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Shedding Light on Racial Inequity in Health, in Conversation with the Author: Black Health: the Social, Political, and Cultural Determinants of Black People’s Health

Journal:	<i>Medical Law International</i>
Manuscript ID	MLI-23-0053
Manuscript Type:	Book Review
Keywords:	Health Inequity, Black Health, Justice, Intersectionality, Social Determinants
Abstract:	<p>Long standing health inequalities occupied the political discourse during the COVID-19 pandemic; however, little attention was brought to their historical roots. In her book, <i>Black Health: the Social, Political and Cultural Determinants of Black People’s Health</i> Professor Keisha Ray looks at the underlying causes of health inequity, specifically calling attention to the reasons behind Black Americans’ ill health. The book stems from Ray’s desire to share knowledge in an accessible and comprehensive manner, which she does using a refined mixture of storytelling -pertinently referencing lived experiences- and research, giving insightful evidence into the importance of considering race as a social construct and racism as a health determinant. <i>Black Health</i> specifically looks at the role of medical professionals in contributing to ingrained prejudice and the intimate relationship between bioethics and medicine and race and racism that has then perfused the realm of law and policy. The fundamental falsehood of Black bodies’ inferiority is addressed throughout with a bioethical approach that looks at experiences in and beyond the healthcare setting. The fatalism, racism, and prejudice faced by Black people in maternity care, the struggle they face with inadequate pain management, the diagnosis of pre-existing conditions and comorbidities are all presented against a bleak historical background. Housing and environmental factors also feature because of the pivotal impact they have had on the Black community’s poor health.</p>

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3 *Shedding Light on Racial Inequity in Health, in Conversation with the Author: Black Health: the Social,*
4 *Political, and Cultural Determinants of Black People's Health.* (Oxford University Press, NY, 2023
5 ISBN 9780197620267, 220 pages, paperback £25.99)
6

7 **Reviewed by:** Sabrina Germain, *City University of London, UK*; Keisha Ray, *McGovern Medical*
8 *School, USA.*
9

10 11 INTRODUCTION

12 Long standing health inequalities occupied the political discourse during the COVID-19 pandemic;
13 however, little attention was brought to their historical roots. In her book, *Black Health: the Social,*
14 *Political and Cultural Determinants of Black People's Health*¹ Professor Keisha Ray looks at the
15 underlying causes of health inequity, specifically calling attention to the reasons behind Black
16 Americans' ill health.
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18 The book stems from Ray's desire to share knowledge in an accessible and comprehensive manner,
19 which she does using a refined mixture of storytelling -pertinently referencing lived experiences- and
20 research, giving insightful evidence into the importance of considering race as a social construct and
21 racism as a health determinant. *Black Health* specifically looks at the role of medical professionals in
22 contributing to ingrained prejudice and the intimate relationship between bioethics and medicine and
23 race and racism that has then perfused the realm of law and policy. The fundamental falsehood of Black
24 bodies' inferiority is addressed throughout with a bioethical approach that looks at experiences in and
25 beyond the healthcare setting. The fatalism, racism, and prejudice faced by Black people in maternity
26 care, the struggle they face with inadequate pain management, the diagnosis of pre-existing conditions
27 and comorbidities are all presented against a bleak historical background. Housing and environmental
28 factors also feature because of the pivotal impact they have had on the Black community's poor health.
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30 The book is organised in four chapters each providing a striking illustration of how inequity affects
31 Black people's health and their lives. Chapter One on pregnancy and birth provides historical highlights
32 around reproduction and Black women's bodies. Ray demonstrates how the violence Black women
33 have been subject to, their lack of bodily autonomy, and the oppression they suffer because of their
34 intersectional identities continue to have a ripple effect today. Black pregnant people have higher
35 mortality rates at birth or soon after, and the social disadvantage affecting pregnant Black people has a
36 substantial physiological impact on them and their foetuses. Chapter Two focuses on pain management
37 and opens with a discussion around systemic racism in healthcare setting. The personal testimonies in
38 this chapter are disconcerting examples of racialised medical perceptions and medical racism that have
39 led to sub-optimal care for Black patients. Chapter Three discusses poorer cardiovascular health in
40 Black people focusing on elements contributing to stress factors such as poor housing condition, low
41 income and racism. Ray looks at lifestyle choices and cultural factors around diet and exercise that
42 medical professionals often discuss in a racialised manner with their Black patients, shifting the blame
43 for poor health onto them and their choices and habits. The fourth and final chapter looks at disparities
44 in sleep, an element often overlooked in health, although it has a critical impact on Black people's
45 health. The causes and consequences of bad or lack of sleep are unpacked looking at the key social
46 determinants leading to sleep inequity: micro-aggressions, racism, housing, and in some ways, levels
47 of education.
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49 The following is an edited transcript of a conversation between Sabrina and Keisha addressing many of
50 the salient themes and questions arising from *Black Health*.
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54 INTERVIEW

