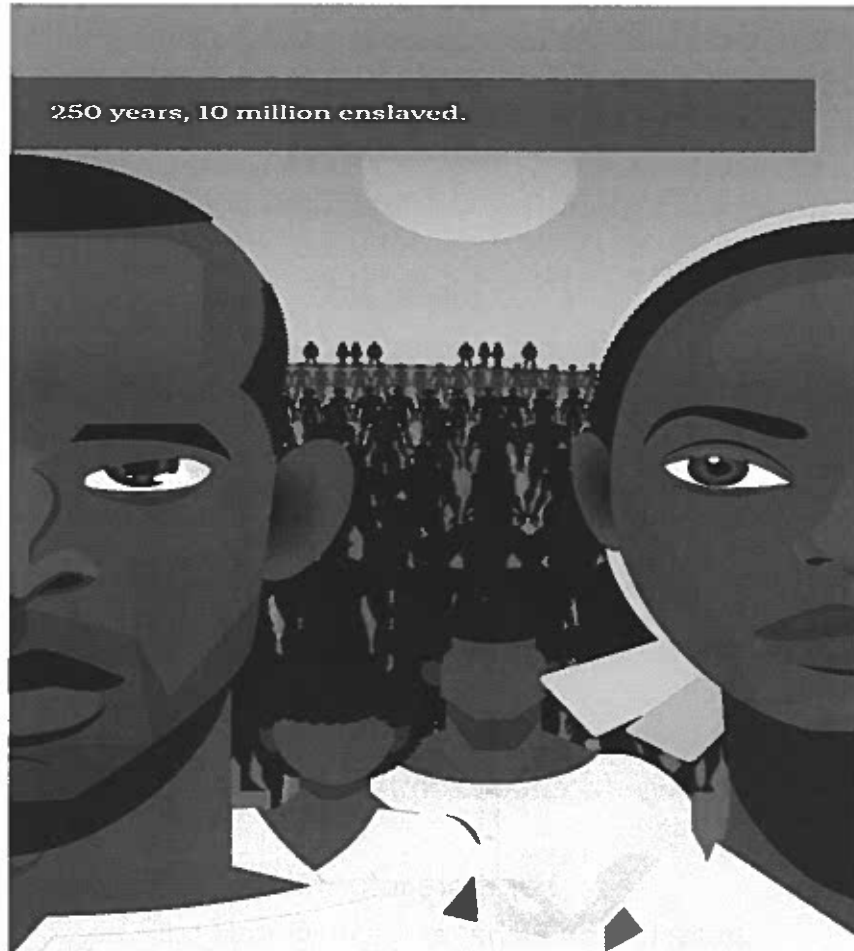


1619 Project Discussion Article Packet



Topic: Slavery and Health Care

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How False Beliefs in Physical Racial Difference Still Live in Medicine Today

 [nytimes.com/interactive/2019/08/14/magazine/racial-differences-doctors.html](https://www.nytimes.com/interactive/2019/08/14/magazine/racial-differences-doctors.html)

By LINDA
VILLAROSA

August 14,
2019

The excruciatingly painful medical experiments went on until his body was disfigured by a network of scars. John Brown, an enslaved man on a Baldwin County, Ga., plantation in the 1820s and '30s, was lent to a physician, Dr. Thomas Hamilton, who was obsessed with proving that physiological differences between black and white people existed. Hamilton used Brown to try to determine how deep black skin went, believing it was thicker than white skin. Brown, who eventually escaped to England, recorded his experiences in an autobiography, published in 1855 as "Slave Life in Georgia: A Narrative of the Life, Sufferings, and Escape of John Brown, a Fugitive Slave, Now in England." In Brown's words, 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."

Hamilton was a courtly Southern gentleman, a respected physician and a trustee of the Medical Academy of Georgia. And like many other doctors of the era in the South, he was also a wealthy plantation owner who tried to use science to prove that differences between black people and white people went beyond culture and were more than skin deep, insisting that black bodies were composed and functioned differently than white bodies. They believed that black people had large sex organs and small skulls — which translated to promiscuity and a lack of intelligence — and higher tolerance for heat, as well as immunity to some illnesses and susceptibility to others. These fallacies, presented as fact and legitimized in medical journals, bolstered society's view that enslaved people were fit for little outside forced labor and provided support for racist ideology and discriminatory public policies.

Over the centuries, the two most persistent physiological myths — that black people were impervious to pain and had weak lungs that could be strengthened through hard work — wormed their way into scientific consensus, and they remain rooted in modern-day medical education and practice. 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 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, he added, "I have amputated the legs of many Negroes who have held the upper part of the limb themselves."

These misconceptions about pain tolerance, seized upon by pro-slavery advocates, also allowed the physician J. Marion Sims — long celebrated as the father of modern gynecology — to use black women as subjects in experiments that would be unconscionable today, practicing painful operations (at a time before anesthesia was in use) on enslaved women in Montgomery, Ala., between 1845 and 1849. In his autobiography, “The Story of My Life.” Sims described the agony the women suffered as he cut their genitals again and again in an attempt to perfect a surgical technique to repair vesico-vaginal fistula, which can be an extreme complication of childbirth.

