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# Bioethical Issues Confronting The African American Community

by Kelvin T. Calloway

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*The bioethical issues confronting the African American community have evolved out of the historical delivery of health care to the community. By examining these issues, learning from the mistakes of the past, and respecting the dignity of every human being, health care professionals strive toward the creation of a level playing field of health for all Americans.*

## Introduction

From slavery to the present, the policies and practices of the medical community have had an enormous impact on the health of African Americans, raising fundamental bioethical issues of justice and equality. While other communities may face similar issues, certain of these concerns are race intensive and will be addressed in this paper.

## Black Health Care: A Historic Perspective

Since the days of slavery, African Americans have experienced poor health in comparison to Euro-Americans. Africans in the New World were introduced to massive overwork, poor food, poor clothing, poor housing, inadequate sanitation, and overexposure to the elements (Byrd and Clayton 1992). There was a scarcity of physicians in the South; they only saw slaves as patients if forced to do so (193), and even then, unless they were liberally compensated, physicians probably did not maintain the highest standards in their care of slaves. The only guard against malpractice in these situations was the physician's conscience (Charatz-Litt 1992 and Savitt 1978).

From 1731 to 1812, a subservient health subsystem was created by the medical profession as a result of its attempt to medically establish through scientific research the racial inferiority of African Americans (Byrd and Clayton 1994). This effort furthered the already "flawed" white physician-black patient relationship. Between 1813 and 1860 the new dimensions of forced sexual promiscuity from slave breeding (after the out-

lawing of the Atlantic Slave Trade) and a reign of terror to suppress slave rebellion changed the profile of slaves illness as more traumatic injuries, obstetrical complications, and gynecological diseases occurred (Byrd and Clayton).

During the Civil War and Reconstruction periods, fewer doctors were assigned by the War Department to black units, resulting in African American soldiers dying of war wounds from which white soldiers recovered. Poverty, the lack of health care, and poor sanitation and housing carried the "slave health deficit" into the twentieth century. Even though science had disproved racial inferiority by the 1930's, some white physicians assisted reactionaries in enacting and enforcing the Restrictive Immigration Act of 1924 and compulsory sterilization laws in as many as thirty states (Byrd, 196). During this time, hysterectomies performed on African American women for eugenic purposes were jokingly referred to as "Mississippi Appendectomies." Unethical experimentations on blacks such as the Tuskegee syphilis experiment and similar studies at Johns Hopkins, Chicago Medical College, and the Medical College of Virginia were in full gear (Byrd).<sup>1</sup>

This historical progression of poor health care for African Americans was punctuated by two brief periods of progressive health reform.

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*Kelvin T. Calloway, D.Min., is senior minister of Trinity African Methodist Episcopal Church, Kansas City, Kansas, and adjunct professor of preaching and ethics at St. Paul School of Theology, Kansas City, Missouri.*

During the Reconstruction following the Civil War, the government passed the Freedmen's Bureau Legislation that opened soup kitchens, clinics, schools, and hospitals for the newly freed slaves. More than ten black medical schools and over fifty black hospitals were in existence by 1910. The second reform period occurred in the 1960s as a part of the Civil Rights movement with the passage of Civil Rights Acts, the hospital desegregation rulings in the courts, the Voting Rights Bills, and the Medicare/Medicaid legislation (196).

### **Black Health Care: A Contemporary Perspective**

According to Byrd and Clayton, the present crisis state of health care in the African American Community is a continuum of black health care historically. Charatz-Litt suggest that the health status of African Americans is often compared to the

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health status of Third World populations (Charatz-Litt 1978, 723). In addressing the Congress of National Black Churches in 1990, Charles Johnson characterized the crisis of health care for African Americans by citing the following facts gathered from 1987 data: life expectancy for the overall population was 75 years, while it was 69.4 years for African Americans; African Americans die at a faster rate from strokes, twice the rate of nonblacks; African American women have coronary heart disease more than other women; African Americans have cancer twenty-five percent more than others and incidence of having cancer forty-five percent more than non-blacks; diabetes is thirty-three percent more common and infant mortality is twice that of non-blacks before the age of one; blacks contract AIDS three times that of whites, with black children accounting for

more than fifty percent of all children with AIDS (Johnson 1991). Perhaps the most alarming statistic of all is that African Americans suffer more than 60,000 "excess deaths" annually (Byrd 1992). Moreover, twenty-two percent of all African Americans are uninsured and not covered by Medicaid (George 1991). The state of health care of the African American community is, indeed, in crisis.

### **The Ethical Issues in Health Care for African Americans**

The issue of justice permeates the historical overview of health care in African American communities. Historically health care resources, the benefits and burdens, have not been allocated equally. From the inadequate health care given to slaves, to the War Department's failure to assign enough physicians to units in which African American soldiers served, to the separate but unequal hospitalization in the South, health care resources have not been allocated to the African American community fairly.

A consideration of equity is also relevant to a discussion of ethical issues in health care of African Americans. The involuntary nature of African migration and the purpose for which Africans were brought to America as cheap labor have made it virtually impossible for African Americans to be viewed as human beings equal to whites. The medical community's role in attempting scientifically to establish racial inferiority through its research compounded this inequity. If African Americans are subhuman, then they do not deserve health care equal to that of humans (white Americans). The medical argument is synonymous to the theological argument purported by Southern ministers centuries ago as to whether or not Africans had souls. If Africans did not have souls, then they were not human. And if Africans were not human, then they were not required to be treated as such; therefore, to enslave them was justified. The poor quality of care given to slaves when they did receive care, the unethical sterilization and experimentation performed on African Americans, and the present day inequitable health care of African American are symptoms of

the greater issue as to whether or not African Americans are human. If they are, then they deserve to be respected as such with health care resources allocated accordingly. Organ transplantation is perhaps the most obvious example of this inequity.<sup>2</sup>

Although many issues faced by African Americans in health care are also faced by nonblacks, several issues are race intensive, namely patient rights, access and availability, and rationing.