55 **Sabrina:** In the introduction of your book you emphasise that race is a social construct and is not
56 directly pertinent to our genetic make-up. So why do you think we need to discuss "Black" health and
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59 ¹ Keisha Ray, *Black Health: the Social, Political, and Cultural Determinants of Black People's Health* (NY:
60 Oxford University Press, 2023).

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3 not racialized people's health more broadly? Does using the term "Black Health" wrongly amalgamate
4 all Black people?
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6 **Keisha:** I do think that it's important to talk about Black health as a topic that examines the health of
7 Black people as a racial group rather than a group of people that are tied by strict biological ancestry.
8 Because first off, Black Americans have a culture here in the United States even with so much of their
9 history having been lost during enslavement. The issues that certain Black people face like higher cancer
10 rates and lesser pain therapies in clinics have a common thread that doesn't fall along these biological
11 or genetic lines, but along social groups. That's why I think it's important that when we speak about
12 Black Americans health, we acknowledge that race is a social construct that binds people together
13 through shared experience. But that doesn't mean that race is not relevant. It doesn't mean that these
14 aren't pertinent issues just because race is a social construct.
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17 Racism as a social construct is really the issue here. What binds people in this community to poor health
18 outcomes is their common experiences of racism. When I talk about Black health, I'm looking at the
19 common experiences of Black people that contribute to their poor health outcomes. I don't think that
20 there is the risk of looking at everyone the same unless you are uninformed. I hope that after people
21 read the book, they will see that not all Black people fit the same mould, but that doesn't mean that
22 someone in their life won't experience some of these issues. You may have had the best doctors your
23 entire life and have never experienced physician bias, but that doesn't mean that other Black people
24 around you have the same fortunate experiences. That's why I wanted people who have these
25 experiences to know that there are other people who are going through the same things as they are: the
26 same social inequities, the same disadvantages, the same racism, sexism, classism and ableism.
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29 **Sabrina:** In chapter one you look at the impact of 'weathering' on Black birthing and the potential
30 consequences on Black people even prior to their birth. Could you expand on this concept and how it
31 impacts Black people differently than other global majority groups?
32

33 **Keisha:** Weathering is the idea that social disadvantages, like not having enough food, not having
34 access to transportation, not having access to healthcare can 'weather' our body. These elements wear
35 down the body mentally, spiritually, emotionally, and wear down our health.
36

37 Scholars have likened it to a piece of paper. Think about a white, crisp, new piece of paper that has been
38 left outside for a year. It would get stepped on, rained on, snowed on and dogs might chew it up. If you
39 left a clean white sheet of paper outside for a year and you came back to it, it would not look the same
40 as it did the year before. This is the same for our bodies. Our social disadvantages wear on us and they
41 contribute to our poor health. The most pertinent social disadvantages that can wear out our health are
42 discrimination and the intersection with other types of discrimination, be it classism, sexism, racism, or
43 ableism. Depending on our marginalised social identities, they will wear down our health. Weathering
44 can be experienced by anyone, as long as those social disadvantages make it harder to access the
45 resources needed for health, but in the United States it greatly affects Black people.
46