Thomas Jefferson, in “Notes on the State of Virginia.” published around the same time as Moseley’s treatise, listed what he proposed were “the real distinctions which nature has made,” including a lack of lung capacity. In the years that followed, physicians and scientists embraced Jefferson’s unproven theories, none more aggressively than Samuel Cartwright, a physician and professor of “diseases of the Negro” at the University of Louisiana, 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 whites and blacks, including the claim that black people had lower lung capacity. Cartwright, conveniently, saw forced labor as a way to “vitalize” the blood and correct the problem. Most outrageous, 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 contracted this ailment when their enslavers treated them as equals, and he prescribed “whipping the devil out of them” as a preventive measure.

Today Cartwright’s 1851 paper reads like satire, Hamilton’s supposedly scientific experiments appear simply sadistic and, last year, 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. And yet, more than 150 years after the end of slavery, fallacies of black immunity to pain and weakened lung function continue to show up in modern-day medical education and philosophy.

Even Cartwright’s footprint remains embedded in current medical practice. To validate his theory about lung inferiority in African-Americans, he became one of the first doctors in the United States to measure pulmonary function with an instrument called a spirometer. Using a device he designed himself, Cartwright calculated that “the deficiency in the Negro may be safely estimated at 20 percent.” Today most commercially available spirometers, used around the world to diagnose and monitor respiratory illness, have a “race correction” built into the software, which controls for the assumption that blacks have less lung capacity than whites. In her 2014 book, “Breathing Race Into the Machine: The Surprising Career of the

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Spirometer from Plantation to Genetics.” Lundy Braun, a Brown University professor of medical science and Africana studies, notes that “race correction” is still taught to medical students and described in textbooks as scientific fact and standard practice.

Recent data also shows that present-day doctors fail to sufficiently treat the pain of black adults and children for many medical issues. 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 appendicitis to elders in hospice care — received inadequate pain management compared with white counterparts.

A 2016 survey of 222 white medical students and residents published in The Proceedings of the National Academy of Sciences showed that half of them endorsed at least one myth about physiological differences between black people and white people, including that black people’s nerve endings are less sensitive than white people’s. When asked to imagine how much pain white or black patients experienced in hypothetical situations, the medical students and residents insisted that black people felt less pain. This made the providers less likely to recommend appropriate treatment. A majority of these doctors to be also still believed the lie that Thomas Hamilton tortured John Brown to prove nearly two centuries ago: that black skin is thicker than white skin.

This disconnect allows scientists, doctors and other medical providers — and those training to fill their positions in the future — to ignore their own complicity in health care inequality and gloss over the internalized racism and both conscious and unconscious bias that drive them to go against their very oath to do no harm.

The centuries-old belief in racial differences in physiology has continued to mask the brutal effects of discrimination and structural inequities, instead placing blame on individuals and their communities for statistically poor health outcomes. Rather than conceptualizing race as a risk factor that predicts disease or disability because of a fixed susceptibility conceived on shaky grounds centuries ago, we would do better to understand race as a proxy for bias, disadvantage and ill treatment. The poor health outcomes of black people, the targets of discrimination over hundreds of years and numerous generations, may be a harbinger for the future health of an increasingly diverse and unequal America.

Linda Villarosa directs the journalism program at the City College of New York and is a contributing writer for the magazine. Her feature on black infant and maternal mortality was a finalist for a National Magazine Award.

Why Doesn't America Have Universal Health Care? One Word: Race

 [nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html](https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html)

By JENEEN INTERLANDI

August 14,
2019

The smallpox virus hopscotched across the post-Civil War South, invading the makeshift camps where many thousands of newly freed African-Americans had taken refuge but leaving surrounding white communities comparatively unscathed. This pattern of affliction was no mystery: In the late 1860s, doctors 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 stop an outbreak in its tracks; they had used those very tools to prevent a smallpox outbreak from ravaging the Union Army.

Smallpox was not the only health disparity facing the newly emancipated, who at the close of the Civil War faced a considerably higher mortality rate than that of whites. Despite their urgent pleas for assistance, white leaders were deeply ambivalent about intervening. They worried about black epidemics spilling into their own communities and wanted the formerly enslaved to be healthy enough to return to plantation work. But they also feared that free and healthy African-Americans would upend the racial hierarchy, the historian Jim Downs writes in his 2012 book, "Sick From Freedom."

Federal policy, he notes, reflected white ambivalence at every turn. Congress established the medical division of the Freedmen's Bureau — the nation's first federal health care program — to address the health crisis, but officials deployed just 120 or so doctors across the war-torn South, then ignored those doctors' pleas for personnel and equipment. They erected more than 40 hospitals but prematurely shuttered most of them.

White legislators argued that free assistance of any kind would breed dependence and that when it came to black infirmity, hard labor was a better salve than white medicine. As the death toll rose, they developed a new theory: Blacks were so ill suited to freedom that the entire race was going extinct. "No charitable black scheme can wash out the color of the Negro, change his inferior nature or save him from his inevitable fate," an Ohio congressman said.

One of the most eloquent rejoinders to the 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. 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 on the burden of disease in black communities. "They seem to forget there is a *cause* for every ailment," she wrote. "And that it may be in their power to remove it."

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. That bloc preserved the nation's racial stratification by securing local control of federal programs under a mantra of "states' rights" and, in some cases, by adding qualifications directly to federal laws with discriminatory intent.

The African-American ward of the Jackson Memorial Hospital in Miami in 1944. Jerry Cooke/The Life Images Collection, via Getty Images

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 — more than half the nation's black work force at the time — were excluded from New Deal policies, including the Social Security and Wagner Acts of 1935 (the Wagner Act ensured the right of workers to collective bargaining), and the Fair Labor Standards Act of 1938, which set a minimum wage and established the eight-hour workday. The same voting bloc ensured states controlled crucial programs like Aid to Dependent Children and the 1944 Servicemen's Readjustment Act, better known as the G.I. Bill, allowing state leaders to effectively exclude black people.

