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"The United States government did something that was wrong—deeply, profoundly, morally wrong. It was an outrage to our commitment to integrity and equality for all our citizens... clearly racist."

—President Clinton's apology for the Tuskegee Syphilis Experiment to the eight remaining survivors, May 16, 1997

For forty years between 1932 and 1972, the U.S. Public Health Service (PHS) conducted an experiment on 399 black men in the late stages of syphilis (Brandt, 1978). These men were predominately uneducated sharecroppers from one of the poorest counties in Alabama. They were never told of their syphilis diagnosis or the seriousness of the disease. Informed that they were being treated for "bad blood" instead, their doctors had no intention of curing them of syphilis during the course of the study. The data for the experiment was to be collected from autopsies of the men, and they were subsequently left to degenerate under the ravages of advanced syphilis—which can include tumors, heart disease, paralysis, blindness, insanity, and death. "As I see it," one of the doctors involved explained, "we have no further interest in these patients until they die" (Jones, 1981, p. 134). The true nature of the experiment had to be kept from the subjects to ensure their cooperation. The sharecroppers' lack of education and low incomes made them prime targets for the experiment. Pleased at the prospect of free medical care—almost none of them had ever seen a doctor before—these unsophisticated and trusting men became the pawns in one of, if not the most, unethical human experiments (Brunner, 2007).

The study was meant to discover how syphilis affected blacks as opposed to whites. The theory proposed by researchers was that whites experienced more neurological complications from syphilis than blacks and that African Americans were more susceptible to cardiovascular damage (Brandt, 1978). How this knowledge would have changed clinical treatment of syphilis is still unclear. When the experiment was brought to the attention of the media in 1972, news

anchor Harry Reasoner described it as an experiment that "used human beings as laboratory

animals in a long and inefficient study of how long it takes syphilis to kill someone" (Jones,

1981, p. 10). By the end of the experiment, 28 of the men had died directly because of syphilis,

100 were dead of related complications, 40 of their wives had been infected, and 19 of their

children had been born with congenital syphilis (Brunner, 2007).

Following the Tuskegee syphilis study being revealed to the public, African Americans

began questioning the government and health care practices involving other illnesses as well. In

1990, a survey found that ten percent of African Americans believed that the U.S. government

created AIDS as a plot to exterminate blacks, and another 20 percent claimed they could not rule

out the possibility that this might be true (Kelley, 2008). As unbelievable and appalling as this

may sound, at one time the Tuskegee experiment must have seemed equally implausible. Who

could imagine the government, all the way up to the Surgeon General of the United States,

deliberately allowing a group of its citizens to die from a terrible disease for the sake of an ill-

conceived experiment? In light of this and many other shameful episodes in our history, African

Americans' widespread mistrust of the government and white society in general should not be a

surprise to anyone (Brunner, 2007). This medical mistrust among African Americans is a long

held attitude, which stems from centuries of racial discrimination and maltreatment, as best

demonstrated by the Tuskegee syphilis study (Paradies, 2006).

Race and Racism

African Americans have been defending their race against discrimination and power

struggles for centuries, but in reality, what really are race and racism and what causes these ideas

to exist in society? According to Paradies (2006), race is not a biological construct, but instead, a

social one. The racial groups as we know of today were actually created before the development

of valid scientific theories about genetics, and so therefore do not represent biological

distinctiveness. According to the American Association of Physical Anthropology, "There is

considerable biological variation in human populations, but our racial categories fail to capture

it. There is more genetic variation within our existing racial groups than between them"

(Paradies, 2006, p. 891). Currently in the United States, the racial groups are constructed to

capture the differences in power, status, and resources. Racial categorization has always been

rooted in racism, and within the U.S. context Whites have always been on top, blacks on the

bottom and other racial groups scattered in between. Racism is demonstrated through the idea

that inferiority is used to justify unequal treatment, or discrimination of members of groups

defined as inferior by individuals and societal institutions. This construct of racism enhances the

understandings of racial inequalities in the health care system because the ideology of inferiority

may lead to the development of negative attitudes and beliefs towards different racial groups and

therefore influence the quality of health care different racial groups receive. Another helpful

definition of racism by Gee (2002) is that racism involves harmful and degrading beliefs and

actions expressed and implemented by both institutions and individuals. This framework of

racism touches on the important idea that not only can individuals be racist, but institutions as

well.