47 There is an argument that Black people aren't doing what they need to do to have proper health. That
48 it's somehow their fault that they're dying; it's somehow their fault that they're becoming disabled.
49 That it's somehow their fault that they're having all these comorbidities. This is why weathering for me
50 is very important, particularly in this chapter about birth. Effects of discrimination are relevant to Black
51 birthing people because they can be passed on to the fetus. Fetuses can be born experiencing the effects
52 of racism without having yet been born into a society. A lot of fetuses come out the womb experiencing
53 racism that's passed down through their parent. This gives some support to the idea that Black birthing
54 people are not inherently more susceptible to death and co-morbidities, and that the social aspects
55 around them make them more susceptible to dying during or soon after childbirth. Our social lives are
56 important to our own health and the health of next generations.
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3 **Sabrina:** In the same vein as Angela Davis² and Dorothy Roberts³, you have highlighted the historical
4 roots of Black people's mortality during or soon after birth. In your opinion, how are contemporary
5 problems affecting Black pregnant people in the realm of obstetric and maternal health, rooted in
6 historical reproductive violence in the US?
7

8 **Keisha:** Black maternal mortality is a great example of how racism and issues of the past in medicine,
9 health sciences, and public health have been repackaged and reshaped into different kinds of problems.
10 Whereas you don't see as much egregious experimentation on people, now biases influence improper
11 health outcomes. Patient's complaints are not taken seriously or are even dismissed. How often do we
12 hear "You're not really in pain. You're OK. Take an aspirin and go home." A lot of egregious actions
13 that were treating Black people's bodies as commodities or as unimportant still exist. They just manifest
14 in different ways.
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17 For me, it was important to talk about this historical aspect. Our history doesn't just go away, and the
18 contemporary problems don't just happen overnight; they stem from these historical roots. The issues
19 take a different shape. Black bodies were historically seen as property. Black men were thought of as
20 tools to help Black women create more enslaved people for their white owners. Now you see Black
21 women treated as people that need less care and deserve less compassion, less humanising. You see
22 Black fathers and partners disrespected in clinical settings and seen as just "baby daddies." Again, this
23 didn't just happen overnight, you can trace this dehumanisation back hundreds of years ago. You see
24 this context in books by authors such as Angela Davis and Dorothy Roberts.
25

26
27 There's always been a political, cultural, and a social interest in Black people's bodies, particularly
28 Black women's bodies. This historical aspect is really pertinent to how we talk about the issue today.
29

30 **Sabrina:** You have looked specifically at pain. In your opinion, why is Black people's pain a complex
31 and multi-layered issue? Are bias and racist perceptions only the results of archaic beliefs around Black
32 bodies or is there elements of contemporary racism that should be highlighted when discussing pain?
33

34 **Keisha:** Pain is one of those hard ones. The subtitle of the book is "The Social, Political and Cultural
35 Determinants of Black People's Health" and pain is where you see all those determinants converge and
36 why they all matter.
37

38
39 If you start with cultural beliefs, a lot of our inherited cultural beliefs, especially thinking about Black
40 women in our families, there is an idea that we must be strong. Black women have kids to take care of,
41 jobs, homes to take care of and sometimes elderly parents. You have all the things to do as a matriarch.
42 When we are feeling pain, we think "This can't stop me! I have to keep going forward. I still have things
43 to do. I still have people depending on me." Working through pain is cultural, but it's not as if Black
44 women want that. It's not as if we decided, we're just going to wake up and be strong women. It's
45 embedded in how we think of ourselves and how other people think of us. This is something again, that
46 started off as something historical, and now it's just within the Black community as something that we
47 just do. When we're talking about pain management and racial biases, we have to first think about
48 cultural beliefs about our pain, and then how those cultural beliefs were even formed in the first place.
49

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51 Thinking about the social and political aspects, we should also think about how clinicians see our
52 bodies, how they see our pain, how they see us and how they do or do not trust us with the narratives
53 of our own lives, our own bodies and our own pain experiences. Pain is the culmination of the cultural,
54 political and the social. I think that's why it makes it such a multi-layered issue. It intersects with things
55 like the "opioid crisis," where doctors don't want to prescribe too many opioids. But then when you are
56 in pain, and you are Black, you are less likely to get this pain relief even when you have a legitimate
57 medical need for opioids. All of the determinants combine and leave Black people in pain and unable
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59 ² Angela Davis, *Women, Race and Class* (London: Women's Press, 1982).