[Myths about physical racial differences were used to justify slavery — and are still believed by doctors today.]

In 1945, when President Truman called on Congress to expand the nation's hospital system as part of a larger health care plan, Southern Democrats obtained key concessions that shaped the American medical landscape for decades to come. The Hill-Burton Act provided federal grants for hospital construction to communities in need, giving funding priority to rural areas (many of them in the South). But it also ensured that states controlled the disbursement of funds and could segregate resulting facilities.

Professional societies like the American Medical Association barred black doctors; medical schools excluded black students, and most hospitals and health clinics segregated black patients. Federal health care policy was designed, both implicitly and explicitly, to exclude black Americans. As a result, they faced an array of inequities — including statistically shorter, sicker lives than their white counterparts. What's more, access to good medical care was predicated on a system of employer-based insurance that was inherently difficult for black Americans to get. "They were denied most of the jobs that offered coverage," says David Barton Smith, an emeritus historian of health care 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."

In the shadows of this exclusion, black communities created their own health systems. Lay black women began a national community health care movement that included fund-raising for black health facilities; campaigns to educate black communities about nutrition, sanitation and disease prevention; and programs like National Negro Health Week that drew national attention to racial health disparities. Black doctors and nurses — most of them trained at one of two black medical colleges, Meharry and Howard — established their own professional organizations and began a concerted war against medical apartheid. By the 1950s, they were pushing for a federal health care system for all citizens.

That fight put the National Medical Association (the leading black medical society) into direct conflict with the A.M.A., which was opposed to any nationalized health plan. In the late 1930s and the 1940s, the group helped defeat two such proposals with a vitriolic campaign that informs present-day debates: They called the idea socialist and un-American and warned of government intervention in the doctor-patient relationship. The group used the same arguments in the mid-'60s, when proponents of national health insurance introduced Medicare. This time, the N.M.A. developed a countermessage: Health care was a basic human right.

Medicare and Medicaid were part of a broader plan that finally brought the legal segregation of hospitals to an end: The 1964 Civil Rights Act outlawed segregation for any entity receiving federal funds, and the new health care programs soon placed every hospital in the country in that category. But they still excluded millions of Americans. Those who did not fit into specific age, employment or income groups had little to no access to health care.

In 2010, the Affordable Care Act brought health insurance to nearly 20 million previously uninsured adults. The biggest beneficiaries of this boon were people of color, many of whom obtained coverage through the law's Medicaid expansion. That coverage contributed to a measurable decrease in some racial health disparities, but the success was neither as enduring nor as widespread as it might have been. Several states, most of them in the former Confederacy, refused to participate in Medicaid expansion. And several are still trying to make access to the program contingent on onerous new work requirements. The results of both policies have been unequivocal. States that expanded Medicaid saw a drop in disease-related deaths, according to the National Bureau of Economic Research. But in Arkansas, the first state to implement work requirements, nearly 20,000 people were forced off the insurance plan.

One hundred and fifty years after the freed people of the South first petitioned the government for basic medical care, the United States remains the only high-income country in the world where such care is not guaranteed to every citizen. In the United States, racial health disparities have proved as foundational as democracy itself. "There has never been any period in American history where the health of blacks was equal to that of whites,"

Evelynn Hammonds, a historian of science at Harvard University, says. "Disparity is built into the system." Medicare, Medicaid and the Affordable Care Act have helped shrink those disparities. But no federal health policy yet has eradicated them.

Jeneen Interlandi is a member of The Times's editorial board and a staff writer for the magazine. Her last article for the magazine was about teaching in the age of school shootings.

Toward a Historically Informed Analysis of Racial Health Disparities Since 1619

 See also Brown, p. 1309.

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

—Martin Luther King, 1966

There has never been a time in the United States without racial health disparities. Although the term “health disparities” is of recent origin, differential health outcomes between Blacks and Whites have been part of the American landscape for 400 years. The sophistication of the analytic approaches taken by journalists, social scientists, government agencies, or health scholars may differ, as do the objects of study, but the narratives are very much the same.¹ The reasons given for such disparities are supposedly either inherent in the Black body or inherent in the inequalities that have shaped the Black experience for centuries.

Yet, most studies of health disparities ignore the real historical past or, at best, classify it as a “variable.”² If historical evidence is used at all, it is said to have two contradictory influences: to make change seem impossible or to make change seem inevitable if attention is given to choices made and not made.³ At the same time, race and racism as factors in the production and maintenance of health disparities are grouped into unchanging categories

requiring little definition or historical contextualization. A more appropriate and truly historical approach could help us see the past reasons for health disparities and how they link the body and the body politic. With this knowledge, public health practitioners can consider what to do to overcome these historical burdens that affect the life chances of African Americans.

RACIALLY DIVIDED HEALTH CARE

The consequences of slavery were to set up racially divided health care: slave owners saw Black bodies that needed to be disciplined and controlled to remain “sound,” while enslaved Africans used skills brought from their homelands, making use of roots, herbs, and communal support to heal their communities. High rates of morbidity and mortality brought about by overwork, horrendous living conditions, sexual abuse, violence, and separation marked the life chances of enslaved Black Americans.