Mechanism

For centuries, African Americans have faced the consequences and daily struggles of

discrimination and racial inferiority in every stroke of life. Healthcare is an area in which many

African Americans have perceived racism and suffered the detrimental health effects and

consequences of this maltreatment. In fact, racism is one of the mechanisms that explains and

expands racial disparities in health (Gee, 2002). Whether indirectly through environmental

factors and educational and economic resources or directly through lack of care and minimal treatment of diseases, African Americans have experienced racial discrimination and racism in the field of health care and have suffered the negative effects of this disparity for centuries. While strides have been taken to improve these conditions that cause racial discrimination, studies suggest these efforts are simply not working.

Many different studies have been conducted on racial discrimination in health care. They all operate under the notion that African Americans have a higher disease rate as compared to Whites and that this has been persistent over time (Williams, 1999). An example was discussed in an article in Newsweek, which stated that the HIV rate has doubled in the African American population while remaining fairly consistent in the white population (Kelley, 2008). African Americans consistently comprise a higher percentage of hypertensive patients and have higher mortality rates as compared to white patients, as well. These differences in health outcomes bring up the question of "why" and "how". What mechanism is causing the unequal distribution of serious medical conditions and outcomes among blacks and whites? According to Williams and Jackson (2005), these disparities in health and health care are rooted in a deeper and larger historical, geographic, sociocultural, economic and political context with the overall consensus being that the indirect and direct effect of socioeconomic status (SES) and the resources and treatment that come with each of these serve as the mechanism by which health disparities operate.

Socioeconomic Status

Socioeconomic status is the social standing of an individual in terms of their income, education and occupational status. Individuals with a lower socioeconomic status face more challenges in regards to accessing health care and preventative services (American Psychological

Association, 2012). It is challenging for those who live in poverty to gain access to health insurance plans or affordable ones at minimum. And the plans sponsored by State Governments are meager when it comes to care, especially in regards to preventative measures. Mental health problems and the therapy needed by these patients are not typically covered under most of these policies, even though a high proportion of the population living in poverty suffers from mental health disorders.

Socioeconomic status predicts variation in health and healthcare within minority and white populations and is responsible for much of the racial differences in health and health outcomes (Williams, 1999). According to the American Psychological Association, 26% of African Americans are currently living in poverty (lowest SES level) as compared to only 8% of Non-Hispanic Whites (American Psychological Association, 2012). This is a huge disparity between these two racial groups. Studies have shown that those who live at lower economic levels have higher rates of morbidity and mortality and are two to five times more likely to be diagnosed with or suffer from a mental disorder than those who are living in the upper socioeconomic statuses (American Psychological Association, 2012). According to the data conducted in a study of psychosocial correlates of medical mistrust by Hammond in 2010, the positive correlation of socioeconomic status and the ability to access healthcare is upheld. It was found that men with more years of education were more likely to report having seen a doctor more recently and having higher quality patient/physician interactions than those with fewer years of education (Hammond, 2010).

Indirect Disparities

The inability of people with lower socioeconomic status receive proper healthcare is a

problem with its source rooted in the racial segregation and discrimination by the government

and citizens themselves. Even though segregation laws in regards to public facilities and housing

are now illegal, the structure and therefore the consequences have remained intact over the

period of time since the 1960's when these laws were repealed and the Civil Rights Movement

occurred (Williams & Collins, 2001). Unfortunately, a person's socioeconomic status greatly

affects the residential area in which he or she will reside and therefore the environment they are

exposed to as well as educational resources and community benefits that are available to them.

According to Williams and Jackson (2005), the residential concentration of African Americans

leads to inequalities in neighborhoods, socioeconomic status and quality of medical care. The

previous racial segregation in residential areas has maintained its prevalence, even through the

twenty first century. It is a vicious cycle, as those who live in impoverished areas have less

access to quality schools, are less likely to graduate and obtain well-paying jobs and therefore

remain in poverty and in the same racially segregated residential areas. And as stated before,

lower income is positivity related to poor and lower standard healthcare (Williams, 1999). This

institutionalized racism and racial segregation within income levels has an indirect effect on

healthcare and health outcomes of minority races.

The inability to obtain affordable healthcare has put a strain on the health of those who

occupy a lower ladder in the hierarchy of the socioeconomic status. According to Newsweek,

children living in poverty are about seven times more likely to be in poor health than children

living in higher income households (Kelley, 2008). The number and severity of health problems

has an inverse relationship with socioeconomic status. As a person's socioeconomic status drops,

the number of health problems and the severity of these issues increase. This is another example

of the indirect effect of economic segregation on the health and health outcomes of those who

live in poverty. Also, chronic exposure to stress can cause altered physiological functioning and

therefore increase risk for a broad range of health conditions (Williams & Jackson, 2005). As

someone's socioeconomic status decreases, the levels of stress a person endures increases

dramatically. And as stress levels increase, there is an increase in a person's vulnerability to the

negative health effects of stressors (Williams & Jackson, 2005).