60 ³ Dorothy Roberts, *Killing the Black Body: Race, Reproduction and the Meaning of Liberty* (NY: Pantheon
Books Penguin, 1997).

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3 to properly treat their pain. For me, if we are unnecessarily leaving Black people in pain, that means we
4 are unnecessarily withholding life's joys from them.
5

6 **Sabrina:** The title of one of the chapters particularly stuck with me "Who believes our pain?", and I
7 wondered if you had some thoughts around what needs to change for us to be believed in our pain?
8

9 **Keisha:** I always come back to this simple, yet very complex, answer: see us as humans. It's really a
10 question of humanity, but it's how do you make people understand that other people are also human or
11 that they have the same human needs or the same human desires, the same pleasure and the same pain?
12 What needs to change for this very simple sentiment to finally be believed? For others to believe that
13 Black people are human like them?
14

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16 A lot of clinicians are taught to think about themselves as a tool of empathy. We teach a lot about
17 empathy in medical and nursing schools. But one of the drawbacks of empathy is that sometimes people
18 will judge other people's circumstances by looking at those circumstances through their own eyes. I'm
19 not asking you to do that as my clinician, I'm saying look at it through my eyes and listen to me. I'm
20 telling you: "This stops me from painting, or this stops me from walking my dog. I don't care that you
21 would be OK and that you could manage this pain. I'm telling you that I cannot." I think a lot of it is
22 how we teach clinicians to think about pain and to think about their patients from marginalized
23 identities, which is something that needs some reformation.
24

25 **Sabrina:** You explore various pathways of sleeplessness that have a substantial impact on health. How
26 does such a basic common biological phenomenon fall on racial lines?
27

28 **Keisha:** It seemed so odd. A lot of people don't sleep. What's the big deal? But not everyone gets less
29 sleep because of who they are. How does such a basic common biological phenomenon fall along racial
30 lines? It's because social resources fall along racial lines that sleeplessness falls along racial lines. If
31 you don't have enough income and you have to work multiple jobs, including night jobs, it's going to
32 affect your sleep. If you don't have enough income to live in a neighbourhood that you deem safe and
33 you're worried about your children being safe, or that there may be an intruder, or if you're worried
34 about your home actually being unsafe from environmental pollutants, you're probably not going to
35 sleep a lot. Same if you're worried about how you're going to pay your rent or your mortgage, or how
36 you're going to pay your health insurance bill. All these things affect sleep. If you are experiencing
37 discrimination at your job and in your daily life, that affects your quality of sleep as well. And it's really
38 because there's inequities in access to these resources that we see racial disparities in sleep. This is not
39 a genetic issue. Black people are not genetically predisposed to not sleeping. It's that they have a lack
40 of resources.
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43 **Sabrina:** Yes, therefore, in your opinion, how does public health in America participate in sleep racism
44 or continue to perpetuate inequalities around sleep?
45

46 **Keisha:** This goes back to the bigger issue of the book. A lot of times when Black people have poor
47 health, it's marketed as an individual failure. "You did something immoral. This is your fault that you
48 have bad health. It's your fault that you're not sleeping." Public health gives us sleep hygiene rules.
49 "Turn off your phone. Make sure your home is properly heated and cooled. Make sure you eat a hearty
50 meal before bed, but not too soon before bed. Make sure you're only using your bed for sleep. Make
51 sure that you have the lights off and noises off." I think a lot of people in America have no control over
52 the light pollution in their home because of streetlamps, or excessive noise pollution in their
53 neighborhoods. Some don't have access to proper heating and cooling because it's expensive.
54

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56 Thinking about how a lot of these public health organisations characterise sleeplessness has an
57 undertone of blame, and they are not looking at the circumstances in people's lives that prevent good
58 sleep, even though you can only sleep as well as the circumstances you live in. Sleep advocacy in
59 America doesn't take into account the racism that exists in access to resources that people need for
60 sleep.