### *Patient Rights*

Historically, physicians have not allowed African Americans to participate in their health care decisions. Author-scholar James H. Jones suggests that there was a "moral astigmatism" by white physicians toward black patients and that blacks were often viewed with negative prejudicial attitudes and as inferior categories of human beings. As a result, black patients at worst were often relegated to the status of human "subjects" or experimental "material," in the health system and, at best rarely worthy of its maximum resources or efforts (Byrd 192). This "flawed" relationship between the white physician and the black patient as characterized by Byrd and Clayton is at the heart of the patient rights issue and the major source of distrust of the medical community by the African American community. According to Charatz-Litt, the physician's control over information places him or her in a unique position to subject the patient to his or her authority. Consequently African Americans find themselves in a "flawed" relationship subject to the authority of the white physician. As a result, African Americans have not participated in their health care decisions to the fullest extent possible because the physician acting as patient agent has made decisions for them, perhaps with their consent but often not with informed consent.

### *Access and Availability*

Although access to and availability of health care services should be a fundamental right granted to all U.S. Citizens by the federal government, the delivery of health care in America is fundamentally private (George). In the early 1960s, the fed-

eral government continued to expand health care services to the under-served through the Medicaid and Medicare programs and the National Health Service Corps. These programs were developed to improve access and availability to health care services to the under-served. During the 1980s the policy of federal government shifted by placing more responsibility on states in the development and implementation of health care programs for the under-served. With the expansion of these publicly funded programs, health care costs escalated to the second largest expense to the nation. Notwithstanding the vast financial expenditure (eleven percent of the GNP) on health care, African Americans lack adequate access and availability to health care services. Eli Ginzberg, in a study of four major metropolitan cities—New York, Los Angeles, Chicago, and Houston—found that access to health care for the poor (thirty-three percent of African Americans live below the poverty line) and the homeless declined during the eighties. He attributes the deterioration in the availability of health care services for the urban poor in the 1980s to a set of financial, structural and professional factors: the reduced coverage provided by state Medicaid programs and inadequate reimbursement for hospital and/or ambulatory services; the growth in the number of uninsured persons and their dependents as a result of the prohibitive costs of private health insurance for many small employers; the declining number of American trained physicians willing to practice in the inner city; and the inadequate capacity of most public sector hospitals to cope with the exploding demands for ambulatory and inpatient care from the rising numbers of the poor (Ginzberg 1994). George attributes three major barriers to the lack of access and availability of health care services to the African American community: the escalating cost of health care services; an insufficient number of African American health care providers; and the erosion of health care in rural areas (George 1991).

Access to health care has always been an issue faced by African Americans. Whether access is denied by legal segregation or the manifestation of inequities in politics and/or economics, the

results have often been fatal. In 1985 alone, 60,000 African American deaths could have been prevented had they received health care that was accessible and available to most non-minority communities.

### *Rationing*

Rationing, according to Rudolf Klein, is a part of the fabric of American health care whether we acknowledge it or not (1992). The denial of access, the exclusion of certain procedures from Medicaid coverage, and the establishment of Medicare's fees for nursing home care represent ways, according to Klein, that rationing is presently done in America. Rationing is not about denying treatment, he writes, but rather it is about how decisions about treating individuals are made. In America there is a rationing of people as opposed to a rationing of treatment, and this rationing has been discriminatory, denying the most vulnerable of society basic health care. The "R" word for African Americans is not rationing but unjust rationing based on race. The consequences of prejudice and discrimination, according to Charatz-Litt, are staggering, with poor health being the most apparent and dangerous.

### **Conclusion**

The bioethical issues confronting the African American community have evolved out of the historic delivery of health care to the community. Racism is the crux of the bioethical issues confronting the African American community. From its manifestation in the violation of patient rights, to the denial of access, to the inequitable and unjust allocation of resources, racism has driven decisions about health care delivery to the African American community.

The white medical community must be cognizant of the history of African Americans with the health care system and their resulting disposition toward the health care community. Fear and distrust of African Americans toward the white medical community are rooted in a history of discriminating attitudes and practices.

Unless we learn from the mistakes of the past and accept the responsibility for those mistakes ,

unless we respect the dignity of every human being and strive toward the creation of a "level playing field" of health for all Americans, the racial health disparities will never be corrected. In the words of Martin Luther King Jr.: ". . .of all the forms of inequality, injustice in health [care] is the most shocking and the most inhuman."

### **Endnotes**

1. The Tuskegee study was a forty-year nontherapeutic experiment spearheaded by the United States Public Health Service and aimed at compiling data on the effects of the spontaneous evolution of untreated syphilis in 600 African American men. These men, most of whom were poor and illiterate, were not informed about the true nature of the experiment and were enticed into participation through the offer of free medical care for minor ailments, free transportation to the clinic, hot meals, and a guaranteed burial stipend (Jones 1981).
2. The present allocation of organs for transplantation magnify racial disparity in health care. The current allocation directives for renal transplant candidates place African Americans at a serious disadvantage. See Gaston (1993) for a complete explanation of these disparities.

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