

3 Racialized Healthcare Inequities Dating to Slavery

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Introduction

The Black Lives Matter movement makes the case that black lives have not always mattered in the United States. Viewed in historical perspective, it seems clear that countless black lives—specifically, the lives of enslaved people—did not matter at all. Foremost among the unrelenting cruelties that masters, overseers, and other white people heaped upon those individuals was a lack of healthcare.¹ Infants and children fared especially poorly. After childbirth, mothers were forced to return to the fields as soon as possible, often having to leave their infants without care or food. One contemporary scholar estimates that, at one time before emancipation, the infant mortality rate was as high as 50 percent.² As for adult people who were enslaved, they often were beaten for showing signs of exhaustion or depression.³

Healthcare inequities remain evident in the US. In the early part of 2020, as the COVID-19 pandemic developed, its global nature conveyed the message that everyone was equally impacted by this global health epidemic but not equally resourced in the fight against the disease. When preliminary data and research related to the morbidity and mortality rates emerged, and when measures to contain the pandemic (e.g., physical distancing, stay-at-home orders) were implemented, the international community witnessed differential impacts on its citizens.

The US Centers for Disease Control and Prevention (CDC) found that, compared with whites and Hispanics, blacks in fourteen states were disproportionately hospitalized in the early stages of the pandemic.⁴ While the total population of blacks living in the selected states was 18 percent on average, they comprised 33 percent of the infection and hospitalization rates compared to whites, who were 45 percent of the population and 8 percent of the hospitalizations.⁵ Hispanics also had disproportionately high hospitalization rates, constituting 59 percent of hospitalizations though only 14 percent of the total population in the fourteen states the CDC surveilled.⁶ In examining fatalities, data from New York showed COVID-related deaths per 100,000 population at 92.3 for blacks, 74.3 for Hispanic/Latinx people, 45.2 for whites, and 34.5 for Asians.⁷

Additional research and data showed African Americans and other racial minorities registering disproportionate COVID-19 morbidity and mortality rates.⁸ For example, using July 2020 data from the Epic health record system for 7 million black patients and 34.1 million white patients, a group of research scholars estimated hospitalization and death rates per 10,000 patients.⁹ According to their research, black people had 24.6 hospitalizations and 5.6 deaths, and white people had 7.4 hospitalizations and 2.3 deaths.¹⁰ Those scholars and others have identified racial segregation as a key driver of the disproportionate impact of COVID-19 on African Americans and other persons of color.¹¹ African Americans are more likely to live in multigenerational households, live in crowded conditions, and have jobs such as nursing aids, transit workers, and grocery store clerks that are difficult to perform remotely. In addition to those factors, many people in predominantly black communities do not own vehicles and therefore are likely to use public transportation.¹² Moreover, high-risk individuals to COVID-19 tend to have at least one chronic condition (e.g., diabetes, hypertension, obesity, cardiovascular disease).¹³

Racism experienced by African Americans is linked to several chronic illnesses.¹⁴ The COVID-19 pandemic has cast a light on the reality of many African Americans, one that has been long denied or ignored by many scholars: medical racism exists.¹⁵ A review of the history illustrates that pathways of racism situate black people in socially murderous conditions that reproduce or perpetuate adverse health consequences. Most important, a critical historical review can help discover potential resources that African Americans have used to endure, resist, and thrive despite racism's unrelentingly pernicious effects on black communities. This essay documents the Black Church as a spiritual and healing resource dating from slavery.

History of Racial Health Inequalities

Racialized ideologies and practices, including those in medicine that undermine health and lead to avoidable deaths in black communities, date back to the slave era in the US. Such practices have produced unequal access to healthcare in ways that disproportionately affect African Americans. Scholarship on the evolution of racism and medical history in the US documents white people's reliance on the racist ideas of black people's animal-like inferiority to justify the dehumanization and exploitation of black people for capital accumulation. Medical science, which evolved slowly in colonial North America compared with Europe, assumed biological differences between black and white people to justify the racist idea of black inferiority and the control over black people through oppressive practices.

