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Black Stitches White Pain

An old man is rushed into the emergency room on a gurney. Unconscious and unaware of the new location his diabetes has brought him, a nurse does a quick overlook before placing him into a room. Doctors that specialize in emergency medicine come rushing in, enacting everything they’ve learned over their almost decade long education. The newly admitted patient returns to active consciousness, looks at his healer and yells, “GET THIS NIGGER OFF OF ME!” Racism has effected everything you could possibly imagine when it comes to social interactions, but what I don’t understand is how it effects medicine. Refusing care from minority physicians forces the healer to either argue with the patient in need, or, find a “white” doctor to tend to the patient. This racism doesn’t stop at the patient, there are physicians who have also found ways around their “Hippocratic Oath” when forced to care for minority patients. A physician is a healer who uses known medicine to help a person return to good health from any ailment that is currently affecting them, however, there are some physicians that will refuse to heal a person in pain because of the color of their skin. Why would a physician refuse a patient care when in the oath itself it says “do no harm?” What this causes in the hospital is a cutoff of proper healthcare executed by doctors, nurses, and other hospital staff, on the most important part of medicine, the patients; for, without them there would not be a need for a hospital in the first place. Race may sometimes effect medicine, but it should never tarnish the relationships between patients and the hospitals who are oath bound to care for all the sick and wounded.

Doctors are well respected individuals within a community, when a patient is prejudiced toward a doctor the assumed response would be to negatively react toward the patient. However, due to ethics that are always evolving, doctors have to shut their mouths and accept the hatred they receive while trying to cure a patient’s sickness. In an essay written in *The New York Times* titled *When the Patient is Racist,* a practicing physician by the name of Dr. Pauline W. Chen pens, “many extend these lessons in modulating one’s responses to situations where patients make demands and behave in ways that in any other public setting would be considered discriminatory or even racist. One study, for example, revealed that up to almost a third of doctors would, without question, concede to a patient’s demand for physicians of a certain race, ethnicity, gender, or religion.” (Chen). This form of racism is unacceptable, inducing a perception that it is accepted to execute hateful acts toward a person who wants to relieve their pain. These accepted atrocities affect how the physician will help their new patient, especially when there is racial bias aimed at them like a gun with a finger on the trigger. In the same article Dr. Chen writes a quote from an associate professor of law at Fordham University, who said,

“The medical profession knows this happens but doesn’t want to talk about it” (Chen). This hatred must be voiced or else change will not mold the future of healthcare. If it isn’t voiced, racism can spread like a virus spreading through a hospital ward, evolving and attaching itself to new hosts that wear white coats.

There are some medical practitioners that don’t break the oath but find other ways around the pledge of “do no harm.” These so called healers find ways to enact their racism on their patients by withholding important tests that will help the physician better understand the sick, causing the patients to not be admitted into special treatment programs. As Tim Wise has scripted in his book *Colorblind*, “there is also a growing body of evidence to suggest that patients of color receive unequal and discriminatory treatment at the hands of physicians, making colorblind universalism even more inadequate for narrowing racial health gaps. For instance, when comparing only Medicare patients of the same age, gender and income, African-American women are 25 percent less likely to receive mammography screening, and even when comparing patients of the same age, gender and severity of disease, living in the same geographic location and with the same access to cardiac facilities, blacks are 60% less likely to be referred for, and to receive coronary angioplasty or bypass surgery” (Wise 117). This mindset is hurting the minority populace by taking away much needed attention to certain areas that require a specialist or surgeon. Physicians need to have more empathetic moments with minorities so that these passive-aggressive actions can evolve into acts of mending not hurting. On the other side of the spectrum there is the patient who needs and has received the proper exams that allows them to be forwarded to a specialist. However, once they arrive to the expert and find that their new physician is of different nationality, a patient will refute treatment to the point where denying treatment would mean death.

