases; and on the Climate of the West-Indies*, a British doctor, Benjamin Moseley, claimed that Black people could bear surgical operations much more easily than white people, noting that "what would be the cause of insupportable pain to a white man, a Negro would almost disregard." To drive home his point, in a later edition he added, "I have amputated the legs of many Negroes who have held the upper part of the limb themselves."¹⁶

Thomas Jefferson, in *Notes on the State of Virginia*, published the same year as Moseley's treatise, listed what he proposed were "distinctions which nature has made."¹⁷ "They secrete less by the kidneys, and more by the glands of the skin, which gives them a very strong and disagreeable odour," he explained, offering no evidence.¹⁸ Jefferson, who both owned and fathered enslaved people, extrapolated that Black people were different emotionally and intellectually. "They seem to require less sleep," he wrote. "A black after hard labour through the day, will be induced by the slightest amusements to sit up till midnight, or later, though knowing he must be out with the first dawn of the morning."¹⁹

In the years that followed, physicians and scientists embraced some of Jefferson's unproven theories, perhaps none more aggressively than Samuel Cartwright, a physician and professor of "diseases of the Negro" at the University of Louisiana in New Orleans, now Tulane University. His widely circulated paper "Report on the Diseases and Physical Peculiarities of the Negro Race," published in the May 1851 issue of *The New-Orleans Medical and Surgical Journal*, cataloged supposed physical differences between white people and

Black people, including the claim that Black people had lower lung capacity—what he called “vital capacity.”²⁰ To pursue this theory, he became one of the first doctors in the United States to measure pulmonary function with an instrument called a spirometer. According to his subsequent “calculations,” “the deficiency in the Negro may be safely estimated at 20 percent.” Cartwright, conveniently, saw forced labor as a way to “vitalize” the blood and correct the problem.²¹

Most outrageously, Cartwright maintained that enslaved people were prone to a “disease of the mind” called drapetomania, which caused them to run away from their enslavers. Willfully ignoring the inhumane conditions that drove desperate men and women to attempt escape, he insisted, without irony, that enslaved people could contract this ailment when their enslavers treated them as equals, and he prescribed “whipping the devil out of them” as a preventive measure.²²

These fallacies had dangerous and terrifying outcomes for Black people. The false theory of higher Black pain tolerance led to the use of Black people as subjects in medical experiments that today we would view as unconscionable torture. The work of physician J. Marion Sims, long celebrated as the father of modern gynecology, offers one of the most infamous examples. Between 1845 and 1849, before anesthesia was widely in use, Sims used enslaved women in Montgomery, Alabama, as the subjects of painful operations so that he could perfect a surgical technique to repair vesicovaginal fistulas, which can be an extreme complication of childbirth. In his autobiography, *The Story of My Life*, Sims described the agony the women suffered as he cut their genitals again and again.²³

A similar testament of torture, told from the other side of the operating table, is offered in *Slave Life in Georgia: A Narrative of the Life, Sufferings, and Escape of John Brown, a Fugitive Slave, Now in England*, which was published in 1855. Brown, who had been enslaved on a Baldwin County, Georgia, plantation in the 1820s and '30s, was lent by his enslaver to a physician named Dr. Thomas Hamilton. This doctor was obsessed with proving the existence of physiological differences between Black and white people, and Brown wrote about the excruciatingly painful medical experiments Hamilton put him through, until his body was disfigured by a network of scars. Among Hamilton's concerns was determining the thickness of Black skin, which he believed was greater than the thickness of white skin. Brown explains how Hamilton applied “blisters to my hands, legs and feet, which bear the scars to this day. He continued until he drew up the dark skin from between the upper and the under one. He used to blister me at intervals of about two weeks.” This

went on for nine months, Brown wrote, until “the Doctor's experiments had so reduced me that I was useless in the field.”²⁴

Hamilton was a courtly Southern gentleman, a wealthy plantation owner, a respected physician, and a trustee of the Medical Academy of Georgia.²⁵ Like many other Southern doctors of the era, he sought to scientifically prove that Black bodies were composed and functioned differently than white bodies. This was in keeping with the prevailing view of Southern white society at the time: that enslaved people were fit for little besides forced labor. Hamilton and other doctors bolstered this view, arguing that Black people had large sex organs and small skulls, which translated to promiscuity and a lack of intelligence and a higher tolerance for heat. These invented “facts,” legitimized in medical journals, justified the barbaric violence of whipping and torture used to maintain slavery.²⁶

The abuse of Black people under the guise of advancing medical discovery would continue even after slavery ended. In the early 1930s, scientists recruited Black men to participate in what would become one of the most notorious episodes in American history, the Tuskegee Study of Untreated Syphilis in the Negro Male. Between 1932 and 1972, the U.S. Public Health Service conducted a study on more than 600 Black Alabama day laborers and sharecroppers, including 399 who had syphilis and were not treated, to examine the progression of the disease.

The subjects were told that they would receive treatment for what was described as “bad blood.”²⁷ They never did. Instead, government clinicians, ignoring the pain and suffering these men endured, allowed the illness to advance. Once the men died, doctors autopsied their bodies to compile data on the ravages of the disease.²⁸

Today, Cartwright's 1851 paper reads like satire and Hamilton's supposedly scientific experiments appear simply sadistic. In 1997, President Bill Clinton apologized for the Tuskegee Syphilis Study, calling it “shameful” and “deeply, profoundly, morally wrong.”²⁹ And in 2018, a statue commemorating Sims in New York's Central Park was removed after prolonged protest that included women wearing blood-splattered gowns in memory of Anarcha, Betsey, Lucy, and the other enslaved women he brutalized.³⁰

Yet fallacies about Black immunity to pain, extra-thick skin, and weakened lung function that were introduced into the scientific literature by these and other racist doctors continue to show up in medical education today. Even Cartwright's footprint remains. Today most commercially available spirome-

ters, used around the world to diagnose and monitor respiratory illness, have a “race correction” built into the software, to control for the assumption that Black people have less lung capacity than white people. In her 2014 book *Breathing Race into the Machine: The Surprising Career of the Spirometer from Plantation to Genetics*, Lundy Braun, a Brown University professor of pathology and laboratory medicine and Africana studies, as well as a professor of medical science at Brown’s Warren Alpert Medical School, notes that the “race correction” is conventional practice, treated as fact in textbooks and still taught in many medical schools.³¹

Other unproven theories persist as well. One-third of the medical students surveyed in the 2016 study published by the National Academy of Sciences still believed the lie that Thomas Hamilton tortured John Brown to try to prove nearly two centuries ago: that Black skin is thicker than white skin.³² Even after many reckonings with its racist past, our medical establishment still has not fully accepted how the distorted beliefs that were born during slavery play a role in creating healthcare inequality today. As a result, scientists, doctors, and other medical providers—and those training to fill such positions in the future—are often unaware of their own complicity in perpetuating the internalized racism and the conscious and unconscious biases that drive them to go against their oath to do no harm.

The hospital system in Indiana where Susan Moore was treated didn’t immediately understand the hurt its staff had caused or the impact of lingering false assumptions about Black bodies and Black pain on medical decision-making. After she died, Indiana University Health conducted an external review, which concluded that Moore’s caregivers had lacked “awareness of implicit racial bias.” Though the report contended that “the medical management and technical care that Moore received did not contribute to her untimely death,” it conceded that “there was a lack of empathy and compassion shown in the delivery of her care.”³³ An earlier statement from the president and CEO of the organization seemed to blame Moore for her own death. He referred to her as a “complex patient” and said that the nursing staff at the facility might have been intimidated by her medical knowledge as she voiced her concerns and critiqued the care they were delivering.³⁴

This is how Black people get killed.