Direct Disparities

Racial discrimination does not only indirectly affect healthcare of African Americans, but

racism and discrimination are directly seen within the actual field of medicine in patient care and

interaction. One study in particular investigated how a patient's race is a determinant of patient

satisfaction, specifically cardiac patients (LaVeist, Nickerson & Bowie, 2000). In the study, 30%

of African American patients endorsed the idea that racial discrimination in a doctor's office is

common while only 7.3% of Whites agreed. On the other side, 88.1% of White patients agreed

that African American patients can receive the care they want as equally a White patients can,

but only 61.2% of African Americans agreed and felt the same way. This says suggests that

African Americans believe racial discrimination occurs more in a doctor's office than White

patients and that Whites tend to be blind to the idea of racial discrimination within the healthcare

setting.

This study also found that African Americans were 91% more likely than White patients

to perceive social class differences in the treatment that patients received at hospitals (LaaVeist,

Nickerson & Bowie, 2000). In a research study by Williams and Jackson (2005), the Institute of

Medicine reported that African Americans also receive poorer quality emergency room care than

do their white counterparts. This relates back to the previous idea that socioeconomic status

plays a great role in the quality of health care received by an individual. When it comes to

satisfaction with the care received, 73% of White patients in the study reported that the doctor

did a good or excellent job providing care overall. Only 61.4% of African Americans said the

same thing. Also, only 65.6% of African American patients felt like the doctor did a good or

excellent job treating them with dignity and respect, compared to 78% of White patients. Overall

results of the study showed that African American patients were significantly less satisfied with

their care and reported more medical mistrust than their White counterparts. In other words,

perceived racism and patient satisfaction are inversely related. As a patient's perceived racism

increases, the patient's satisfaction decreases (LaVeist, Nickerson & Bowie, 2000).

Perception of racism in healthcare by African American men was found to be the most

powerful correlate of medical mistrust (Hammond, 2010). This perception of racism stemmed

from personal past experiences and expectations of disparities in treatment. In other words, the

men go into the appointments thinking that they will be treated differently because of their race

and therefore increase their personal medical mistrust. According to a study by Gamble (1997),

this perception of racism stems back to the Tuskegee Syphilis study previously discussed.

African American men constantly are shadowed by the umbrella of Tuskegee nightmare and the

way the medical community treated them and therefore, still feel like they do not know whom

they can trust. According to Gamble (1997), the Tuskegee experiment is the singular reason why

African American men still distrust the high institutions of medicine and the public health

system.

This medical mistrust has also progressed into limited participation of African Americans

in medical research trials since the truth of the Tuskegee experiment came to light (Gamble,

1997). This critically low black participation in research trials and organ donations, has caused

issues and complications in studying future procedures and medications, and will only continue

to disable and handicap researchers in finding cures and solutions to problems which affect

African American's predominately (Gamble, 1997).

   Another example of direct racial disparity in healthcare is the fact that the number of

Blacks living in the United States with hypertension is more than twice that of the White

population (Krieger & Sidney, 1996) . In a study using CARDIA (coronary artery risk

development in young adults) (Krieger & Sydney, 1996), the authors determined that self-

reported experiences of racial discrimination and blood pressure were related and this

mechanism helped explain the disparities in elevated blood pressure between the two racial

groups. The results indicated that racial discrimination shapes patterns of hypertension among

Blacks and Whites differently.

   This pattern could also be related to socioeconomic levels and ability to obtain and

maintain a healthy, well-balanced diet. People living in poverty typically suffer from a poorer

diet of processed food, get little to no exercise and experience daily stress, which increases the

likelihood of elevated blood pressure (Krieger & Sidney, 1996). Ares of urban development

sometimes become known as food deserts, which are neighborhoods and communities that have

limited or restricted access to nutritious and health food choices (Whitacre, Tsai, & Mulligan,

2009). In these food deserts, individuals of lower socioeconomic status are more likely to eat

energy dense foods that are nutrient-poor compared to higher income individuals who eat more

fresh and protein rich diets (Darmon & Drewnowski, 2008). In these neighborhoods with limited

access to supermarkets and grocery stores that provide shoppers with healthy food options,

individuals have higher rates of obesity, diabetes and cardiovascular disease (Whitacre, Tsai, &

Mulligan, 2009).

