The toxic brew of sexism & racism in American medicine

Dispatcher: 911, what's your emergency?

Caller: America's healthcare system is broken and people are dying! (ambulance siren)

Welcome to **Code WACK!,** where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar.**

(music)

This time on **Code WACK!** Why is it that the richest Black women have about the same infant mortality rates as the poorest White women? Why do Black babies tend to have more risk factors like being born premature or underweight? And how could single payer help? To find out, we spoke to **Dr. Diljeet Singh**, a women's health advocate and integrative gynecologic oncologist who has practiced for nearly 25 years. She's also the vice president of Physicians for a National Health Program, which advocates for single-payer Medicare for All.

Welcome to Code WACK, Dr. Singh. We're so glad you could join us today.

Singh: So happy to be here with you.

Q: So tell us a little bit about yourself. Where do you live and what do you do?

Singh: I am a gynecologic oncologist. I live and work in the Norfolk, Virginia Beach area of Virginia. Although I'm new to here. I've lived in Chicago and Washington DC for long periods of time, both of them. And I also work as, I don't know if it's work, it might be, I also "fun" as, as the vice president for Physicians for a National Health Plan and I've been involved in that organization for a long time.

Q: Did you have a specific experience that led you to support single-payer health care?

Singh: It's hard to say that because I've been involved now for over 20 years. I think. Being involved with Physicians for a National Health Plan (PNHP) allows me to tolerate all of the bad things about our current profit driven system that make it hard for people to get care that make it unfair, that impact negatively their outcomes that limit the amount of time I get to have with them that limit the time and we spend with patients versus writing papers, filling out forms, doing things for insurance companies. So I'll say like, there wasn't a specific experience that made me do join, but every time I have a really bad experience with a healthcare insurance provider, I think to myself, okay, I'm doing that work for Physicians for a National Health Plan, trying to get everybody health care, trying to fix our system. But I mean, I think I have a bad experience with our healthcare system every day – like so many of my patients and the women I take care of, unfortunately.

Q: Wow. Thank you for sharing that. We'd like to talk about the recent study by the National Bureau of Economic Research, which showed the richest Black mothers and their babies are twice as likely to die as the richest White mothers and their babies. It was in the New York Times, I'm sure you caught it. The study examined women in California specifically and found that the richest Black women have infant mortality rates at about the same level as the poorest White women. Black babies tended to have more risk factors like being born premature or underweight. What are your thoughts about these inequities?

Singh: So I thought it was a really interesting study in a lot of ways, but I do want to point out the number one piece was it they were comparing to women in Sweden and everybody in America, all the kids, all the people having kids do worse in America no matter what their income, no matter what their race, which

is kind of shocking considering we spend twice as much on every single person in America as they do in most of the rest of the world, for us to have such worse outcomes. The issue about why Black women are having these increasing maternal mortality, Black babies are having these increasing infant mortality. I mean, the other thing that's interesting in that study was White women actually had higher rates of low birth weight and prematurity. And that's thought to be related to White women at the highest income level being more likely to have twins and have gotten pregnant through infertility [treatments].

You know? And so it was kind of interesting that although they had higher rates of low birth weight and prematurity, they still had the best outcomes. Right? So we know it's actually not that thing. You mentioned that those babies have bad outcomes because they have high risk factors. There's something else in the system, and we know it's everything in our system, right? It's the access to healthcare, and we are along a person's life, a person who decides to be a mother, do they get the opportunity to engage with health care? How much preventive work do they do before they get pregnant? During their pregnancy? What kind of care do they get? And then immediately postpartum, right? I mean, the maternal mortality rates, the all cause mortality rates that just came out. And that was in JAMA said, all-cause mortality, not just pregnancy, but homicide, drug-related death for women is up in America 2018 even compared to 2020 and all dramatically higher than the rest of the world.

Wow.

Singh: So how do we connect race to bad health outcomes? I think the majority of the data is saying to us, it's about racism and how that manifests is really complicated, right? So there's the chronic stressors for people who experience racism. There's the unconscious bias of healthcare providers and how they take care of people of different races and gender. And then there's the way we listen to and talk to women in general, and then how it impacts pregnant women as in, you know, we know if a woman shows up pregnant or not pregnant in an emergency room and she's in pain, she's going to wait longer than a man would wait. She's less likely to get pain medicine. She's less likely to get any kind of test to evaluate the pain, and she's more likely to be given an antidepressant, right, which that's all kind of crazy making if you think about it.