White physicians assumed Black bodies were fit for slavery and thrived under White control, and feared that once slaves were emancipated their increased rates

of illness and demise were inevitable. These “logics of difference” between Blacks and Whites, based on Biblical readings or scientific dogma, would follow Black Americans through slavery and the Civil War.

RACIST PUBLIC HEALTH SYSTEM

In the immediate aftermath of the war, the rising rates of illness and death of newly emancipated Black citizens were caused by the loss of plantation health care; the illnesses and disease epidemics brought on by starvation, disruption, and lack of work; and the inability and unwillingness of an underdeveloped and racist southern public health system to take up the slack. Fear that “dependency” on governmental largess would undermine White authority and support Black citizenship made introduction of public health services difficult politically as well.

To counter these conditions, African Americans made

demands on the local and federal governments, built up mutual aid societies, and formed separate medical and nursing schools when denied access to those controlled by Whites.⁴ These efforts, however, could not be sustained by an economically distressed population alongside the social conditions that underlay the epidemics, poverty, and poor sanitation that caused widespread illness and death. Above all, the lack of political power in southern Black communities after the end of Reconstruction thwarted African Americans’ abilities to make public health any kind of priority at a local or federal level.

Throughout the late 19th century and into the 20th century poor health and lack of access to health care, coupled with theories of innate weakness, followed African Americans out of the rural South and into the cities. The housing segregation, crowding, and heavy manual labor faced by Black men and women took their toll as infectious diseases spread. At the end of the 19th century, statistician Frederick Hoffman claimed that differential health outcomes were an inherent biological phenomenon. Sociologist W. E. B. DuBois countered, describing the social causes of illness in his monumental study

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*The Philadelphia Negro.*⁵ These strikingly different arguments, which located the cause of disparities as either in the body alone or in social conditions, would continue to frame explanations by public health experts.

SEGREGATION

By the early 20th century, the understanding that disease would not stay on one side of the tracks separating Blacks and Whites had spread. Public health officials in some of the less segregated cities found that newer water purification and sewage systems, aimed at improving the health of White urban dwellers, could better the life chances of their Black neighbors too. With the organization of National Negro Health Week and various efforts by organized Black women's groups, more consciousness about what could be done both individually and collectively to improve health outcomes emerged. Health education, building of privies and wells, and a collective effort to make health care matter all had a positive impact. Yet, dismantling the segregated health care system that most Blacks experienced proved difficult.

Contemporary civil rights lawyer Bryan Stevenson noted that "slavery didn't end in 1865, it just evolved."⁶ The same is true for the nation's segregated health care system; it evolved from a system of strict segregation to one riven with inequalities. Health disparities in the 20th century were produced both by practices based on ideologies of racial difference and by the fact that Blacks still were not recognized as full citizens whom public health interventions had to address.

MASS INCARCERATION

During the 20th century, through the work of Black churches, women's organizations, civil rights and radical political groups, and Black nurses and doctors, health became central to the continued struggle for equality. By the mid-1970s, structural injustices in health care came into sharper relief as US incarceration rates began to spiral upward, disproportionately affecting Black communities. Mass incarceration has also been recognized as a cause of ill health in Black communities, and not only for those imprisoned and subjected to the gross inadequacies of prison health care.⁷ Separation of families, loss of income, and the return to their communities of untreated or badly treated formerly incarcerated individuals all affect health outcomes in Black communities.

Public health practitioners need to be teamed with community activists, criminal justice advocates, housing and job organizers, and radical politicians if there is ever to be change in this long story. Methodologically, we need analyses of health disparities that include greater engagement with history aimed toward examining the specific mechanisms and social factors that produced health disparities in the past. We need a better understanding of the individual effects of structural racism and inequalities in the body politic when inequality and racism become biologized.

HISTORICALLY INFORMED ANALYSES

Finally, we need historically informed analyses that reveal, rather than obscure, the forces that are intensifying health

inequalities in the present. Unless this happens, the challenge for public health will also remain unchanged from the era of slavery to the present: how to extend the benefits of public health interventions to the most vulnerable populations in our increasingly racially and ethnically diverse and economically stratified country. Discussions of the need for reparations ought to look at health outcomes, too, as an index of the cost of racism through the ages. *AJPH*

Evelynn M. Hammonds, PhD
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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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Black Maternal and Infant Health: Historical Legacies of Slavery

The legacies of slavery today are seen in structural racism that has resulted in disproportionate maternal and infant death among African Americans.

The deep roots of these patterns of disparity in maternal and infant health lie with the commodification of enslaved Black women's childbearing and physicians' investment in serving the interests of slaveowners. Even certain medical specializations, such as obstetrics and gynecology, owe a debt to enslaved women who became experimental subjects in the development of the field.

Public health initiatives must acknowledge these historical legacies by addressing institutionalized racism and implicit bias in medicine while promoting programs that remedy socially embedded health disparities. (*Am J Public Health*. 2019;109:1342–1345. doi:10.2105/AJPH.2019.305243)

Deirdre Cooper Owens, PhD, and Sharla M. Fett, PhD

 See also Brown, p. 1309.

In February 2019, embattled Virginia governor Ralph Northam referred to Virginia's racist past by connecting it to the assumed healing power of medicine. Shortly after conservative political rivals published a racially offensive photo allegedly of Northam and a medical school friend in blackface, the governor responded, "Right now Virginia needs someone who can heal. There's no better person to do that than a doctor."