Colonial racism also justified the precarious living and working conditions, and even rationed medical care, by white slave owners to enslaved black people. Oftentimes, enslaved people were isolated geographically into environments where they were overworked, fed poorly, and housed in

overcrowded conditions. Those circumstances promoted the transmission of germs, thereby increasing vulnerability to disease. Moreover, because enslaved people received no pay, they equally as often lacked proper resources to maintain good personal hygiene. They lived with unwashed clothes, infrequent baths, limited dental care, and unclean beds. These living conditions, coupled with sexual, physical, psychological, and spiritual abuses, not only facilitated adverse conditions such as body lice, ringworm of the skin and scalp, and bedbugs¹⁶ but also perpetuated the “assumption of poor health as ‘normal’ for Blacks.”¹⁷

The oppressive practices and dehumanizing treatments mentioned above began at slave dungeons in forts established by Europeans on the coastal shores of Africa, where they captured and kept Africans before shipping them.¹⁸ In Ghana, for example, such dungeons had very limited ventilation. Captives could not shower for months. Dungeons were where they ate, urinated, defecated, and did everything else. Archeological evidence indicates that, because of deadly conditions, even cleaning dungeons was a feared operation for white people: they were likely to contract smallpox, an intestinal infection, or some other condition.¹⁹

Numerous white slave traders and physicians across the globe justified the horrendous treatment of enslaved people on partial readings of both the Old and New Testaments.²⁰ For example, an 1833 report indicated the Harmony Presbytery of South Carolina passed a resolution noting that human bondage had “existed from the days of those good old slave-holders and patriarchs Abraham, Isaac and Jacob (who are now in the kingdom of heaven), to the time when the Apostle Paul sent a runaway home to his master, Philemon.”²¹ Therefore, the report concluded, “the existence of slavery itself is not opposed to the will of God.”²²

The generally terrible conditions that enslaved people endured in the US and elsewhere in the world led to their tending to have a higher prevalence of disease than free people.²³ Common health problems among those who were enslaved in the US included typhus, measles, mumps, chickenpox, typhoid, and other respiratory or intestinal diseases.²⁴ Because an enslaved labor force was essential to the wealth of free people, some masters showed interest in the health of their human chattel. Such masters relied on three primary sources to provide care: the enslaver himself or herself, someone enslaved (e.g., older woman, granny doctor), or, frequently of last resort, a white physician.²⁵

In numberless instances, white slave masters called for white physicians to treat enslaved black people only when illnesses were severe or when normal procedures became complicated; difficult pregnancies were exemplars.²⁶ Slave masters typically summoned white physicians to provide services to certify enslaved people were fit to work,²⁷ and patients, as chattel, often had no say in their plans of care.²⁸ The possibility that white people would use sick black bodies for experimentation generated substantive fear and mistrust in the healthcare that white physicians provided to enslaved

black people in an already class and caste stratified, ethically/racially segregated health system.²⁹ As a result of the aforementioned tendencies, the best healthcare an enslaved person could expect was combined treatment from a fellow enslaved person, a master, and a physician.³⁰

African health practices became part of cooperative exchanges within an emerging Black Church.³¹ Overall, the history of health and status of blacks in colonial America presents a nuanced and complicated picture of religion, racism, and health before the creation of the US. When black bodies were certified fit to work, they provided free labor and benefited whites financially. When black people became sick or died, their bodies were integral to establishing medical institutions, training white medical professionals, and achieving medical breakthroughs.³²

White scientists inflicted tremendous pain on pregnant enslaved women, resulting at times in infant deaths. Nevertheless, many white physicians and medical institutions gained considerable wealth or fame. James M. Sims, a physician and a practicing Christian known today as the “father of American gynecology,” treated black women in his care as commodities.³³ One enslaved woman, Lucy, was the subject of thirty gynecological surgeries that Sims performed without anesthesia to perfect his medical procedure before using it on white women he anesthetized.³⁴ Sims’s brand of Christianity aligned with biased concepts, so he accepted a false belief regarding the divine order of slavery and there being both spiritual and physical differences between white and nonwhite people.³⁵