In an article in the *American Journal of Public Health* written by van Ryn and Fu (2003),

direct provider racism is also discussed. It states that providers may have preconceived beliefs

and expectations of a patient based on their race, socioeconomic status and education level

before even giving the patient a fair chance. These biased beliefs lend themselves to unequal

treatment and unwillingness to aggressively treat patients. The article showed that providers who

perceive that their patients are less likely to adhere to the necessary treatment, are less likely to

aggressively treat their illnesses or prescribe more complicated, yet helpful, procedures and

treatment plans (van Ryn & Fu, 2003). An example of this is the procedure recommendation and

information given by physicians to African American individuals in regards to kidney

transplants. Van Ryn and Fu (2003) found that African Americans are less likely to be told about

transplant options, obtain all medical information in regards to transplants, be engaged in

discussion about receiving a kidney from a family member and recommended for

transplantation. This treatment by physicians occurs because of the preconceived notion that

African American and lower income individuals are less likely to care about their health

procedures are simply less likely to follow instructions and orders following treatment (van Ryn

& Fu, 2003).

Research and data, however, does support the idea that African Americans are less likely

to change health practices that are associated with major risk factors for diseases such as cancer

and heart disease as compared to White counterparts (Williams & Jackson, 2005). African

Americans are less likely to change their dietary behavior, physical activity levels, tobacco use

and alcohol abuse in order to decrease their risk for coronary heart disease and cancer as

compared to Whites (Williams & Jackson, 2005). While this is no excuse for treating patients

differently based on race or economic status, the data presented by Williams and Jackson (2005)

show that as socioeconomic status decreases, the participation in high health risk behavior

increases and the likelihood of changing those risk behaviors decreases. Instead of using this data

to form preconceived biases, it would be more beneficial for providers to use this information to

better form treatment plans for their at risk clients and create individualized approaches to

helping those who fall within these categories achieve the changes in their lifestyle necessary to

decrease their risk for such diseases.

      African American's not only are affected by different illnesses disproportionately to

Whites, they also suffer direct racial discrimination in healthcare in regards to the number of

procedures received. Overall, White patients typically undergo more procedures, tests,

examinations, etc., within the world of health care and patient treatment (Krieger & Sidney,

1996). White and Black patients that have similar rates of hospitalization for chest pain undergo

coronary angiography procedures at disproportionate rates. White patients are one third more

likely to undergo this procedure as compared to black patients and are twice as likely to be

treated with bypass surgery or angioplasty than black patients (Gamble, 1997). Also, older black

patients who are on Medicare receive coronary artery bypass grafts only a fourth as much as

white patients with comparable conditions and statuses (Gamble, 1997). There are only four

procedures Blacks receive more than their White counterparts. These include the amputation of a

lower limb, the removal of both testes, the removal of tissue related to decubitus ulcers and the

implantation of shunts for renal dialysis. These procedures typically result from delayed

diagnosis and initial treatment by physicians, poor or infrequent medical care and attention and

failure in the management of chronic illness (Williams, 1999). Yet again, this seems to fall back

onto socioeconomic class and the ability to obtain medical insurance that will cover preventative

care procedures and treatments.

No Disparities

While many diseases and illnesses do have disparities based upon race, there are some

illnesses, which show no disparities. These include the flu and pneumonia. In 1950, there was a

large racial difference in those diagnosed with these two illnesses, but by 2000, minimal

differences were shown. So why did this change happen? The flu and pneumonia are acute

illnesses that differ from chronic illnesses such as high blood pressure or cardiovascular disease,

which have symptoms that are not always as evident, because they have a large behavioral

component and are long term in development (Williams & Jackson, 2005). Chronic illnesses

have more disparity between African Americans and Whites because it takes more than simply

some antibiotics or fluids to treat these diseases. To treat or prevent chronic illnesses, it requires

regular doctor visits, preventative medical procedures and tests, and the resources to receive such

medical care, which African Americans are less likely to receive (Williams & Jackson, 2005).

According to Williams and Jackson, (2005) social motivation, knowledge and resources are

required to eliminate the disparities of health and diseases.

Solutions

Whether consciously or unconsciously, a proportion of the health care workers

discriminate against African Americans (Williams, 1999). If this is true, what can be done to

offset this discrimination and increase the positivity and quality of care that African Americans

receive? The American Psychological Association has some suggestions. These include

improving access to mental and behavioral health care by eliminating barriers such as limitations

in health care coverage, intervening in early childhood to support the health and educational

development of low SES children and supporting research on socioeconomic status and its

relationship to health, education and well-being (American Psychological Association, 2012).