As a pediatric neurosurgeon, Governor Northam relied on the language of healing and the presumed belief that many Americans have that doctors are committed to curing what ails us all. Surely anti-Black racism, if thought of as a disorder, as Northam suggested, should be cured by neurosurgeons who are charged to rehabilitate disorders affecting the brain. In light of the medical field's racist past, can we trust physicians and surgeons such as Governor Northam with such an important task? More specifically, as historians who work on the effects of racism on Black people's bodies, especially women, we focus much of this commentary on how reproductive justice and birthing justice must be attained by and for Black women systemically.

MEDICINE'S RELATIONSHIP TO US CHattel SLAVERY

Any honest examination of racism as a widespread affliction

of American medical practice must acknowledge that the medical profession was entangled in the institution of slavery from its beginnings. From the earliest origins of chattel slavery in North America, Europeans with medical training served the interests of slaveowners rather than enslaved patients.

Some transatlantic slave traders hired surgeons for the horrific Middle Passage in hopes of preserving their human "cargo" for maximum profit.¹ In the slave markets of the antebellum South, physicians inspected the bodies of enslaved men, women, and children before signing certificates of "soundness" for buyers or sellers. These distorted priorities were reflected in an 1858 medical journal article by Savannah Medical College professor Juriah Harriss, who declared that the ability to accurately determine the market value of Black bodies was one of the key professional competencies needed by southern doctors. Insurance companies too hired White doctors to examine enslaved men and women before issuing life insurance policies to protect slaveholders' financial well-being.²

Finally, Black bodies continued to be disrespected and

commodified after death when used as teaching "material" in the form of cadavers and medical specimens in the dissecting rooms and medical museums of White medical schools.^{3,4} White physicians in 18th- and 19th-century slave societies built their reputations by "medicalizing Blackness" in their professional writing. Racialized medical thought reached beyond proslavery practitioners and became part of the language of the broader profession.⁵ This early history of physicians, slavery, and racial theory belies the notion that medicine is a value-neutral profession devoid of the toxicity of racism.

ENSLAVED WOMEN'S CHILDBEARING

Legal and medical attention to enslaved women's bodies played an especially important role in the entrenchment of American racism and its manifestation as a public health crisis today. As far back as 1662, colonial Virginia legislators made Black women's childbearing a centerpiece of the system of chattel slavery when they passed a law stating that the

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status of a child would follow that of his or her mother. This principle, known as *partus sequitur ventrem*, legalized chattel slavery as an inheritable status applied to Africans and their descendants. Seventeenth-century European exploration literature also depicted African women, in comparison with European women, as especially capable of both childbearing and field labor.^{6,7} The principle of *partus* thus not only defined legal slavery but also carved out a racial distinction. Continuing up through the Civil War, White women's childbearing built free patriarchal lineages while southern laws forced enslaved Black women to bear children who would build capital for enslavers.

When both Britain and the United States banned the transatlantic slave trade in 1807–1808, cutting off the sources of African captives, slaveholders began to bank their future increasingly on the fertility of enslaved women. Medical journals and planter records in the British West Indies and the United States reveal growing attention paid by White physicians to enslaved women's reproductive lives. Although enslaved midwives and nurses supplied much of the daily plantation health care, slaveowners called upon White physicians for cases such as assisting difficult births with forceps, examining the causes of an enslaved woman's infertility, or investigating cases of infant mortality.⁸ Infant mortality in plantation settings remained high, however. In the South, an estimated 50% of enslaved infants were stillborn or died within the first year of life.⁹

Without a well-developed field of pediatrics, White physicians had little to offer. Consequently, they often blamed

enslaved mothers and midwives, using harsh gendered and racist language, for infant deaths that were more likely a result of mothers' hard labor and poor nutrition.¹⁰ Beyond these verbal attacks, antebellum US physicians also began to use their access to Black and enslaved bodies to expand their scientific knowledge and build their professional reputations.

The impact of racialized science on the field of medicine today is painfully illustrated by the deep linkages that American gynecology has with slavery. Many of the field's most pioneering surgical techniques were developed on the sick bodies of enslaved women who were experimented on until they either were cured or died. A slaveholding surgeon, François Marie Prevost, pioneered cesarean section surgeries on American enslaved women's bodies through repeated experimentation. James Marion Sims, another famed 19th-century gynecologist, created the surgical technique that repaired obstetrical fistula by experimenting on a group of Alabama enslaved women.

That gynecology advanced from American slavery means that Black people have always had a precarious relationship to the field and its practitioners.¹¹ How does a community learn to trust doctors whose forefathers were interested only in repairing and restoring Black women's reproductive health so that slavery could be perpetuated? How can doctors learn to be more sensitive to the concerns, both personal and cultural, of Black people who still hold secrets about the forced sterilizations that older southern members of their families endured? How does the medical profession unlearn a pattern of dismissing Black women's self-reported pain

when that pattern is rooted in centuries-old soil?

