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English 105 AA

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Notes: Colorblind by Tim Wise

Racism, discrimination, and healthcare

Whether regarding life expectancy, infant mortality rates, rates of low birth weight for newborns or the rates at which adults die from largely preventable diseases, whites are in far better shape than those that are black or brown. (Wise 112)

Three schools of thought: (Wise 112 – 113)

1. Argument of racial health gaps due to economic inequity
2. Argument of differential health outcomes reflect different lifestyles and choices made by whites as opposed to people of color.
3. Argument that racial disparities in health reflect a bit of economic and behavioral factors, but also racism itself: first, the health effects of society-wide racism and discrimination, which accumulate over time, and second, racially disparate treatment by physicians themselves, even those with no intent to injure people of color but who are influenced, like everyone else, by implicit biases.

Obama states that black folks need more exercise and access to fresh food (Audacity of Hope)

The effects of discrimination on black health over time, in a variety of settings; and differential treatment at the hands of physicians. (Wise 116)

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)

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 116)

Notes: Black Man in a White Coat by Damon Tweedy

Discrimination

“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)

“Racial insults – big and small – were a part of our lives and sometimes humor was the best way to deal with it.” (Tweedy 13)

“Had race played a role? 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-abusing pregnant woman, Leslie had put the worst face of black America on full display for this white medical audience” (Tweedy 40)

“For the patients, in a town with no physician and many people without health insurance, the clinic offered some residents their only opportunity to see a doctor. One Saturday each month, these two worlds joined hands” (Tweedy 54)

When the Patient Is Racist

But 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](http://emj.bmj.com/content/27/6/465.long) 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.

He hands over the patient’s care to another doctor, but finds when he seeks out the advice and support of colleagues that they are quick to admonish him and even make light of the patient’s behavior. One doctor even urges Dr. Jain to go back to the patient’s room and apologize.

Still, the medical profession’s current stance is far from ideal. [Ongoing initiatives](http://well.blogs.nytimes.com/2013/05/02/the-changing-face-of-medical-school-admissions/%5D) in medical schools and training programs to increase diversity among the next generation of doctors will likely have an effect; but much more needs to be done to foster open and nuanced discussions of the profession’s attitude toward race and ethnicity and to assess the profession’s at times overly exuberant interpretations of “putting the patient first.”

“There’s something wrong,” Dr. Jain said, “when a person can go to work, be subject to intolerance or abuse and have it be ignored and accepted by colleagues as part of the job.”

AMA apology

Dr. Levi Watkins, a cardiologist at Johns Hopkins Hospital, as well as associate dean of the medical school. Watkins, 62, who grew up in pre-civil rights era Montgomery, Ala., was the first black person to attend Vanderbilt Medical School. He has long been involved in civil rights.

He noted that many studies show that every year in this country, 120,000 extra deaths occur among African-Americans because of disparities in care between whites and blacks. Watkins said that institutional racism remains entrenched in health care. "Right now," he said, "I would like apologetic action."

Without membership in medical societies, black physicians were denied admitting privileges at hospitals, financial support such as loans to open practices, leases for office space and even medical malpractice insurance, said Dr. Matthew Wynia, director of the AMA's Institute of Ethics. Continuing education was also difficult because black doctors couldn't attend meetings to learn about new treatments and research.

Physicians Must Stand for Racial Justice

Racism is one of the major causes of health problems in the United States. Between 1970 and 2004, the Black-white mortality gap resulted in more than 2.7 million excess Black deaths [1], making [racism](http://journalofethics.ama-assn.org/2011/02/msoc1-1102.html) a more potent killer than prostate, breast, or colon cancer.

Physicians are intimately involved with institutions that contribute to the victimization of Black people and other people of color. As is widely documented, Black and Latino patients are less likely to receive the care they need, including adequate [analgesia](http://journalofethics.ama-assn.org/2015/03/medu1-1503.html), cancer screening, and organ transplants [3-6].

clinicians are paid less to care for patients who are uninsured, underinsured, or publicly insured, and these patients are disproportionately people of color. As a consequence, people of color are often denied access to the health care they need [8, 9].

https://www.ted.com/talks/dorothy\_roberts\_the\_problem\_with\_race\_based\_medicine#t-864664