Letters to the editor

To the editor:

I compliment Ms Sheana Whelan Funkhouser, RN, MN, and Ms Debra K. Moser, RN, MN, for addressing the serious multifaceted issue of delivering health care services to the underserved in their article, "Is health care racist?" (ANS 12:2, January 1990). However, their conclusion that the problem of inadequate health care for African-Americans is largely due to socioeconomic constraints rather than race is inconsistent with the history of African-Americans.[1-5] The authors also fail to make clear distinctions regarding issues related to race, in contrast to issues related to class, sex, and socioeconomic factors.[6-10] By including the poor, uninsured, underinsured, Medicaid recipients, people of color, and the underclass in the same discourse, issues which are unquestionably interrelated have nevertheless been confused, one distracting from the others.

The authors state that "because free white workers were not central to the labor supply, slavery became a mode of increasing production and the economic power of the white plantation owners."[11(p48)] From my perspective, this simplified view of slavery does not contribute to knowledge, insight, or a better understanding of the problems currently present in the African-American community as a consequence of the slavery experience. During the Middle Passages and later in America, Europeans nurtured their superiority and religiosity. The resulting dehumanization of African women and men required concerted efforts to obliterate culture, values, traditions, and institutions. Furthermore, the lack of hardiness of Europeans and Native American slaves, economic dependence of the plantation system upon slave labor, and dehumanization of Africans by slave owners were contributing factors to the institutionalization of racism and discrimination in this country.[1-3,12-14]

The authors suggest that the racial antagonism which continued after the Civil War might be explained by economic theory. They also maintain that during the 19th century managers used African-Americans as strikebreakers or permanent replacements for white American workers, and that the more management used African-Americans "to undercut white laborers the more racial conflict arose between the two groups."[11(p49)] The authors propose that racial conflict also increased because of "added pressures from racial competition for housing, neighborhoods and recreational areas."[11(p49)]

After the Civil War, racial discrimination and economic slavery continued in the form of sharecropping in the South and low wages in the North.[3-4,8,13] Also, during the early 20th century, African-American workers usually were hired at a lower wage than white American workers, were the last hired and the first fired, and were usually offered jobs unacceptable or undesirable to white Americans.[10,15,16] The use of the expression "to undercut white laborers" shows a lack of sensitivity to the life situation of the strikebreakers, immigrant workers, unemployed, and poor in America as a labor force for jobs unacceptable to others. The consequences of de facto segregation in the North and de jure segregation in the South have historically minimized equal competition by African-American with white Americans for the same housing, neighborhoods, and recreational areas.

The authors state that the ultimate basis for the current racial tension is the deleterious effect of basic structural changes in the modern economy on black and white lower-income groups. This premise confuses similar but different problems and does not consider the pervasive and malignant effect of racism, the primary cause of poverty in the African-American community.[4,13,16-20] Ms Funkhouser and Ms Moser cite the International Council of Nurses and the World Health Organization in support of their argument. Based on my experience with these organizations, although both are excellent institutions, neither can be considered authoritative sources for issues associated with the African-American community and health care access issues in America. Further, there is ample evidence which suggests that three of the major explanations regarding the health conditions of African-Americans are institutional racism, economic inequality, and access barriers.

Discrimination in medical services can be traced to the historical relationship between African-Americans and dominant medical institutions in the South. Slaves were given necessary primary care because of their value as property, while during the post-Reconstruction era, newly freed slaves were excluded from receiving medical services in most Southern states. Separate, unequal, and inadequate services and facilities were established. For example, Bessie Smith, the world famous blues singer, died because of denial of medical services in the South. Also in 1950, Dr Charles Drew (who developed the technique for long-term blood preservation) died, ironically, after being denied a blood transfusion which would have saved his life. As late as 1970, 10 private hospitals in New Orleans were sued alleging a variety of discriminatory practices. In New Orleans, African-Americans and the poor were being directed to the Charity Hospital System. In a city

with a 45% African-American population, two of the hospitals involved had no black patients and the other hospitals had served only a token number of African-Americans.[21]

Institutional views toward the treatment of the poor tend to parallel their attitudes and treatment of African-Americans and other people of color. Racism can be seen in the admission practices of hospitals, bed assignments, assignment of physicians/interns, and the careless use of African-Americans in research. Please, let us not ever forget the infamous Tuskegee study.[22]

There are many dedicated health professionals concerned about the health challenges facing the poor and people of color. However, how can one begin to answer the complex question, "Is health care racist?" without including the perceptions, voices, and experiences of the people of whom you speak? While trying to see, understand, and resolve the challenges presented to us all, a common ground is needed. A sharing of perceptions, experiences, and knowledge so that an environment may evolve which will help generate meaningful answers to very complex problems as experienced by the poor and people of color using the health care system. Unfortunately racism does exist in the health care system. We can be caring and culturally sensitive to the voices, perception, and lived experiences of the poor and people of color and continue to work to humanize a very imperfect health care system and strive to make a difference.

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Author's reply:

We appreciate Ms Swinney's thoughtful and scholarly response to our article. There is no question in our minds that this topic is indeed a multifaceted one. We certainly don't deny that racism exists; however, we still maintain that poverty is a large force in the inadequate delivery of health care to the poor and people of color. We refer her to Wilson's works[1,2] and would suggest that this complex problem will not be solved if only racism is addressed.