We have long understood the crisis of poor health outcomes for Black Americans as a problem of race. But this implies an inferiority of Black bodies or Black culture. What happened to Dr. Moore speaks to the pervasive, long-running racial bias in the U.S. healthcare system, an erroneous set of deep-

seated beliefs formulated during slavery and perpetuated over the decades since by social, political, and economic inequality.

In reality, it’s never been race that predicts the disease and disability that disproportionately afflict Black Americans, but racism. Until we come to terms with the discrimination and inequality in American medicine, Black people will continue to be harmed by the very system that’s supposed to take care of them.

That is how Black people get killed.

It was the signature policy proposal of the nation's first Black president, a sweeping overhaul of the healthcare system that broke a decades-long stalemate and brought health coverage to nearly twenty million previously uninsured adults. "It has now been nearly a century since Theodore Roosevelt first called for healthcare reform," President Barack Obama told Congress in the fall of 2009. "Our collective failure to meet this challenge, year after year, decade after decade, has led us to a breaking point." When the Affordable Care Act (ACA)—Obamacare, as it quickly became known—was signed into law, Vice President Joe Biden was heard leaning over to Obama and whispering, "This is a big fucking deal!"

Bigger, perhaps, than Biden even knew.

In the decade that followed, Obamacare became a touchstone for both sides of a political debate that swung numerous state and national elections. Republican promises to "repeal and replace" the law, and Democratic vows to save and strengthen it, have echoed down through just about every national election since the original bill was signed into law. On the surface, these were fights over how to fix the nation's exorbitantly priced and deeply inequitable healthcare system. But as charges of socialism and fearmongering over death panels soon revealed, deeper anxieties were also at work.

The United States is the only high-income nation that does not guarantee some form of healthcare to all of its citizens. Medicine here is a commodity, and access to it depends on a suite of factors, including age, income level, employment status, geographic region, and—to an alarming and undeniable extent—race. African and Latino Americans have the highest uninsured rates in the country and, as a result, shoulder a disproportionate burden of the

health system's failings: they are more likely to die during pregnancy or from cancers that are treatable when caught early, and more likely to suffer the worst outcomes associated with chronic medical conditions like diabetes.

But while the picture is particularly bad for people of color, they are hardly the only ones suffering from the healthcare system's failings. In fact, America has the lowest life expectancy, the highest incidence of chronic disease, and the highest rate of avoidable hospitalizations and avoidable deaths when compared to other high-income countries, despite spending more money on healthcare by far.²

The ACA managed to put a measurable dent in at least some of these grim statistics. But its successes have been uneven and precarious. Republican-led states have spent years resisting the law however they could, including through relentless legal challenges and misinformation campaigns. Twelve states (most of them in the former Confederacy) refused to participate in the ACA's central provision: an expansion of Medicaid, the federal program that provides health coverage to low-income Americans. And in at least twelve other states, Republican lawmakers have tried to restrict access to that program through cumbersome work requirements.

This struggle—between using state resources to provide citizens with healthcare and withholding those resources from people deemed unworthy of support—has become one of the biggest conflicts in contemporary politics, not to mention an incredibly consequential debate for the future of the country's health and well-being. But it's not new. It began during Reconstruction, with four million newly emancipated African Americans.

In the aftermath of the Civil War, the nation faced a full-blown humanitarian disaster. Freed people did not have enough food, clothing, shelter, or medical care. They were plagued by dysentery, cholera, and a bleak roster of other diseases. And they had no reliable help for addressing these problems. Hospitals were few and far between at that time, and most of them were either overwhelmed by the needs of white citizens—to whom hospital administrators granted priority—or unwilling to admit formerly enslaved people under any circumstances, or both. As a result, the death toll of Black people surpassed that of white people by an overwhelming and consistent margin. As the historian Jim Downs details in his 2012 book *Sick from Freedom*, the newly emancipated died in such high numbers that in some communities their bodies littered the streets.

Smallpox was one of several killers that hopscotched across the South dur-

ing this period. It invaded the makeshift “contraband camps” where Black Americans had taken refuge during the war but left the surrounding mostly white communities comparatively unscathed. The pattern of affliction was no mystery: in the late 1860s, scientists had yet to discover viruses, but they knew that poor nutrition made people more susceptible to illness and that poor sanitation contributed to the spread of disease. They also knew that quarantine and vaccination could help quell outbreaks; they had used those tools to prevent the very same diseases from ravaging the Union army.³

In one of their first attempts to claim the rights of citizenship, at least some freed people asked that the same methods be employed in their own burgeoning communities. As Downs notes, one group of newly emancipated men asked for humane quarantine facilities to be erected; others asked for latrines to be moved away from tents in refugee camps. But rather than help these communities, Downs writes, medical authorities often blamed them for causing diseases to spread.⁴

Some of these debates took place in the context of the Freedmen’s Bureau. Congress had established the bureau in 1865 as a federal entity meant to oversee the transition from slavery to freedom, including helping the newly emancipated become a paid workforce at the close of the war and ensuring that they were treated equally in judicial procedures. But elected officials were deeply divided over what this bureau’s responsibilities should be, or whether it should even exist at all, and some of the disputes concerned healthcare. Some lawmakers, including a contingent of Radical Republicans, believed it was the government’s duty to provide medical assistance and other aid to freed people. Opponents of the bureau, including President Andrew Johnson and most Democratic members of Congress, argued that such assistance would only breed dependence, which would keep freed people from returning to the plantations, where their labor was still needed. Black people were idle and depraved by nature, they said. And when it came to Black infirmity, hard work was a better salve than any medicine.⁵

Nevertheless, in 1865, the bureau’s commissioner, General O. O. Howard, inaugurated its Medical Division, which, in turn, worked to establish a system of hospitals for the formerly enslaved across the postwar South.⁶ The program was unprecedented—the first federally funded healthcare system ever created in the United States—but its goals were never entirely humanitarian. The bureau director put in charge of the program aimed to provide just enough care to just enough freed people to maintain the plantation labor force. And from the start, the program’s efforts were mired in anxiety over Black dependency. Officials deployed a mere 120 or so doctors across the war-torn South, then

ignored those doctors’ pleas for personnel and equipment. They erected more than forty hospitals, often in response to specific medical emergencies in specific jurisdictions, but shuttered most of them long before those emergencies had been resolved or the freed people’s medical needs addressed. These contradictions reached their apotheosis in the fall of 1866, when white doctors in Charlotte, North Carolina, discovered smallpox in their city’s only hospital for freed people. Terrified, and with no other means of preventing the disease from spreading, they did the only thing they could think of: they burned their own hospital to the ground.⁷

As the smallpox epidemic persisted, and the death toll continued to rise, those who opposed providing any assistance to freed people developed a new and darker argument: Black people were so ill-suited to freedom that the entire race was going extinct, and the best lawmakers could do was let nature take its course. “No charitable black scheme can wash out the color of the Negro, change his inferior nature or save him from his inevitable fate,” Ohio Democratic congressman Samuel Cox said in 1865 on the floor of the House of Representatives.⁸ Several newspapers agreed, including *The New York Times*, which wrote that the “mortality of the negroes” continued to be very great and that “dirt, debauchery, idleness are the causes of this inordinate mortality.”⁹

One of the most eloquent rejoinders to this theory of Black extinction came from Rebecca Lee Crumpler, the nation’s first Black female doctor. Crumpler was born free and trained and practiced in Boston. But at the close of the war, she joined the Freedmen’s Bureau and worked in the freed people’s communities of Virginia. In 1883, she published one of the first treatises by a Black writer on the burden of disease among Black communities. Her book, which addressed Black women specifically, was intended to serve as a call and a guide for the newly emancipated—a message that they could and would survive, even amid so much hatred and neglect. But Crumpler might as well have been speaking to Congressman Cox directly when she wrote that the nation’s lawmakers “seem to forget that there is a *cause* for every ailment, and that it may be in their power to remove it.”¹⁰ Those causes were external, she explained, not innate.