Another way to offset this discrimination would be for the United States Government to make

the moral and political commitment to guarantee equal access to medical care to all citizens as a

fundamental right of American citizenship (Williams & Rucker, 2000). By ensuring everyone,

no matter of income level or race, received health care and removing financial barriers, the

health of individuals would increase, their socioeconomic status would increase and therefore

their earned respect of others would increase. Physicians would be more inclined to treat the

patients with more respect and dignity (Williams & Rucker, 2000).

Another way to reduce the disparities in health care among African Americans deals with

the idea that minority patients often feel most comfortable in the health care setting when a

physician of the same race provides care to them (LaVeist, Nickerson, & Bowie, 2000).

Physicians of color are in high demand in areas with larger minority populations and could help

decrease the perceived racism felt by patients and therefore increase their satisfaction and

treatment. According to Betancourt, Green, Carrillo, and Ananeh-Firempong (2003), only 4% of

the nation's physicians are African American, and as stated earlier, many patients prefer to be

treated by physicians of the same race. So the small number of African American physicians

lends itself to problems in equal availability of services among minorities in America. A

proposed solution to this problem was and still is affirmative action. Started in 1961, the idea of

affirmative action was to promote equal opportunity to all minority groups within society and

within all government and educational settings. It was justified as a compensation for past

discrimination persecution and /or exploitation by the majority over minorities in the past. An

increase in multicultural and minority physicians could help with the percentage of minority,

specifically African Americans, who perceive racism within health care.

According to a study conducted by Betancourt et al. (2003), a concept entitled "cultural

competence" is a strategy to address the disparities in health care delivery in America. Cultural

competence, as defined by Betancourt et al., (2003) is the ability to understand the importance of

the social and cultural influence on how a patient views health and health care and how these

factors interact on a multi-level basis within the health care delivery system and can be used to

develop interventions to ensure equal treatment of all patients. By developing cultural

competence, the racial disparities in health care can be reduced by those who work in the field.

Suggestions to eliminate these disparities include a framework approach addressing

organizational, structural and clinical divisions of cultural competence. Two main points within

this framework are the recruitment of minority health care providers and increasing provider

education on cross cultural and racial issues. With the recruitment of more minority physicians

and the increase awareness or development of "cultural competence" by current physicians, the

disparities in health care among African Americans and Caucasians in America can be reduced.

Other potential solutions to eliminating health disparities include increasing the economic

infrastructure of disadvantaged communities, narrowing the income gap between African

Americans and Whites, improving the quality of medical care, and rethinking health care policies

on the state, regional and federal level (Williams & Jackson, 2005). According to the research by

Williams and Jackson (2005), to effectively address the racial disparities in health and health

care, it will require addressing distal social policies and arrangements that created the disparities

in the first place. By increasing the economic capital and standing of individuals in

disadvantaged neighborhoods, the wealth will spill over into increasing health and narrowing the

income gap as well (Williams & Jackson, 2005). Then the access to preventative medical

services will not only increase, but also save lives and money down the road.

The most important aspect to eliminate disparities is the improvement and

implementation of new health policies. According to Williams and Jackson (2005), it is

important to have policies that directly affect health and health disparities and promote equal

access to health care for all. The research suggests engaging multiple departments such as Labor,

Education, Justice, Energy and Transportation on a federal level and then on state levels as well

to work together to address the problems and barriers to equal access to health care for all

Americans, no matter race (Williams & Jackson, 2005). Until equal access to health care is a

reality, the disparities in health care and health between African Americans and Whites will not

begin to disappear and will only continue to increase.

Conclusion

Racism and discrimination are two things that, unfortunately, have been around for

centuries and seem to find unique ways to interfere with the lives of those who are affected.

Health care is something that everyone should be entitled to and something that is necessary in

order to live and maintain a healthy life. Racial discrimination against African Americans in

health care has been shown to exist directly and indirectly through perceived racism by patients

in the quality of care, lower socioeconomic status, and the resources that are available and

unavailable to its members.

Money can, unfortunately, buy better health (Williams & Collins, 2001). Those who

make more money are able to afford better care and avoid preventable health problems at a much

greater level than those who live at or below the poverty line. And unfortunately, economic

segregation correlates to racial segregation, with a higher percentage of the African American

population living in poverty compared to the white population. Racism and discrimination still

exist in society today, and one of the negative indirect effects of this is the decreased patient

satisfaction and quality of services and quality of health for those minorities being discriminated

against. Until healthcare becomes affordable for all, not dependent on someone's economic

status, minorities and lower income individuals will continue to face the adverse effects of

limited and lower quality healthcare and healthy living environments.

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