That is crazy.

And I think the tragic piece of this is, is that Black women are kind of literally at the intersection of that, right? They're getting all the negative impact of being a woman, of being female, and then they're getting all the negative impact of race

and racism and, you know, yeah, we could talk for a while like all the things that have poor impact. But I think that sort of summarizes it. And I think we have to be really, really clear that there is a lot of sexism and misogyny and racism that's built into American medicine. And one of the reasons we don't have universal healthcare is because back in the 1940s when Truman was trying to introduce universal health care, the American Medical Association did not want to cover Black people, period. They wanted them to be cared for separately. So, you know, and that's the beginning, right? Like that's early in the history of modern medicine as it exists now in America.

Q: Right, and this happened less than a century ago, as you said in the 1940s?

Singh: Yeah, in the 1940s. Actually, if people in the audience are interested, the 1619 podcast episode four speaks of it so ... it's a really nice short way to get a good history of racism in America and how kind of worked into it. There's also a really wonderful journalist and writer Linda Villarosa, who has a book called Under the Skin, yeah. She talks about the traditional ways of thinking. I mean, you know, now we look at these things that we think it's stupid, right? Like, 'oh, well Black women have worse outcomes because they're genetically inferior or different.' And now we look at it and we're like, 'wow, that would be like saying, wow, everybody who has blue eyes must be weaker than everybody who has brown eyes.'

Like, you know, even scientifically it didn't make sense connecting skin color to other characteristics. And the funniest, or the most complicated thing about that for me is like, but now we know there is a way that race, you know, impacts genes. Mm-Hmm. <affirmative>, it's the trauma of racism that causes those epigenetic changes that we almost think, you know, the trauma of generations before us might impact the younger generations. And that's where even like the thing you mentioned about, you know, the highest income Black women, right? We know then race must be a part of it if it's not about socioeconomic status. But then if we think of the generational trauma even of her parents and her ancestry and how that impacts how genes function, not what genes we have, but how well our genes work, you know, and that's what we call epigenetics and how those things impact health outcomes and we know they do. Yeah. It's hard to imagine that nobody could see that before and that they chose to blame it on other factors. And it's not that low socioeconomic status and lack of insurance and poverty doesn't play a role in health. Absolutely it does, but it's not the only factor.

Q: Mm-Hmm. <affirmative> Got it. Thank you. Right. So I know that you're not an OBGYN, but do you happen to have any stories you can share related to the study's findings about black women and their babies?

Singh: So I am an OB-GYN. I just don't practice obstetrics so to be a gynecologic oncologist, first you become an OB-GYN, then you do a cancer fellowship. But I don't take care of pregnant women except for when some context related to me comes up. But, you know, I mean, I hate to be like a media hound and you know, like talk about Serena Williams, but to me, like she's the most telling, right, because she is the greatest athlete of all time, right? <Laugh>. So she knew her body. She had a history of a blood clot. She was pregnant. She had an emergency C-section. She was having symptoms of a possible new blood clot and she could not get people to listen to her about shortness of breath and that she might have a blood clot.

And she had to push so hard and advocate so hard to get the CAT scan that diagnosed her, you know, pulmonary embolism that is life-threatening and to imagine, right, somebody not as empowered as she is and talk about somebody who's in good health, right? And she had this pregnancy related complication but didn't get listened to ... because she has everything, right? She had money, she had fame, she had a platform, she had credibility when it came to health and that her, you know, exchange with the healthcare system was so challenge and then imagining women who don't have that piece of, you know, she's extremely articulate. She's been on the world stage since she was like a preteen and, you know, understands how to voice her feelings. That to me is the story that tells us the role that both race and gender play in how women interact with health care and how that has the potential to lead to bad outcomes.

Cuz if it hadn't been her, if it had been somebody who just said, you know, oh, you must be right, I'm just in pain cause I had a c-section, the likelihood she would've fallen into that statistic of a maternal mortality is high and we never would've heard that story. And you know, we can take every one of those 26 deaths per a hundred thousand lives births. And there's a story like that there, you know, are some of those deaths not preventable, you know, not preventable. Possibly the literature tells us, you know, in countries like New Zealand where they have five, you know, maternal deaths for a hundred thousand births, and here in America we're in this range of 26 to 50 something for Black women and you know that there's a story in at least, you know, 50 of those women of something preventable because somehow in the rest of the world, we are successfully preventing those deaths.