Crumpler died in 1895, but her spirit lived on in an organization founded that same year, the National Medical Association (NMA), a pioneering organization of Black doctors. Its first president, Robert F. Boyd, had been born into slavery. Through annual conferences and its own medical journal, the NMA became the leading voice on issues surrounding the health and medical treatment of Black people and other disadvantaged groups. As the founding editor

of the organization's journal wrote, the NMA was "conceived in no spirit of racial exclusiveness, fostering no ethnic antagonism, but born of the exigencies of the American environment."¹¹ And one of the best ways to improve health outcomes, the NMA understood, was through increased access to healthcare. At the start of the twentieth century, the group began to argue for nationalized medicine.

This argument, of course, went nowhere. In the decades following Reconstruction, the former slave states came to wield enormous congressional power through a voting bloc that was uniformly segregationist and overwhelmingly Democratic. During the 1930s, Southern congressmen headed many of the key committees in Congress. They used this power to ensure that New Deal measures did not threaten the nation's racial stratification. For example, as the Columbia University historian Ira Katznelson and others have documented, it was largely at the behest of Southern Democrats that farm and domestic workers—who made up more than half the nation's workforce at the time, and an even higher percentage of the Black workforce—were excluded from New Deal policies, including the Social Security Act; the Wagner Act, which ensured the right of workers to collective bargaining; and the Fair Labor Standards Act, which set a minimum wage and established the eight-hour workday. The same voting bloc ensured that states controlled crucial programs like Aid to Dependent Children and the 1944 Servicemen's Readjustment Act, better known as the GI Bill. In the South, especially, state leaders then excluded Black Americans from these programs through a variety of dubious mechanisms, including by creating onerous and subjective tests for determining need.¹²

Southern Democrats also secured local control of other federal healthcare programs under the mantra of "states' rights." In 1945, when President Truman called on Congress to expand the nation's hospital system as part of a larger healthcare plan, they obtained key concessions that excluded Black Americans both explicitly and implicitly and would shape the American medical landscape for decades to come. The Hill-Burton Act provided federal grants for hospital construction to communities in need and gave funding priority to rural areas, many of which were in the South and predominantly Black. But the law also put state leaders in charge of disbursing those funds and did not make any rule against segregating the new facilities. As a result, white communities were prioritized, and Black Americans in the rural South were left in the worst of circumstances: living in the least-resourced part of

the country, and deliberately excluded from the exact program meant to fix that problem.¹³

Employer-based health insurance, which took off in the wake of World War II, put yet another hurdle between African Americans and equitable healthcare. "They were denied most of the jobs that offered coverage," says David Barton Smith, an emeritus historian of healthcare policy at Temple University. "And even when some of them got health insurance, as the Pullman porters did, they couldn't make use of white facilities." White doctors helped widen the gap even further: professional societies like the American Medical Association (AMA) allowed Black doctors to be excluded, medical schools barred Black students, and most hospitals and health clinics segregated Black patients. The cumulative effect of these and other privations was to leave Black Americans with statistically shorter, sicker lives than their white counterparts.

But Black communities of the 1930s, '40s, and '50s were no more apt to accept these exclusions than their forebears. Echoing the efforts of Crumpler, Black women began a national community healthcare movement that included fundraising for Black health facilities; campaigns to educate Black communities about nutrition, sanitation, and disease prevention; and programs like National Negro Health Week that drew attention to racial health disparities.¹⁴

One of the leaders of this effort was the NMA. By the 1950s, after a decades-long debate, its members were pushing aggressively for a federal health-insurance program that would serve all citizens equally—a fight that put them in direct open conflict with their colleagues at the AMA.

The AMA was vehemently opposed to nationalized healthcare. Its members had already defeated two such proposals in the late 1930s and '40s, with a vitriolic campaign whose slogans still reverberate today: they called the idea socialist and un-American and warned of government intervention in the doctor-patient relationship. In the early 1960s, when proponents of a national health plan introduced Medicare, the AMA quickly and aggressively revived those same arguments, and doctors' wives organized "coffee meetings," where they persuaded friends to write letters opposing the program. Their effort, dubbed Operation Coffee Cup, secured an endorsement from Ronald Reagan, who in 1961 recorded an album with a gravelly voiced speech warning that Medicare would lead to "statism or socialism."

But this time, the NMA delivered a countermesssage of its own: healthcare was a basic human right, inextricably bound to racial equality. "Man is such a slow learner," NMA president William Montague Cobb said of the fight. "But

let us recognize our mistakes and remedy them, without having to repeat the historical process again and again and again."¹⁵


Together, Medicare and Medicaid helped bring hospital segregation to a circuitous but definitive end: the 1964 Civil Rights Act outlawed segregation for any entity receiving federal funds, and Medicare and Medicaid soon placed every hospital in the country in that category. The programs also secured reliable healthcare for whole swaths of the population—namely, low-income and elderly Americans—for the first time.¹⁶ As has happened so often in our history, Black struggles for equality resulted in greater rights for all Americans. In its fight to secure healthcare for Black Americans, the NMA helped to dramatically improve access for citizens across the racial and socio-economic spectrum.

Many forces have prevented the United States from achieving universal healthcare, including a failure to properly regulate the trillion-dollar healthcare industry and a near-total unwillingness to grapple with the ethics of for-profit medicine. But the role of racism and the legacy of slavery cannot be denied. The same arguments—about dependency and socialized medicine, equity and human rights—that thwarted the Freedmen's Bureau Medical Division in Crumpler's time and blocked universal healthcare during Cobb's time have echoed down to the present day.

People of color continue to suffer most from the failure to resolve these arguments; Black and Latino Americans still have the highest uninsured rates in the country and still shoulder a disproportionate share of the nation's poor health outcomes. But they are not alone. After all the debates and elections and bills and lawsuits, millions of Americans—of every race, ethnicity, and political persuasion—still don't have health insurance of any kind, and millions more are still forced to ration crucial medications, or to forgo critical procedures, or to choose in some other way between receiving healthcare and meeting other essential needs.

In the end, everyone is harmed.

In 1918 and 2020, race colors America's response to epidemics

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Soraya Nadia McDonald

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In American epidemics, race is a preexisting condition.

Whether it's the influenza pandemic of 1918 or COVID-19 over a century later, race and ethnicity have been, and continue to be, enormous factors in determining whether people will receive medical attention when they become ill, and the sort of attention they will receive.

In "The 1919 Influenza Blues," Essie Jenkins documented the toll the flu took on the country, noting that viruses don't discriminate when it comes to their victims. She sang:

*"People died everywhere
death went creepin' through the air
and the groans of the rich
sure were sad*

*But it was God's own mighty plan
He's judging this old land
North and South, East and West
can be seen*

*He killed rich and poor
and he's going to
kill some more ..."*

According to the Centers for Disease Control and Prevention estimates, the 1918 flu infected 500 million people worldwide and resulted in 50 million deaths around the globe, 675,000 of which were American. But while viruses don't discriminate, people do. In cities across the nation, black people struck by the flu were often left to fend for themselves. They received substandard care in segregated hospitals, where they could be relegated to close quarters in basements, or they were only allowed admittance to black-only hospitals. Even in death, black bodies were neglected by white public infrastructure. In Baltimore that year, white sanitation department employees refused to dig graves for black flu victims after the city's only black cemetery, Mount Auburn, could not accommodate any more graves.