Though racism is nothing like it was back in the 1800’s, however, race-based medicine is still a problem today. Taking lives slowly but surely, racism itself scars those who have been lashed by its hatred. Sounding the alarm on the impact of racism, Wise writes, “Research has found that experiences with racial discrimination increase stress levels among persons of color, thereby elevating blood pressure and correlating directly with worse health. Being the target of racial bigotry causes the brain’s hypothalamus to send an alert to the adrenal glands, resulting in a release adrenaline along with the release of endorphins in the brain and cortisol (stress-related hormone) throughout the body. Over time, these experiences can damage the hypothalamic-pituitary-adrenal (HPA) axis” (Wise 116). Also with surmounting evidence, Dorothy Roberts – a social justice advocate, author, and law professor – speaks at a TED Talk and states, “Even today, many doctors still use race as a medical shortcut; they make important decisions about things like pain tolerance based on a patient's skin color instead of medical observation and measurement.” Medicine practitioners have traditionally used race as a medical shortcut, with the idea that black ancestor’s adaptations are the cause for their high blood pressure. Disconnecting their personal stress with those of blacks while also congruently projecting their stress due to the acceptance of racism within whites, minority patients have been scientifically found to be physiologically hurt by racism. As a result, racist physicians are causing a never ending cycle of stereotyping in the form of medicine, while being the actual cause of the disease that white physicians are charting onto black patient logs.

The majority of the hospitals admitted black patients come from low income housing, who are unfortunately also the majority of crack users like Leslie, an African-American crack addict who is pregnant. Her story unfolds in *Black Man In A White Coat*, that is written about “a doctor’s reflections on race and medicine.” The author, Damon Tweedy – a graduate of Duke University School of Medicine, assistant professor of psychiatry at Duke University Medical Center, staff physician at the Durham Veteran Affairs Medical Center and who’s reflections are scribed in the book – tells the story of young Leslie, who’s unborn child meets a devastating fate while Tweedy is working at Duke Universities hospital. On a specific shift, Leslie comes in with searing pain in her stomach, not wanting to divulge that she is a crack user, she denies the accusations that Dr. Garner – attending physician at the time Tweedy was working his shift – of being a crack user that Dr. Garner made while patching Leslie’s bleeding miscarriage. Tweedy reconstructs the memory he witnessed, remembering the racial profiling in the hospital while assisting Dr. Garner on the case by writing, “Yet Dr. Garner’s approach troubled me. What was it about Leslie that made Dr. Garner so certain she used drugs? And crack in particular? Was it her appearance, her speech, her race? Some combination? Would Dr. Garner have done that to a Duke graduate student, even one whom she suspected might have snorted a few lines? Or to any patient who looked and acted middle class? What did it say about the vastly different ways that patients could be treated? Moreover, if Dr. Garner hadn’t demanded answers, if she’d continued to accept Leslie’s denials as I had, what might have happened?” (Tweedy 35). Confused by his leader’s actions, Tweedy is pondering the profiling Dr. Garner made on Leslie. The question of accepting profiling does loom over his head, however, instead of profiling by race, a physician can get a lot more answers from learning what the person’s background is. While they’re not that pretty, statistics always come into a medical practitioners’ mind while in emergency situations, and these stats didn’t lie. Forcing Tweedy’s eyes to focus on stereotypes when faced with an emergency medical situation.

While on the same case, an experienced nurse was helping Dr. Tweedy with Leslie. The nurses anger and distain toward the patient was also due to the over whelming surveys on black pregnant woman being common crack users. He describes his ideas of the nurse, who goes by the name of Carla by penciling, “Carla, a white woman from the Northeast, seemed especially focused on crack, a drug widely known to be used more often by black people. A national survey in the mid-1990s revealed that black women were ten times more likely than white women to use crack during pregnancy. The same survey, however, found that pregnant white women were more likely to abuse alcohol, a substance that can produce its own distinct set of severe problems: fetal alcohol syndrome. Would Carla have reacted the same way if Leslie had been a married, white suburban schoolteacher who drank three glasses of wine every night?” (Tweedy 40). As a crack-addicted pregnant woman, Leslie had only proven the data correct to a hospital staffed by white faces, in particular, Carla’s. Due to the same skin tone wearing common illnesses, this breach of accepted racial profiling has only strengthened the divide between medical staff and African-Americans facing injury. Therefore, causing a racial bias when a doctor or nurse first lays their eyes on a patient.