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4 **Sabrina:** That brings us already to the conclusion. You have written an excellent accessible book that
5 is grounded in science and lived experiences. So how would you like us to use your book? How would
6 you suggest we use it in a very different context? For example, in the United Kingdom?
7

8 **Keisha:** One way to use the book is to better understand racial disparities that exist for Black people
9 and to understand Black people's health, the social, political and cultural determinants of our health,
10 and those barriers causing inequities. It can be used to examine this often-marginalized group of people.
11 Why do Black Americans have generally worse health outcomes than other people? How do I go about
12 talking about it? How do I go about researching it? How do I think of myself, my family, my friends
13 and their health within the realities of health and health care?
14

15
16 This book is also a case study in the barriers to health equity. Health equity is a word that is thrown
17 around a lot, it was especially discussed during the COVID-19 pandemic. My book gives a case study
18 for what has to change for health equity to be a reality. Black people don't have health equity. Why
19 don't they have it? That can be applied to a lot of different groups. Particularly in America, we have
20 Latinos, we have Natives and Indigenous people, who also don't have health equity. Some of the issues
21 are different depending on the racial groups because of their history with the government and public
22 health organizations. But some of these lessons can be extracted to these groups as well. In the same
23 way with disabled people, in the same way with transgender people, they don't have access to health
24 equity for political and social reasons. Using some of the lessons that we have learned about Black
25 people and their barriers and looking at barriers that are external to these communities, we can apply
26 some of the information in this book to these groups as well. "Black Health" is an examination of one
27 racial group, but the book can also be used to think about health equity, what that truly means, what is
28 required of us, and what are some of the values that we must have if we really want health equity in our
29 countries.
30

31 In places like the United Kingdom, I would like to see it being used as a way to think about health
32 equity and what are some of the lessons for the groups that are marginalised and that are struggling in
33 the UK. This can be a case study for how to approach these conversations, examine power dynamics
34 that affect health equity, and how to focus on the actual root of the problem.
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37 Accessibility is also something that's important to me. I intentionally wrote this book to be used in
38 classrooms. I didn't use a lot of jargon. I wrote shorter chapters, used many section headings, and
39 language that was appropriate for a first-year college student, even high school students. It's very
40 important to me that this book be accessible to people that are not academics and who perhaps want to
41 read just one of the chapters that interests them so I wrote the book with stand-alone chapters-each
42 chapter can be read without reading any of the other chapters. Linguistic justice is something crucial to
43 my work. I feel like we talk a lot about justice in our field, but how can we talk about justice if we're
44 writing for people, and we're writing about people, that can't read our work? It was very important to
45 me to make the book linguistically accessible to as many people as I could. I just wanted to make sure
46 that this book could be read by a lot of different kinds of people from different backgrounds.
47

48 **Sabrina:** I am sure it will be!
49

50 51 CONCLUSION

52 *Black Health* is an ambitious epistemological project in its object and reach. It is an important piece of
53 research that is often "in conversation" with, and adding to, seminal work of other Black feminists such
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3 as Davis⁴ and Roberts⁵, and more recently with Sowemimo⁶'s equally necessary book on race and health
4 in the UK that echoes many of the themes and issues addressed in *Black Health*. The book may feel
5 personal in its delivery, but it is not anecdotal. Ray's insights add to the veracity of the narrative to
6 produce an informative and competent book making a crucial contribution to a better understanding of
7 the root causes of health inequities. *Black Health* is a great starting point for difficult conversation as it
8 offer many avenues for rich discussions. Medical lawyers, bioethicists, health scholars and teachers will
9 find it to be an excellent resource.
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56 ⁴ Angela Davis, *Women, Race and Class* (London: Women's Press, 1982).

57 ⁵ Dorothy Roberts, *Killing the Black Body: Race, Reproduction and the Meaning of Liberty* (NY: Pantheon
58 Books Penguin, 1997).

59 ⁶ Annabel Sowemimo, *Divided: Racism, Medicine and Why We Need to Decolonise Healthcare* (London:
60 Wellcome Collection, 2023).