"The mayor then had to appeal to the War Department, which is now called the Defense Department," said Marian Moser Jones, a social historian and ethicist of public health at the University of Maryland. "The War Department sent 342 black soldiers, black American soldiers to do the task, which is very much in keeping with the way black soldiers were treated by the Army in the war. They were detailed to the worst duties, the most grueling labor details were the ones who were most often sent out to clean out the trenches after a battle and even exhume and rebury dead soldiers' remains.

"It's sort of a continuity from the war. The resources that were there, that were limited, the resources to address African American health and even death were overwhelmed in cities like Baltimore."

The flu epidemic is inextricably linked to World War I. The first cases in the U.S. were identified in soldiers living in close quarters in Army barracks before heading to Europe to join the war, which the United States entered in April 1917. Even the name that we use to identify the disease, the "Spanish flu," is inaccurate, according to historian Kenneth C. Davis, author of *More Deadly Than War: The Hidden History of the Spanish Flu and the First World War*.

"Fear driven by propaganda, censorship and lies were so much a powerful part of the spread of the Spanish flu. People were misled, often deliberately, by officials," Davis said. "Newspapers were censored. The reason it is the Spanish flu is because of censorship. [During the war] Spain was a neutral country. It didn't censor its news reports as rigorously as some of the warring countries did, so the first report of a massive epidemic comes out of Madrid in the spring of 1918 and that's the reason it was reported by Reuters in London that Madrid was under a mass epidemic. That's the reason it was called the Spanish flu. It certainly didn't originate there."

Today, in the age of COVID-19, it's worth examining the social dynamics of 1918 and how their legacy continues to shape modern public health.

"A lot of my historian friends have a cottage industry now talking about the lessons learned. I'm a bit more cautious," said Vanessa Northington Gamble, a medical doctor and professor of medical humanities and American studies at George Washington University. "Who you are — and I mean in terms of your race, your gender, where you live — will have a major role in how you experience COVID-19. It also will play a major role in the services that you get. ... If there's anything we can learn from the 1918 influenza epidemic, is that we really have to look at issues around race and class and racial and social inequities."

Race and patient care

When the flu epidemic of 1918 came to Chicago, black people were blamed, and that blame came directly from John Dill Robertson, the city's commissioner of public health. It wasn't just white medical officials who engaged in this sort of blame. Robertson had a tremendous influence on the way the *Chicago Tribune* covered migration, and there, the prejudice was plain. Even before the pandemic reached Chicago, the *Tribune's* coverage of migration was alarmist.

A March 5, 1917, headline from the *Chicago Daily Tribune*, as it was known at the time, blared, *Rush of Negroes to City Starts Health Inquiry*.

The flu simply heightened those existing prejudices.

Half a Million Darkies from Dixie Swarm to the North to Better Themselves, the paper proclaimed July 8, 1918. In the corresponding article, reporter Henry M. Hyde laid out a series of pathologies: Black people moving to Chicago from the South, he wrote, "are compelled to live crowded in dark and insanitary rooms; they are surrounded by constant temptations in the way of wide-open saloons and other worse resorts."

The reason for such ills wasn't any innate inferiority that could be attributed to blackness. In an academic paper about Jim Crow and public health, Betsy Schroeder Schlabach, a professor of history and African American studies at Earlham College in Richmond, Indiana, explained how discriminatory housing policies created ghettos. Black people were relegated to limited parts of the city. Housing was overcrowded, and white landowners became slumlords, charging rents that were 15% to 25% higher for black tenants, and then refused to make needed repairs when asked.

"The way that the *Tribune*, especially, talks about disease is the same way they talk about the Great Migration: swarms of migrants coming to the city and bringing with them all sorts of disease," Schroeder Schlabach said. "There's similar ways that today we talk about the border or the way definitely [President Donald] Trump talks about immigration crisis and disease."

Interestingly, the Nov. 2, 1918, edition of the *Cleveland Advocate* bore the headline: *Flu Shuns Us, Says Health Doctor*, referring to black people. The idea that black people were not getting the flu, or dying from it the way white people were, was a widely held belief at the time, Gamble said. Getting a clear picture of what black people experienced nationally during the flu pandemic is difficult. Gamble thinks that segregated black neighborhoods may have functioned as a makeshift quarantine. But it's also likely that instances of black illness were underreported.

"The only year in the 20th century when black people in the USA had lower influenza mortality than white people was 1918," researchers Helene Økland and Sverre-Erik Mamelund wrote in the *International Journal of Environmental Research and Public Health*. "One hypothesis is that black people, who mainly lived in the South and under miserable living and working conditions, cramped conditions, white racism and violence, and poor medical care, were less susceptible to the 1918 influenza pandemic autumn wave due to higher exposure to the less virulent spring and summer waves. However, this hypothesis, the mechanisms for the crossover in the role of race in 1918 pandemic mortality, and the subsequent return to the 'normal' pattern of higher black than white mortality in 1919, have received little attention in the literature, nor has this [or other] hypothesis been theoretically or empirically substantiated."

Gamble was also circumspect about fully trusting black infection statistics. "I do not say it's definitive. There's some indications [that black people were less affected]," she said. "And black physicians believed it too. But even if the incidence was lower, the number of black people who got influenza in 1918 overwhelmed the health care and social services institutions that were available to black people. So black hospitals were overwhelmed. Black nurses were overwhelmed. Things such as the National Urban League, they had volunteers to go into homes to try and take care of people. They were overwhelmed, and especially because the black community, for the most part, was left on its own."

Schroeder Schlabach found that Robertson's public health edicts functioned as another layer of Jim Crow laws, limiting the movement of black Americans, and effectively quarantining them to ghettos on the city's South Side. Public health officials became a de facto police force. Beginning in 1917, Robertson's health department passed 75 regulations, regulating where people could drink water to where children could play. It also implemented mandatory reporting of flu cases.

"If you caught influenza, you were obligated to self-quarantine and then report that you had caught it to the Department of Public Health, and then they would come to your house and placard your house, like put a big red sign up on your house," Schroeder Schlabach said. "That served to stigmatize disease. The Public Health Department sent visiting nurses on expeditions to find people who were sick. They would visit homes, and that resulted in about 40,000 visits [across the city] during the pandemic where nurses and public health officials could come into your house without your permission and ask if you were infected."

“What that does, especially for black households during the pandemic, is it takes away the sanctity of the home, giving the Public Health Department, who also had the power of the police, entering into your home. For the black family in early 20th-century Chicago, that’s a direct threat to their safety. These ordinances about mandated reporting of disease were the ones that functioned similarly to Jim Crow laws that regulated all facets of black life.”

Black people who were wealthy enough could visit a doctor in his office. Dr. Roscoe Giles, for example, placed ads in *The Chicago Defender* announcing his services. But for those who were less fortunate, Provident Hospital, the nation’s first black-owned and -operated hospital, was one of the few places where black people could be seen and treated. While black medical schools, such as Howard University Medical School, which grew out of the Freedmen’s Hospital in Washington, and Meharry Medical College in Nashville, Tennessee, were instrumental in turning out black physicians, Provident was crucial in training black nurses.

The Defender also ran columns by Dr. Wilberforce A. Williams advising black readers how to avoid the flu.

“He combines really practical advice about washing your hands, covering your mouth when you cough, but also, ‘If you want to be a good black citizen, donate to these things,’ or, ‘Live hygienically, and that means you can be a good person,’ ” Schroeder Schlabach said. “I found that to be a really interesting mix in his articles. In one article, he chastises a young mother who didn’t want to report that her child had contracted the disease because she feared social isolation. He just rakes her over the coals like, ‘This is foolish. You can’t put your pride before the well-being of the community.’ ”

Even as they were relegated to inadequate medical facilities, with black doctors and nurses facing shabby treatment and disrespect, black people still found ways to make the best of horrible situations.