Q: Mm-Hmm. <affirmative>. Right. Good point. Let's talk about some of the reasons this is happening. You mentioned racism and Tiffany Green, an economist who focuses on public health and obstetrics at the University of Wisconsin-Madison told the New York Times that it's not race, it's racism. And this is about the environments where we live, where we work, where we play, where we sleep. What do you think she meant by that?

Singh: There's two pieces to it. There's the racism that means that in a predominantly Black neighborhood, you're more likely to live near a landfill, right? And the pollution that comes from that and the environmental impact of that. You're potentially more likely to not have access to fresh fruits and vegetables. You're potentially less likely to have access to non-dairy milk alternatives. Right? There's all these things I'm going to keep in there the complexity of socioeconomic status. That if you take the highest income Black women and they're still having these bad outcomes, that there is something beyond the environmental interplay when it comes to those kinds of things and then we're talking about an environment where they are subjected to some element of daily ongoing chronic stress. Their symptoms are not listened to or ignored based on the color of their skin alone.

I won't say every Black woman of high socioeconomic status didn't come from low.... Right. They might, she might have, people might have a history of coming from, so it's, you know, higher, but that epigenetics or, you know, other generational trauma and how that impacts, I think it all plays in. And I think when I talk about racism in like, what does it mean, you know, it means like how do people talk to you when you come to the hospital? It means how do people listen to you? It means what do they think when they're going to take care of it? You, and, and I do find it challenging when I talk to physicians, groups and medical students about this because I think the unconscious bias part of things is really challenging. Right. You know, the fact that the father of modern gynecology, right, Marian Sims experimented and practiced surgery on Black women slaves with no anesthesia.

And the fact that he could say like, well they don't feel pain the same way, which was this tenant of slavery of how they could get away with treating people so poorly. But it's hard to imagine those women didn't cry. It's hard to imagine those women didn't react to being cut open.

Oh my gosh, that's horrible.

Right? And so the, the kind of recently in 2015, there was an editorial in a major OBGYN journal written by somebody justifying his behavior, saying, well, he was just a creature of his time. He was a physician taking care of somebody. And it's just hard for me to imagine they didn't express pain. But meanwhile, you come now and there's studies from 2015, 2016, and I think it came from in Virginia, somebody interviewed and did studies on University of Virginia, I believe medical students and asked them about pain tolerance. And there were medical students in our day and age who thought Black people have higher pain tolerance based on skin color again, right.

That's this weird genetic thing of like, really pain tolerance is like built into a gene that's connected to the melanin in your skin? Like it makes no scientific sense, but it has been a part of "science" in quotes - eugenics - not real science, but it was put forward. And I think we have to remember right, medicine is science, but medicine is culture. And so the misogynist and racist culture that our medicine grew up in, fixing misogyny and racism in medicine in many ways is not hard. In many ways it's really difficult cause it's so deeply ingrained.

Q: I see. So could single payer, Medicare for All affect these high rates of infant and maternal mortality among Black women in America and if so how?

Singh: So I think everybody having access to the same basic level of health care, not having to prove that you are pregnant. And so you can get Medicaid if you didn't have insurance. Not having to make choices about what work you do in order to have insurance absolutely could make dramatic changes. And there's a lot of well-spoken, well thought of policy advocates who say, you know, universal health care could be the most pro-women anti-racist policy we could move forward and I 1000% agree that if you automatically had access to care and the care was the same for everybody, right? It's not like, 'oh, you have Medicaid, it doesn't reimburse as well so not every doctor in this hospital takes your insurance, so we're going to put you in a slightly different category.' Or, 'oh, you're from the free clinic. Hmm. That must mean you are addicted to drugs' or you know, like all the biases and stuff.

If it were all the same, that would change. And as we think about like, how do New Zealand and Sweden and Canada and Denmark and the UK and Germany have maternal mortality rates that are, you know, five versus 50 for Black women.

Right? How do they do that? Well, everybody gets health care and most people get care within the same system and they get access to everything long before they became pregnant and cared for long after. So I think by kind of raising the bar on health care, on prevention, absolutely will make a difference. Is it the only thing we need to fix? Nah, we got other things that we would need to fix as well.

Thank you Dr. Singh of PNHP. Stay tuned next time when we talk to Dr. Singh about why Black women face a greater risk of gynecologic cancers.

Do you have a personal story you'd like to share about our 'wack' healthcare system? Contact us through our website at heal-ca.org.

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