CONTEMPORARY MATERNAL AND INFANT MORTALITY

These questions acquire pressing urgency in the face of the continuing disparities in the health and survival of Black mothers and children today. Distressingly, although infant death rates overall have plummeted since the 19th century, the disparity between Black and White infant deaths today is actually greater than it was under antebellum slavery. Historical demographers estimate that, in 1850, enslaved infants died before 1 year of age at a rate 1.6 times higher than that of White infants (340 vs 217 deaths per 1000 live births).¹² In comparison, Centers for Disease Control and Prevention figures from 2016 show that today non-Hispanic Black infant mortality is 2.3 times higher than mortality among non-Hispanic White babies (11.4 deaths and 4.9 deaths, respectively).¹³

In addition, although Black women live longer lives now, the effects of racism have reverberated in their lives and those of their children in damaging and fatal ways. Since 1994, maternal mortality has dropped by almost 50% worldwide. Yet, between 2000 and 2013, high Black maternal death rates placed the United States second worst in maternal mortality among 31 Organisation for Economic Co-operation and Development nations.¹⁴ In the United States, pregnancy-related mortality is three to four times higher among Black women than among White women.¹⁵

Since the 1990s, research on maternal and infant death disparities has increasingly pointed to structural racism in society at large as a stressor that harms African American women at both physiological and genetic levels.^{16,17} Conditions such as hypertension, which have been linked to the stress of living in a racist society, contribute to disparities in pregnancy-related complications such as eclampsia.¹⁸ These detrimental health effects of daily life are then further compounded by racial discrimination and disregard within medical institutions.¹⁹

Yet, as reproductive justice groups such as the Black Mamas Matter Alliance point out, expecting and new Black mothers often find their self-reports of painful symptoms overlooked or minimized by their practitioners.²⁰ It seems that, rather than addressing systemic racism in obstetrics and gynecology, medical practitioners have instead to some extent emphasized all of the ways Black women allegedly make themselves prone to being ill during their pregnancies. Black pregnant women and non-gender binary folks are told their fatness, advanced age, dietary choices, and lack of prenatal care have increased their chances of dying during childbirth. Yet, whereas Black pregnant people and mothers are made into culprits and the initiators of their deaths, doctors, nurses, and the hospitals they run are not looked at as critically as they should be.

ANTIRACIST PUBLIC HEALTH INTERVENTIONS

Public health professionals are charged with preventing illness

and injuries before they occur, so how do we use the framework of prevention to eradicate medical racism? Two projects launched in the Civil Rights and Black Power movements of the 1960s and 1970s offer models of community health care informed by antiracist political analyses. The health activists involved in these projects sought to address deep societal inequalities and empower their clientele by transforming the spaces and hierarchies of traditional medicine.

The Tufts-Delta Health Center, established in 1965 in the all-Black town of Mound Bayou, Mississippi, offered comprehensive health care funded by federal Office of Economic Opportunity grants. Local leadership on the advisory committee, as well as practitioners, administrators, and outreach workers hired from the local population, helped to overcome the well-justified distrust of medical facilities. In the Mississippi Delta, infant mortality among Black families was three times higher than that among Whites. Local input gathered through many hours of community organizing ensured that women's and children's health would be central to the center's mission. As a result, attention to clean water sources, food security, and safe shelter complemented the center's obstetrics and gynecology services. Still, some radical health activists argued that their local efforts did not truly transform American health care or the inequality endemic in the broader society.²¹

The People's Free Medical Clinics, founded by the Black Panther Party, embraced a more autonomous model of community health as part of their revolutionary politics. Required by 1970 in each local chapter, the Black Panther Party opened

clinic spaces in or near their offices that sought to empower patients and demystify both medical procedures and medical authority. As noted by historian Alondra Nelson, the white coat in the clinics became a sign of radical access to health as a human right rather than a dreaded symbol of racist abuse.

Free clinics made up one component of the Black Panther Party's "serve the people" programs that especially attended to mothers' and children's health through free breakfast programs, sickle-cell screening, well-baby checkups, and gynecological exams. Although stretched for funds and space, the clinics became "sites of social change" that supported, celebrated, and empowered Black life.²² The health activists associated with both the Tufts-Delta Health Center and the People's Free Medical Clinics challenged the idea of race as a causal determinant of poor health outcomes by exposing the impact of racism and poverty on Black health and well-being.

Historical examples such as these can show us possible alternatives, but deeply embedded health disparities today require new frameworks of understanding and systemwide interventions. Given how damaging and violent racism is in the lives of pregnant people and infants, public health investigators must work alongside scholars of race studies and medical personnel to eradicate the structural racism in medicine that is killing Black women and Black people more broadly. In a 2010 article published in this journal, public health and race studies scholars Chandra Ford and Collins Airhihenbuwa argued that the application of critical race theory and racial equity models could move the

field toward an "antiracist praxis."²³ Dayna Bowen Matthew, a University of Virginia law professor, complements this perspective by offering an ambitious remedy from the perspective of civil rights law. Matthew calls for critical self-reflection within medical professions and legal reform of Title VI legislation that would create a structure of legal accountability for implicit bias and unconscious racism.²⁴

Despite the merit of these incisive proposals, the effects of structural racism on Black lives are still decimating Black communities. We need bold, concrete plans to move forward. Medical professionals know the impact of racism but seem to think it is not fully applicable to the way they manage their hospitals and treat patients. They are aware of the unfair burden placed on medical staff at hospitals who are overworked, sometimes practice lax routines around hygiene and sanitation, do not have sufficient access to continued education and training, and still seem to believe that poorer patients, many of whom are Black, are not trustworthy, are heavy drug users, are ignorant, and are to blame for their illnesses.