“Black Chicagoans responded with innovation and tremendous grit and determination,” Schroeder Schlabach said. “At one point, the Public Health Department mandated that people needed to wear a mask. And what a group of black Chicago ladies do is that they start innovating with the masks and making them out of delicate lace and exquisite jewels. So even in the face of the pandemic, they were looking fabulous in these diamond-studded flu veils. Doctors and nurses just refused to accept any form of segregation. They’re more like icons. I see that as remarkable determination.”

Race, professionalism and modern inequality

The effects of America’s doctrine of separate and unequal life permeated everything during the 1918 flu epidemic. It not only shaped who received treatment and where, but also which people were deemed qualified to provide medical care.

In the midst of the first World War and the flu epidemic, there was a hope that black people could prove themselves as full Americans by serving their country, both in the medical field and in the military. The occupations, they hoped, would function as a “citizenship machine.”

“It was W.E.B. Du Bois who really motivated African Americans to enlist and join the Army,” Davis said. “He thought this would really prove how they were loyal Americans who could make a great contribution to the war effort and to fighting. And some of the first American troops to go to France were African American troops, including the very famous group known as the Harlem Hellfighters.”

Yet white institutions like the American Red Cross (ARC) were loath to accept black nurses into their ranks to help with the war effort until the situation was so dire that they had no choice.

"Many African American women were rebuffed by ARC chapters when they sought to participate, and had to create their own alternatives for wartime voluntarism," Moser Jones wrote in a case study of the American Red Cross's response to the flu pandemic. "Similarly, black women seeking to enroll as ARC nurses met with frustration. During the war, the ARC served as the official recruiter of nurses for the U.S. Armed Forces. The nursing division, which required every ARC nurse to have completed three years of training in an accredited nursing school, enrolled 24,000 trained nurses. Trained black nurses, however, were rejected for service abroad, and were only enrolled as reserve members of the home defense program."

"They were finally allowed to come in and treat white soldiers, but they were still of course living in segregated facilities," Davis said. "So, even the angels of mercy taking care of these dying soldiers still had to confront the racism of the day."

A job listing in the December 1918 *Monthly Bulletin of the Department of Public Health and Charities of the City of Philadelphia* was openly discriminatory:

There are four vacancies for assistant physicians at the Philadelphia Hospital for the Insane. Thirty-fourth and Pine Streets, two at a salary of \$900 per annum and two at \$720 per annum, including board, lodging, and laundry. Applicants must be white, twenty-one years of age, residents of Philadelphia, and licensed to practice in the State of Pennsylvania. These positions are open to both sexes. Successful candidates must reside at the hospital.

The Nov. 2, 1918, edition of *The Chicago Defender* reported that a black nurse named Olive Walker in Ohio was "denied the privilege of helping the Red Cross nurse committee to down the influenza epidemic at Hiram College. The dean of the college refused to allow her to serve when he became aware of her racial identity." Lincoln Hospital in New York would hire black nurses, but not black physicians, Gamble said. And even the famous Dr. Giles of *The Chicago Defender* was asked to leave a new job at a tuberculosis sanitarium after six hours on the job. White patients didn't want him to treat them.

Public health historians say that prejudice in American health care is once again at the forefront with the emergence of COVID-19. This time, Asians are the target of racialized scapegoating, from the Trump administration labeling COVID-19 the "Chinese virus" to Asian Americans being blamed for the pandemic's presence in America.

"I called my mother, who works at a hospital in Northern California," wrote Frank Shyong, a columnist for the *Los Angeles Times*. "I asked her to stay home, but her boss told her if she didn't show up, she would lose her job. At work, patients sometimes refuse to be seen by her, because suddenly an Asian woman in a face mask is a threat."

In November 1918, the Rev. Francis J. Grimke preached a sermon about the flu epidemic and what lessons could be gleaned from it. His words, delivered to the 15th Street Presbyterian Church in Washington, still hold tremendous relevance:

Jesus said, "The first and great commandment is, 'Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind, and with all thy strength.' And the second is like unto it, 'Thou shalt love thy neighbor as thyself.' Upon these two commandments hang all the law and the prophets." Race prejudice, colorphobia, runs directly counter to both of these great commandments. And, therefore, never mind what the white man may think of it, we see clearly what God thinks of it, and it is the estimate that He puts upon it that is to determine its character. Let us hope, therefore, not only for the sake of people of color, but also for the sake of the white people themselves that the great lesson as to the folly of race prejudice — of assuming that a white skin entitles one to better treatment than a dark skin, which this epidemic has so strikingly taught, may not be lost upon them. It is a lesson which for their own sake it is well for them to learn. It will be better for them here, and it will be better for them hereafter, if they learn it, and learn it well. And, of course, it will be better for us as a race in this country. It will remove out of the way some very serious obstacles to our progress, and will relieve us of many of the disagreeable things that we are at present forced to endure, though not without protest.

COVID-19 has not only brought interpersonal racism to the fore, but heightened the degree to which structural racism affects treatment and care.

Public defender Scott Hechinger and defense attorney Rebecca Kavanagh have pleaded with officials to release inmates as COVID-19 has spread through the close quarters of Rikers Island, New York City's main jail complex. Similar situations exist in U.S. Immigration and Customs Enforcement detention facilities, where detainees are facing shortages of soap. Both places disproportionately house black and brown people.

"My worry is that there will be two standards of care, that incarcerated patients with one set of symptoms may be denied access to hospitals, even though in the community people with the same sets of symptoms do go to the hospital," Dr. Homer Venters, the former chief medical officer for New York jails, told *The Guardian*. "And then that will lead to different rates of deaths and certainly to different rates of preventable deaths among people who are behind bars."

As with the 1918 flu, responses, or lack thereof, to COVID-19 have become tied up with patriotism and xenophobia in ways that exacerbate the spread of disease. In the midst of the 1918 pandemic, Philadelphia hosted a massive parade to sell war bonds to pay for the American war effort.

"There was enormous pressure," Davis said. "If you didn't buy the war bonds, you weren't doing your part. You were a slacker. So 200,000 people go out, even though the health department knows that the virus is in and around Philadelphia, on the Navy bases, and they were going to have this parade and soldiers and sailors were going to be marching in the parade. Two days after that parade, every hospital bed in Philadelphia was filled and it was a complete disaster and it was a disaster because the authorities ignored the advice not to cancel this parade."

In a live chat with constituents on Facebook, Tate Reeves, the governor of Mississippi, explained his opposition to giving official orders to the public to implement COVID-19 quarantines. "Eric Worth [a constituent] says 'China did a lockdown and it was good for them. Why can't Mississippi?' Well, Eric, I'm going to tell you that Mississippi is never going to be China," Reeves said. He has since given a shelter-in-place order to one county in the eastern part of the state, but insisted that a statewide shelter-in-place order was "not sustainable."

In 1918, "things like the war effort and paying for the war and patriotism and support for the war, really outdid the concern for public health," Davis said. "They were so interested to keep the troops going to Europe that they kept filling these ships up with sick men and these ships became what were called floating coffins. So, that's a really important lesson as well. Misplaced priorities. When you place things like the economy over the public health, you do so at grave peril to many, many people."

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How unjust police killings damage the mental health of Black Americans

H news.harvard.edu/gazette/story/2021/05/how-unjust-police-killings-damage-the-mental-health-of-black-americans/

Christina Pazzanese

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Health & Medicine

Health & Medicine

Harvard Chan's David R. Williams, whose research looks at how discrimination affects Black people's health, appeared on "60 Minutes" in April.