Though much has been said about the receiving of hate, the spotlight must be shined on those scholarly warriors, who grab our attention by forging words into strength. Using the mightier pen in place of the sword, these heroes have voiced their experiences so that bicentennial mistreatment of the black soul can finally be rectified. The two hundred-year maltreatment comes from The American Medical Association, who repeatedly rejected African-American physicians into their fold. The American Medical Association (AMA), finally wrote an apology letter after years of written justice that shredded their racial claims. In their apology on the AMA’s journal of ethics, the association states who started the charge, “Leading the delegation was Robert Reyburn, a white former Union army officer, military surgeon, and the first dean of the Howard Medical College. His three Negro colleagues were Alexander Thomas Augusta, who was a Union army military surgeon, Charles Burleigh Purvis, and Alpheus W. Tucker. All four of these physicians were experienced and licensed to practice medicine who had received their medical training from allopathic medical schools, not from homeopathic or other alternative schools. Their integrated medical society, the NMS, had been founded in 1868-1869 because the established all-white Medical Society of the District of Columbia (MSDC) refused to admit Negro physicians.” These brave soldiers fought the free practice of racial discrimination which was investigated, and found that the MSDC was in fact refusing to admit, “Negro physicians solely on account of color.” Finding ways around the systematic fall of racism, the AMA blocked their admissions to their national meetings by charging the freedom warriors with “contempt of the organized Medical Society.” Without access to the AMA’s findings, minority physicians were forced to continue treating patients with their old ways, all the while the AMA had some of the leading technology in medicine hidden away in their vault of secrets, causing many patients to undergo fatal treatments because of withheld information.

Though these liberators of hate are long gone, their fight didn’t go unnoticed and after a two-hundred-year battle for equality that started in 1868, the AMA was finally ready to right their wrong. On July 30, 2008, the AMA wrote a letter that states, “I humbly come to the physicians of today’s National Medical Association, to tell you that we are sorry…on behalf of the American Medical Association, I unequivocally apologize for our past behavior. We pledge to do everything in our power to right the wrongs that were done by our organization to African-American physicians and their families and their patients” (AMA Journal of Ethics). Asking for forgiveness itself is a start, even though nothing can erase the years of discrimination, one step toward equality has been taken; with this beginning first step, a new trail can be made parallel to the blood drenched trail that our ancestors have left behind. It must be parallel in order to remind those who walk its newly folded blades of grass, that racial injustice will not be tolerated. A path I wish to travel on one day myself, this history is important for a future physician who wants to heal the worlds pain and suffering.

As a student who has decided to take the pre-med route in life, this social issue is important to me. I want to change America’s perception and regardless of my perceived race I will start in a career I feel passionate about. To successfully be a part of the solution, medical professionals need not mix personal beliefs with the situations they daily face, instead realize that healthcare is a necessity for all, and by discriminating against a certain skin tone they are taking away from basic human rights. Dr. Martin Luther King Jr. could not wrap his mind around the idea of racism affecting healthcare and stated, “Of all the forms of inequality, injustice in health is the most shocking and the most inhumane.” Thanks to so many people like Dr. King, research and activism have paved the way for racist Americans to accept and understand the similarities that every human shares no matter their skin tone. Paving the way for future leaders in a Huffington Post article, former President of the United States Bill Clinton states, “if you just look at our genome, we are all 99.5 percent the same,” Clinton goes on to say, “We spend 99 and a half percent of our time fixating on that half of a percent.” We humans, can focus our attention on bigger futuristic tasks, when people stop projecting their racial insecurities on other people with a higher count of melanin. Medicine has no color, it only has the sick and those who swore an oath to do anything it takes to rid the sickness from our future. Black doctors have stitched the gash left by racism, now their focus is on managing the searing white pain.

Works Cited

*"#BlackLivesMatter: Physicians Must Stand for Racial Justice."* The AMA Journal of Ethics 17.10 (2015): 978-82. Web. Access date, Dec. 10, 2016.

*“Bill Clinton Says ‘We Are All Mixed-Race.’”* The Huffington Post. Feb. 2016. Page 1. Access

date, Dec. 12, 2016.

Chen, Pauline W. “*When the Patient Is Racist*.” The New York Times*.* Jul. 2013. Page 1. Access date, Dec. 08, 2016.

Roberts, Dorothy. *“The problem with race-based medicine”* TED. Nov. 2015. Lecture. Access date, Dec. 09, 2016.

Tweedy, Damon. *Black Man In a White Coat: a doctor's reflections on race and medicine*. New York: Picador, 2015. Print.

*"The American Medical Association and Race."* The AMA Journal of Ethics. Virtual Mentor

16.6 (2014): 479-88. Web. Access date, Dec. 2, 2016.

Wise, Tim J. *Colorblind: the rise of post-racial politics and the retreat from racial equity*. San Francisco, CA: City Lights, 2010. Print.