It is not surprising, for example, that in Brooklyn, a borough with an overwhelmingly large Black and brown poor population, more Black women and their children die from pregnancy- and delivery-related conditions than anywhere in the state. In fact, they are eight times more likely than White women to die from either pregnancy or delivery. The crisis is so deleterious that, in July 2018, New York City mayor Bill de Blasio launched a four-point plan with an investment of \$12.8 million over the subsequent three years. This plan would implement implicit bias training for city

public and private health care providers, support more effective data tracking and analysis of maternal mortality and morbidity rates for better prevention, improve maternal health care at city hospitals and other health care locations, and create a partnership with community-based organizations to expand public education on issues of maternal health.²⁵

This is one of the most comprehensive and progressive plans that incorporates an antiracist public health model. It recognizes that the system is broken and does not rely on the centuries-old practice of blaming victims. New York officials also looked to California, which took the lead in working to dismantle structural racism in maternal medicine: "Established in 2006, the California Maternal Quality Care Collaborative (CMQCC) has used data-driven approaches in an attempt to understand the root causes of maternal mortality."^{26(p51)} The CMQCC has, in 13 years, reduced the maternal mortality rate from 16.9 per 100 000 population to 7.3.²⁶ In large part, it is demonstrating for Americans how a commitment to antiracism work can save lives and acknowledging that any system built on the backs of the enslaved needs repairing.

Black people have a right to be suspicious of an institution that has historically victimized their ancestors for centuries. It is up to all of us, but especially medical doctors and public health professionals, to decolonize obstetrics and gynecology specifically, and American medicine more broadly, and to apply comprehensive antiracist policies in the prevention of Black people's deaths. Harkening back to Governor Northam's statement that there is no better person to heal illness than a doctor, perhaps doctors, and all medical

personnel—including those in public health—should accept that they need healing too. *AJPH*

CONTRIBUTORS

Both authors contributed equally to this commentary.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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13

Assumptions can no longer drive the work

Myth	Reality
Babies are dying due to poor or no prenatal care.	Cuyahoga County has the highest rate of prenatal care in the state and the worst IMR.
Poor Black babies are dying, so poverty must be key.	In 2017, 50% of African American babies who died from prematurity and birth defects were on Medicaid and 50% on private insurance.
Babies who are dying are born to teen moms and/or moms who abuse drugs and alcohol.	In the past 10 years, less than 4% of all infant deaths were born to teen moms and/or moms with addiction or mental health issues.

Since 2015...In Cuyahoga County

- Decrease in the overall infant mortality rate (10.51 to 7.0 per 1,000 live births)
- Decrease in premature infant deaths and births
- Decrease in number of babies born at 22 weeks or less gestation
- White infant mortality rate is 3.40 (5.77 in 2015)
- Black infant mortality rate is 13.26 lowest since 2015 (18.45)

SOURCE: FIRSTYEARCLEVELAND.ORG

First Year
Cleveland

VIEWPOINT

Racial Bias in Health Care and Health Challenges and Opportunities

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A landmark report from the Institute of Medicine (IOM) in 2003 documented that from the simplest to the most technologically advanced diagnostic and therapeutic interventions, African American (or black) individuals and those in other minority groups receive fewer procedures and poorer-quality medical care than white individuals.¹ These differences existed even after statistical adjustment for variations in health insurance, stage and severity of disease, income or education, comorbid disease, and the type of health care facility. Very limited progress has been made in reducing racial/ethnic disparities in the quality and intensity of care.² The IOM report concluded that multiple factors contribute to racial disparities in medical care and that unconscious bias by health care professionals contributes to deficits in the quality of care. This Viewpoint discusses the potential contribution of societal racial bias to disparities in health care and health status.

Sources of Bias and Its Consequences

A possible role of racial bias is surprising to many people, given that large positive changes in the racial attitudes of white people have occurred in the last 60 years. However, research also reveals that implicit bias is one of the multiple ways in which racial bias and racism manifest but makes it less readily recognizable. In navigating their social world, all humans engage in conscious, deliberate cognitive processes, as well as implicit (unconscious) automatic evaluative processes based on images stored in memory. Negative beliefs about race are deeply ingrained in US culture, with many images in popular culture devaluing nonwhite racial populations. For example, greater exposure to television programs that portray black people negatively is associated with higher levels of racial prejudice toward blacks. Although blacks appear more frequently on television programs than in the past, more negative nonverbal behavior (facial expressions and body language) is directed toward black characters than to status-matched white ones, and exposure to nonverbal bias increases viewers' racial biases, even though viewers are not consciously aware of these patterns. A study of the books, newspapers, and other materials that many college-educated US adults may read in their lifetimes found that the word "black" was most frequently paired with, in order of frequency, *poor, violent, religious, lazy, cheerful, dangerous*.³ "White" was most frequently paired with *wealthy, progressive, conventional, stubborn, successful, and educated*. Thus, negative stereotypes of black individuals (violent, lazy, and dangerous) reflect, in part, how often US adults have seen these words paired with *black* over their lifetime.

The presence of implicit biases that favor whites over blacks is consequential for the behavior even of in-

dividuals who sympathize with those who have experienced injustice and are committed to principles of racial equality. Higher levels of implicit bias among clinicians have been directly linked with biased treatment recommendations in the care of black patients, although the pattern is not uniform.⁴ Implicit bias by clinicians has also been associated with poorer quality of patient-physician communication and lower patient ratings of the quality of the medical encounter.