Courtesy of Harvard Chan School

Research tracks the ways racial discrimination wreaks a physical, psychological toll

Since the murder of George Floyd by Minneapolis police officer Derek Chauvin, many African Americans have reported feeling overwhelmed at times by the trauma, anguish, and outrage stirred up by Floyd's death, as well as other incidents of police violence against Black victims. The disturbing frequency of these events, and the relentless news coverage of them in the last year, has been taking a real emotional toll.

A first-ever study in 2018 found that a police killing of an unarmed African American triggered days of poor mental health for Black people living in that state over the following three months — a significant problem given there are about 1,000 police killings annually on average, with African Americans comprising a disproportionate 25 percent to 30 percent of those. The accumulation of painful days over the course of a year was comparable to the rate experienced by diabetics, according to the study's author, David R. Williams, Florence Sprague Norman and Laura Smart Norman Professor of Public Health and chair of the Department of Social and Behavioral Sciences at the Harvard T.H. Chan School of Public Health.

Williams, a leading expert on the social influences of health and a professor of African and African American Studies and Sociology at Harvard University, spoke with the Gazette about what he's seen in the past year, the mental and physical tolls discrimination take on Black lives and what individuals can do to help mitigate them.

Q&A

David R. Williams

GAZETTE: This is a new area of scholarly inquiry. What have you found thus far about the causal links that police killings have on Black people's mental health?

WILLIAMS: What we sought to do was to identify if a police killing of civilians had negative effects not just on the victim's family, immediate relatives and friends, but on the larger community. We looked at every police shooting in America over a three-year period [between 2013–2015] and then linked that, in a quasi-experimental design, with data from the CDC [Centers for Disease Control and Prevention] on the mental health of the population in every state. And what we found was that every police shooting of an unarmed Black person was linked to worse mental health for the entire Black population in the state where that shooting had occurred for the next three months.

It wasn't every police shooting that did that. If the Black person was armed, there was no negative effect on Black mental health. We also didn't find any effect of police shootings of Blacks, armed or unarmed, on the mental health of whites in those states. And we didn't find any effect on Black mental health of police shootings of [unarmed] whites. So we found a very specific effect. We think it's both the perception of it being unfair and the greater sense of vulnerability that it creates.

GAZETTE: Were you surprised at all by those results?

WILLIAMS: It's a striking finding, and it's the first time it has been documented in that way. On the other hand, it's not totally surprising. There's a body of evidence emerging that suggests these incidents are having a negative impact not just on [victims'] family members, but there's a broader community grieving; there's a broader "threat" to the community; there's a broader increase in personal vulnerability that's having mental health consequences. ... We are still in the beginning of understanding of what is happening.

" ... it is not just what happens in the big things, like at discrimination at work or in interactions with the police. But there are day-to-day indignities that chip away at the well-being of populations of color ..."

GAZETTE: Since the murder of George Floyd in May 2020, there's been a heightened focus on police violence and anti-Black racism in the country. Between video, audio, expert analysis, and ordinary conversation, as well as acts of police violence and intimidation of Black Lives Matter protestors, how do you think this last year has affected the mental health of Black people?

WILLIAMS: I haven't done any specific work on this specific topic in the last year, but I want to emphasize that we're dealing with two pandemics. On the one hand, we're dealing with the pandemic of racial injustice, as captured by police shootings. But we're also dealing with the pandemic of COVID-19, which has had a disproportionate, negative impact on populations of color. If you look at the data for the African American population, for the Latinx population, for the Native American population, for Native Hawaiians and other Pacific Islanders, all those populations have death rates from COVID-19 that are at least twice that of whites. So we are looking at populations that are dealing with increased experiences of grief and loss at a time when people can't come together and mourn and go through the grieving process in the normal ways because of the pandemic.

The economic impact of the COVID-19 pandemic has also been much more severe on poor Americans of all racial/ethnic groups, and on African Americans and Latinos, in particular. So we are looking at populations that are also dealing with elevated levels of financial stress.

There is a vaccine for the COVID 19 virus, but there is no vaccine for mental health. So as a nation, as community leaders, as public health leaders, we need to think about how we provide the support and the resources and create the spaces to help people deal with the trauma, the emotional, physical symptoms — anxiety, helplessness, nausea, headaches — that they may be struggling with.

I believe we are seeing emerging mental health effects right now. Longer term, I would expect that we would see some adverse physiological effects. There is a body of research — I haven't done most of it, but my work is consistent with it. Some scientists use the term "accelerated aging"; in other studies, they use the term "biological weathering." What that body of research is suggesting to us is that in the United States, African Americans are aging biologically more rapidly than whites. At the same chronological age, African Americans are 7.5 years older or 10 years older, on average, compared to their white counterparts. We think that what this more rapid aging and physiologic deterioration reflects is the accumulation of all of these negative, stressful exposures in the physical, chemical, and psychosocial environment.

The Everyday Discrimination Scale

The Everyday Discrimination Scale (EDS) it is used as a measure of subjective experiences of daily discrimination against the minority population. This measure contains nine elements that assess the person's daily life, followed by a follow-up question about what the person believes was the reason for that daily discrimination. This measure also presents a short version of five elements. It takes five to 10 minutes to administer.

In your day-to-day life, how often do any of the following things happen to you?

1. You are treated with less courtesy than other people are.
2. You are treated with less respect than other people are.
3. You receive poorer service than other people at restaurants or stores.
4. People act as if they think you are not smart.
5. People act as if they are afraid of you.
6. People act as if they think you are dishonest.
7. People act as if they're better than you are.
8. You are called names or insulted.
9. You are threatened or harassed.
10. You are followed around in stores.

Recommended answer categories for all items

- Almost every day
 - At least once a week
 - A few times a month
 - A few times a year
 - Less than once a year; never
-

Follow-up question: Asked only of those answering “A few times a year” or more frequently to at least one question.

What do you think is the main reason for these experiences? (check more than one, if volunteered)

Your Ancestry or National Origins

Your Gender

Your Race

Your Age

Your Religion

Your Height

Your Weight

Some other Aspect of Your Physical Appearance

Your Sexual Orientation

Your Education or Income Level

Other possible categories to consider:

A physical disability

Your shade of skin color

Your tribe

Other (specify)

Developed for the Chicago Community Adult Health Study (CCAHS)

Source : Sternthal, M., Slopen, N., Williams, D.R. “Racial Disparities in Health: How Much Does Stress Really Matter?” Du Bois Review, 2011; 8(1): 95-113.

GAZETTE: You also study the effects that racism has on Black physiological health. You developed a very widely used scale to measure a person's exposure to everyday discrimination that you say is highly predictive of health problems. What have you learned so far?

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WILLIAMS: The evidence is clear that discrimination matters for health. And it is not just what happens in the big things, like at discrimination at work or in interactions with the police. But there are day-to-day indignities that chip away at the well-being of populations of color: How often do people act as if you are not smart? How often do people act as if they are afraid of you?

We found what we call in scientific research a “dose-response relationship” between the number of stressors individuals score high on and the number of depressive symptoms. So the more domains of stress you are high on, the higher are your levels of depressive symptoms. So reports of discrimination are linked to worse mental health, and also linked to lower levels of engagement with the health care system. People who score high on the everyday discrimination [scale] are less likely to follow through on the recommendations from their [health care] provider in terms of screening and follow-up tests.