Today, racism remains embedded in American society and culture. In many places, racism sustains individual and collective structures that concentrate black people in segregated spaces characterized by under resourced schools, limited employment prospects, food insecurity, a lack of access to healthcare, and higher mortality rates.³⁶ In a 2020 survey exploring black adult perceptions of racism during the COVID-19 pandemic, 73 percent identify individual acts of racism while 79 percent named structural or systemic racism as obstacles to achieving equal outcomes with white people.³⁷ In the same survey, the majority of blacks—65 percent of whom were men, and 59 percent were women—indicated that it was a bad time to be living as a black person in the US.³⁸ Their experiences were continuums of a long history of racism that continues to breed mistrust in black communities. Widespread black concern about COVID-19 vaccinations reflect that stained legacy.³⁹

Historical and contemporary evidence suggests that residential segregation is another critical pathway through which racism operates to adversely affect the health of African Americans. Although the court-ordered desegregation of public places like hospitals has existed for generations, high levels of residential segregation have persisted for many more generations. Even churches have been affected. Most blacks and whites still worship separately, so Sunday from 11 a.m. to 12 p.m. remains “the most segregated hour of the week,” to quote a 1965 statement by the Rev. Martin Luther King Jr.⁴⁰

Continued residential segregation affects the health and other elements of African Americans' well-being in multiple ways, including access to quality healthcare services, food, housing, schooling, and employment. High poverty and violence rates in many neighborhoods hurt economic status. The concentration of individuals and families into different neighborhoods by race/ethnicity exacerbates matters. A racial empathy gap exists between racial/ethnic groups rather than members within homogenous groups, according to scholars David Williams and Lisa Cooper.⁴¹ The gap, moreover, is longstanding. Because slave owners, including so-called Christian slave owners, dehumanized their human property, enslaved blacks people often fended for themselves. Today, the involvement of black communities in their healthcare needs are rooted in the historical legacies of white exploitation and racial/ethnic bias.

How Have Black Communities Responded? The Black Church as a Case in Point

In the same way that racism has been unrelenting in undermining African Americans' health, black communities have been actively resisting racism's effect on their health.⁴² Spirituality, as expressed through black churchgoing, has been a central mechanism by which African Americans from slavery forward have had at their disposal for promoting health and coping with sickness.⁴³ Spirituality provides comfort and strength to cope with health and has been shown to have a positive effect on the progression of disease and, in some cases, mortality.⁴⁴

Historically, the Black Church has been the cornerstone of black communities, providing the context for developing substantial economic, political, and social capital. It remains a viable institution to confront racism and negative health consequences in black communities.⁴⁵ Beyond direct advocacy, black churches engage in several approaches to good healthcare (e.g., education, food pantries, counseling, prayer, collaboration with professionals).⁴⁶ Black churches also collaborate with independent researchers as well as colleges and university departments to deliver healthcare services.⁴⁷ In addition to those endeavors, black churchgoers provide emotional support to suffers and encourage a range of other health-related activities, to include physical exercise and nutritional guidance, to help others promote wellness.⁴⁸

According to social and behavioral scientist Marino Bruce, faith within black communities represents assets and competencies that address acute health crisis like COVID-19 and sequelae; hence, people should support black churches and engage in the fight against the racial health inequities the COVID pandemic has amplified.⁴⁹ Indeed, the pandemic has cast a spotlight on the pre-COVID injustice contexts: many advances in biomedical research did not address health inequity among racial/ethnic groups before COVID; therefore, concerned individuals must understand that advances

in medicine alone likely will not address post-COVID challenges in black communities.

The Black Church has been a safe haven for black communities. They have received spiritually affirming messages and social supports that have bolstered their coping capacities in racialized healthcare contexts. The role of black churches in deconstructing racial mistrust and increasing African Americans' access to quality healthcare services in culturally responsive ways is key to achieving equitable healthcare services and better health outcomes.

The COVID-19 pandemic has cast a spotlight on the everyday reality of many individuals within black communities. This reality is likely attributable to both historical and contemporary forms of racism. Moving forward, efforts to care for the health needs of African Americans and to acknowledge the consequences of racial health inequities must also recognize the indispensable role of black churches in promoting health and connecting communities to healthcare practitioners and other healthcare resources.

Notes

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