Race/Ethnicity and Health

Disparities in medical care contribute to the even larger challenge of pervasive and persistent racial/ethnic disparities in health status. In the United States, compared with white individuals, black individuals have earlier onset of multiple illnesses, greater severity and more rapid progression of diseases, higher levels of comorbidity and impairment throughout the life course, and increased mortality rates. Where data are available, similar patterns are evident for American Indians, Native Hawaiians and other Pacific Islanders, low socioeconomic status (SES) Asian populations, and US-born Latinos and those with long-term residence in the United States. These racial/ethnic disparities in health are costly to society in terms of loss of life in the most productive years of life. For example, black-white differences in mortality have been estimated to account for the premature deaths of 260 African Americans every day.⁵

Although racial disparities in access to care, as well as in the quality and intensity of care, contribute to racial/ethnic disparities in the severity and course of disease, most racial disparities in the onset of illness occur prior to the presentation of patients to receive health care. Racial/ethnic differences in SES are large and contribute to racial/ethnic differences in health. In 2013, for every dollar of household income white people earned, Hispanic households earned 70 cents and black households earned 59 cents (identical to the black-white gap in income in 1978).⁶ Socioeconomic status, whether measured by income, education, or occupational status, in the United States and globally is a central factor associated with variations in health. The opportunities to be healthy in the environments in which individuals live, learn, work, play, and worship are key determinants of health. In US data, SES tends to be a stronger factor related to variation in health than race, and SES disparities in health are evident within each racial group.

Discrimination and Health Effects

When the health of black and white people are compared at equivalent levels of income and education, racial disparities are reduced but remain evident at all levels of SES.⁷ A growing body of evidence suggests that

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societal racial bias contributes to these residual effects of race in multiple ways. Scientific evidence indicates that conscious and unconscious bias combine to create patterns of racial/ethnic discrimination in employment, bank loans, housing, purchasing a car, and hailing a taxi.⁸ Individuals who face discrimination are aware of some of these experiences, which are a source of psychosocial stress. A recent review⁹ documented that self-reported measures of discrimination were adversely related to multiple indicators of health (eg, hypertension, all-cause mortality, incident asthma, incident breast cancer, and poor mental health), several early indicators of clinical disease (eg, inflammation, carotid intima-media thickness, visceral fat, obesity, coronary artery calcification, shorter telomeres, and cortisol dysregulation), and health behaviors (eg, poor sleep quantity and quality, cigarette smoking, and substance use). In addition to exposure to discrimination, similar to other types of stressors, the threat of discrimination was also related to increased cardiovascular response, symptoms of poor mental health, and hypertension. Perceived discrimination has also been associated with lower levels of health care seeking and adherence behaviors, and research in the United States, South Africa, Australia, and New Zealand has revealed that discrimination makes an incremental contribution over SES in accounting for racial disparities in health.

Racial bias also affects health through institutional mechanisms. Although segregation has been illegal since 1968 and black individuals show the highest preference for residing in integrated neighborhoods, declines in segregation in recent decades have been very small and have had negligible effects on the residential concentration and isolation of most African Americans and the geographic concentration of urban poverty. Segregation affects health by restricting socioeconomic attainment through limiting access to quality educational and employment opportunities. Segregation also leads to residence in poorer-quality housing and in neighborhood environments with elevated risk of exposure to acute and chronic psychosocial stressors and toxic chemicals and reduced access to resources and amenities that enhance health, including medical care.

What Can Be Done?

Some physicians are unaware that racial disparities exist and question the evidence of disparities.² Successfully addressing the possibility of clinician bias begins with awareness of the pervasiveness of disparities, the ways in which bias can influence clinical decision making and behavior, and a commitment to acquiring the skills to minimize these processes.

Medical schools, health care organizations, and credentialing bodies should pay greater attention to disparities in health and health care as a high national priority. These organizations should redouble their efforts to increase awareness of disparities, enhance diversity in the health professions, and work toward eliminating discrimination and its adverse effects on health and health care. Considerable evidence is available to guide in the implementation of interventions to reduce racial/ethnic differences in health and health care.² Moreover, the United States is not unique. Similar patterns of racial health disparities are found in other countries, such as the United Kingdom, Australia, Canada, New Zealand, South Africa, and Brazil. Leadership on racial equity to address health disparities in the United States could have positive national effects and additional potential effects on stigmatized racial populations around the world.

The health care system cannot eliminate racial/ethnic disparities in health. Health care professionals need to collaborate with other sectors of society to increase awareness about the health implications of social policies in domains far removed from traditional medical and public health interventions. Much of the contemporary disease burden is linked to behaviors that are potentially modifiable with access to timely information and the necessary resources and opportunities to facilitate the challenge of behavioral change. Many individuals live, learn, work, and play in disadvantaged contexts where it is nearly impossible to pursue healthy choices. Multilevel policies and interventions in homes, schools, neighborhoods, workplaces, and religious organizations can help remove barriers to healthy living and create opportunities to usher in a new culture of health in which the healthy choice is the easy choice.

Focusing only on racial disparities in health, in which the health of white people is used as the reference, obscures a major challenge that the United States faces in improving health. A recent IOM report indicated that people in the United States have poorer health than individuals in other high-income countries and that even the most advantaged individuals had worse health than their peers in other affluent nations.¹⁰ Health policy initiatives in the United States are needed to improve the health of all, even while those policies seek to enable those farthest behind to improve their health more rapidly than the rest of the population so that the large gaps in health by race and SES will ultimately be reduced. Large social inequities in health are unacceptable in a nation founded on the principles of liberty, equality, and justice for all, and there is inadequate recognition that dismantling racial bias in all of its forms is likely to be a potent health intervention.

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