A review of studies of discrimination and sleep found that in every single study, no exception, discrimination was associated with poorer sleep, both in quantity and in quality. We also see higher levels of everyday discrimination linked to increased obesity. We see it linked to a broad range of health outcomes ... incident diabetes, incident cardiovascular disease, incident breast cancer ... as well as a range of other underlying indicators of chronic disease, such as inflammation. So the evidence is clear: These little indignities add up and take a toll on individuals.

GAZETTE: One key revelation is that while income and education levels are influential drivers of health for every racial group, they provide less of a buffer from the negative effects of discrimination for Black people.

WILLIAMS: My motivation for developing the everyday discrimination scale was to try to understand the stress of racial discrimination and the contribution that it makes to the racial disparities in health. When my career started, most researchers thought that racial differences in health were simply a function of racial differences in income and education and occupational status. For most indicators nationally, the gaps in health between whites with a college degree and whites who have not finished high school is bigger than the Black/white gap. And the gap within African Americans between the college-educated and those who have not finished high school is bigger than the Black/white gap. So income and education matter for your health, regardless of your race.

But at the same time, race still matters. At age 25, for example, the worst-off whites, in terms of future life expectancy, [are those] who have not finished high school. But they live 3.1 years longer than African Americans who have not finished high school. The gap widens as education increases, with a 4.2-year gap among college-educated whites and Blacks.

There is a stunning statistic [from] analyses we did: The best-off African Americans in terms of life expectancy at age 25, those with a college degree, have lower life expectancy than whites with a college degree; have lower life expectancy than whites with some college education; and have lower life expectancy than whites who have finished high school. [That] tells us there’s something profound about income and

education that drives health regardless of your race, but there's something else about race that matters even after we've taken income and education into account. That's why I began to look at what else is it in the social environment? What does it mean to be Black in our society, and how does that shape health?

GAZETTE: Aside from stopping these police killings and eliminating racism, what steps can individuals take today to protect their own mental and physical health?

WILLIAMS: What research shows quite compellingly is that the quality of social relationships can have a huge impact in reducing the negative effects of discrimination and of other types of stressful experiences. One study looked at African American teenagers at ages 16, 17, and 18 and measured the discrimination that those adolescents reported. Those kids who [scored] consistently high on reported discrimination at 16, 17, and 18 had higher levels of stress hormones — cortisol, epinephrine, norepinephrine — higher levels of inflammation (C-reactive protein), higher BMI [Body Mass Index], and higher blood pressure by age 20, not age 30 or 40. However, that association is completely erased, it's not evident, among those teens who had good, supportive relationships with their parents, their teachers, and their peers. So the quality of social ties seems to be an effective strategy to reduce all or at least some of the negative effects of discrimination. Building that sense of community is important.

Another resource that's particularly powerful in the African American community is religion: A national study of Black Americans found that higher levels of religious engagement, as measured by church attendance, by greater supportive contact with members of their religious community, and by "seeking God's guidance in their everyday life," those three religious strategies, reduced the negative effects of exposure to racial discrimination on mental health.

Another example [comes from] a study done among First Nation communities in Canada, indigenous communities. As a group, this population had some of the highest rates of youth suicide in the world. But researchers were struck by the fact that half of the almost 200 communities had no suicides at all in the previous five years. What they found was that those communities that were involved in challenging the federal government of Canada over treaty rights, over control of their public services (their schools, health care, etc.), and that had places in the community where their traditions were celebrated, had lower rates of suicide. Each of those indicators — of protest, advocacy, and empowerment — was associated with the lower rates of suicide. It suggests that being engaged and fighting for one's future and trying to make a difference is actually a resource that is protective for at least some mental health outcomes.

Interview has been edited for clarity and length.



"Diseases and Peculiarities of the Negro Race"

"Diseases and Peculiarities of the Negro Race," by Dr. Cartwright (in DeBow's Review)

DRAPETOMANIA, OR THE DISEASE CAUSING NEGROES TO RUN AWAY.

It is unknown to our medical authorities, although its diagnostic symptom, the absconding from service, is well known to our planters and overseers...

In noticing a disease not heretofore classed among the long list of maladies that man is subject to, it was necessary to have a new term to express it. The cause in the most of cases, that induces the negro to run away from service, is as much a disease of the mind as any other species of mental alienation, and much more curable, as a general rule. With the advantages of proper medical advice, strictly followed, this troublesome practice that many negroes have of running away, can be almost entirely prevented, although the slaves be located on the borders of a free state, within a stone's throw of the abolitionists.

If the white man attempts to oppose the Deity's will, by trying to make the negro anything else than "the submissive knee-bender," (which the Almighty declared he should be,) by trying to raise him to a level with himself, or by putting himself on an equality with the negro; or if he abuses the power which God has given him over his fellow-man, by being cruel to him, or punishing him in anger, or by neglecting to protect him from the wanton abuses of his fellow-servants and all others, or by denying him the usual comforts and necessaries of life, the negro will run away; but if he keeps him in the position that we learn from the Scriptures he was intended to occupy, that is, the position of submission; and if his master or overseer be kind and gracious in his hearing towards him, without condescension, and at the same time ministers to his physical wants, and protects him from abuses, the negro is spell-bound, and cannot run away.

According to my experience, the "genu flexit"—the awe and reverence, must be exacted from them, or they will despise their masters, become rude and ungovernable, and run away. On Mason and Dixon's line, two classes of persons were apt to lose their negroes: those who made themselves too familiar with them, treating them as equals, and making little or no distinction in regard to color; and, on the other hand, those who treated them cruelly, denied them the common necessaries of life, neglected to protect them against the abuses of others, or frightened them by a blustering manner of approach, when about to punish them for misdemeanors. Before the negroes run away, unless they are frightened or panic-struck, they become sulky and dissatisfied. The cause of this sulkiness and dissatisfaction should be inquired into and removed, or they are apt to run away or fall into the negro consumption. When sulky and dissatisfied without cause, the experience of those on the line and elsewhere, was decidedly in favor of whipping them out of it, as a preventive measure against absconding, or other bad conduct. It was called whipping the devil out of them.

If treated kindly, well fed and clothed, with fuel enough to keep a small fire burning all night—separated into families, each family having its own house—not permitted to run about at night to visit their neighbors, to receive visits or use intoxicating liquors, and not overworked or exposed too much to the weather, they are very easily governed—more so than any other people in the world. When all this is done, if any one of more of them, at any time, are inclined to raise their heads to a level with their master or overseer, humanity and their own good require that they should be punished until they fall into that submissive state which it was intended for them to occupy in all after-time, when their progenitor received the name of Canaan or "submissive knee-bender." They have only to be kept in that state and treated like children, with care, kindness, attention and humanity, to prevent and cure them from running away.

DYSAETHESIA AETHIOPICA, OR HEBETUDE OF MIND AND OBTUSE SENSIBILITY OF BODY—A DISEASE PECULIAR TO NEGROES—CALLED BY OVERSEERS, " RASCALITY."

Dysaesthesia Aethiopica is a disease peculiar to negroes, affecting both mind and body in a manner as well expressed by dysaesthesia, the name I have given it, as could be by a single term. There is both mind and sensibility, but both seem to be difficult to reach by impressions from without. There is a partial insensibility of the skin, and so great a hebetude of the intellectual faculties, as to be like a person half asleep, that is with difficulty aroused and kept awake. It differs from every other species of mental disease, as it is accompanied with physical signs or lesions of the body discoverable to the medical observer, which are always present and sufficient to account for the symptoms. It is much more prevalent among free negroes living in clusters by themselves, than among slaves on our plantations, and attacks only such slaves as live like free negroes in regard to diet, drinks, exercise, etc. It is not my purpose to treat of the complaint as it prevails among free negroes, nearly all of whom are more or less afflicted with it, that have not got

some white person to direct and to take care of them. To narrate its symptoms and effects among them would be to write a history of the ruins and dilapidation of Hayti, and every spot of earth they have ever had uncontrolled possession over for any length of time. I propose only to describe its symptoms among slaves.

From the careless movements of the individuals affected with the complaint, they are apt to do much mischief, which appears as if intentional, but is mostly owing to the stupidity of mind and insensibility of the nerves induced by the disease. Thus, they break, waste and destroy everything they handle,—abuse horses and cattle,—tear, burn or rend their own clothing, and, paying no attention to the rights of property, steal others, to replace what they have destroyed. They wander about at night, and keep in a half nodding sleep during the day. They slight their work,—cut up corn, cane, cotton or tobacco when hoeing it, as if for pure mischief. They raise disturbances with their overseers and fellow-servants without cause or motive, and seem to be insensible to pain when subjected to punishment. The fact of the existence of such a complaint, making man like an automaton or senseless machine, having the above or similar symptoms, can be clearly established by the most direct and positive testimony. That it should have escaped the attention of the medical profession, can only be accounted for because its attention has not been sufficiently directed to the maladies of the negro race. Otherwise a complaint of so common an occurrence on badly-governed plantations, and so universal among free negroes, or those who are not governed at all,—a disease radicated in physical lesions and having its peculiar and well marked symptoms and its curative indications, would not have escaped the notice of the profession. The northern physicians and people have noticed the symptoms, but not the disease from which they spring. They ignorantly attribute the symptoms to the debasing influence of slavery on the mind without considering that those who have never been in slavery, or their fathers before them, are the most afflicted, and the latest from the slave-holding South the least. The disease is the natural offspring of negro liberty—the liberty to be idle, to wallow in filth, and to indulge in improper food and drinks.

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How bigotry created a black mental health crisis

Racism has led to misdiagnosis, incarceration instead of treatment

Perspective by Kylie M. Smith

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July is Minority Mental Health Month, established to spotlight the flawed diagnosis of mental illness among minorities. Black men, for example, are nearly six times as likely to be diagnosed with schizophrenia as white men. That problem is compounded by the fact that for minorities, especially African Americans, mental-health care often gets provided in prison, where the standard of care is so low that lack of treatment has fueled a suicide epidemic.

States are repeatedly finding themselves in court for this malpractice. Just last month, U.S. District Court Judge Myron Thompson ordered the Alabama Department of Corrections to take immediate steps to improve its mental health services or face a court takeover of the prison system management.

Why is so much mental health care provided to African Americans in prison? First and foremost, because African Americans are overrepresented in our prisons and jails.

There are also other historical factors that exacerbate the problem. Over the past two centuries, medical and legal professionals mislabeled behavior such as escaping slavery and advocating for civil rights as a byproduct of psychiatric madness. Even worse, instead of treating this purported madness, they simply locked patients in facilities with deplorable conditions. This criminalization of mental health has strengthened the control of white authorities over African Americans by simultaneously delegitimizing activism and justifying incarceration. The racial disparities in mental health today have grown from centuries of racism, and only by addressing these systemic problems can we adequately provide mental health care to minority populations.

Racial disparities in diagnosing conditions such as schizophrenia are sometimes presented as an effect of biology, but they are not. Instead, they are the direct result of racist thinking about African American psychology that dates to at least the 18th century. Slave owners and their apologist physicians invented psychiatric "disorders" such as "draeptomania" to explain the urge to run away. In the lead-up to the Civil War, they distorted statistics to argue that freedom would drive

the ex-enslaved crazy. They also propagated the idea that African Americans were more childlike and simplistic, incapable of feeling pain or sorrow, to justify experimentation and exploitation.

After the Civil War, as the South struggled with emancipation and Reconstruction, the black psyche was increasingly portrayed as immoral and inherently criminal, justifying both the need for Jim Crow and mass incarceration, in prisons and psychiatric hospitals. Sometimes the line between the two was exceedingly thin, with mental health-care facilities that functioned more like prisons than places of treatment.

Across the country, but especially in the South during the era of Jim Crow, these hospitals were segregated, with black patients held in separate parts of the institutions or in separate locations entirely. While the Supreme Court's infamous *Plessy v. Ferguson* decision mandated these facilities be equal to those provided to white patients, in practice, they most certainly were not.

Instead, in many states such as Georgia, Alabama and Mississippi, African American patients suffered from state-sanctioned confinement and neglect. In Alabama alone, thousands of people were subjected to decades of substandard housing and nutrition in deathtrap buildings. Hospitals were presided over by white male superintendents who employed unlicensed Cuban refugee doctors, ordered massive amounts of electroshock and chemical "therapies," and put patients to work in the fields as though the hospitals were still plantations. These states were not outliers — they were just the tip of the national iceberg.

In Alabama, these conditions went unchallenged until 1969, when Judge Frank Johnson heard a case brought by civil rights advocates and the federal government after a joint Justice Department and Department of Health, Education and Welfare investigation revealed horrendous conditions and almost no state spending on black patients, including children. Less than 50 cents per patient per day was allocated for food and clothing. Searcy, the black-only hospital in Mobile, had never applied for federal funds to develop treatment programs because it did not believe black patients would respond. Science, however, did not back this claim. Numerous witnesses declared there was no medical justification for segregation and no scientific difference between black and white mental illness. Looking at this evidence, Johnson declared the conditions for African Americans in Alabama's mental hospitals unconstitutional and ordered they be fixed.

The state largely avoided enacting such changes, however, and this problem would only be exacerbated because, just as activists were tackling these deplorable conditions, their civil rights activism prompted the psychiatric community to create new justifications for diagnosing mental health issues among African Americans. In 1968, the American Psychiatric Association took deliberate steps to change the definition of schizophrenia to include "aggression" where it had previously not. While the APA denied (and has continued to do so) charges that such a definition would target the civil rights activism of black men, the research of historian Jonathan Metzl reveals this claim to be disingenuous. The anger of black men was

portrayed as a byproduct of mental illness, rather than a fight against oppression. New drugs intended to target the angry black man were advertised to psychiatrists.

The mislabeling of African American activism as a pathology and the intertwined history of racism and abuse has had long-lasting consequences. The effort to demonize activism as a mental illness has meant those who are sick may struggle to seek treatment — African Americans are significantly less likely than white people to trust a psychiatrist. They are also less likely to be covered by insurance that includes mental health services, especially in states such as Alabama that refused to expand Medicaid under the Affordable Care Act. These structural problems often lead to a cycle of lack of care, homelessness and imprisonment.

Rather than receiving treatment for illness, African Americans end up incarcerated because of its symptoms. As the ongoing Alabama lawsuit demonstrates, the same states that warehoused African Americans without offering adequate treatment for mental illness more than 50 years ago are still locking away people in the same hideous conditions. This tendency to incarcerate the mentally ill instead of treating them is not just a Southern problem. It's a national one. The largest mental health facility in the country is the Los Angeles County Jail. But prisons are not mental health-care providers, and prison life itself is known to make mental illness worse.

The consequences of a system that overlays race with criminality is a lack of funding for mental health services where people need them and a continued belief that there is something biologically wrong with African Americans. We are both over-diagnosing some mental illnesses, such as schizophrenia, and under-diagnosing others, such as depression, mistaking symptoms for criminality that deserve punishment, not treatment.

Instead, we should be making mental health services affordable and accessible, and keeping people with mental illness out of jail. We must also be careful not to see mental illness in activism and assertiveness. When we talk about disparities in mental health, we need to look at these systemic issues, and not perpetuate myths about biological difference. The problem in psychiatry is not race — it's centuries of racism.

