Addressing Racial/ Ethnic Disparities with Liberation Psychology, and Critical Consciousness: The Role of Social Medicine in Medical Education.

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Abstract

Addressing Racial/ Ethnic Disparities with Liberation Psychology, and Critical Consciousness: The Role of Social Medicine in Medical Education.

Doctor of Medical Humanities by

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Despite the medical advancement of the U.S. healthcare delivery system, our healthcare system continues to be plagued with racial/ethnic disparities. These disparities not only exist but are neither going away nor diminishing. Racial/ ethnic disparities are well-documented. These well documented studies seem to explore and present one determinant as the cause of these racial/ ethnic disparities. This author believes that the real determinant is—not acknowledging that unrealized racialized ideology is the foundation of all these determinants. With the use of concepts from Liberation Psychology, critical consciousness

and social medicine, there is the potential to assist healthcare professionals in becoming aware of their stereotypes, prejudices, and biases. Through the development and implementation of progressive medical education in the U.S. healthcare, social medicine could be the key for integrating a new approach in medical education via its curriculum that could enlist physicians in reducing and/ or eliminating racial/ ethnic disparities in the U.S. healthcare delivery system.

Dedicated to

Veronica Prieto Ramos 1940- 1991

To a beautiful lady, who despite the hardships she experienced, she continued to live with hope and love. Mommy, I truly miss you so much.

Juan Diaz 1964-2008

To my cousin “My Brother” Pete-O, I miss you. Wishing you were here. We all miss you tremendously.

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Chapter 1- The Problem-Racial/ Ethnic Disparities in the U.S. Healthcare Delivery System

America, a nation with a troubling racial past, celebrated the election in 2008 as well as the re-election in 2012, of Barack Obama, the first African American President which marked a historical event. This momentous and historic occasion signaled that America had moved towards reducing its racial and ethnic bias and stereotyping to the extent that a non-white person could be elected President of the United States. The steady increase and integration of people of color into the mainstream of America can be attributed to the concerted efforts of many individuals involved in the long history of the civil rights movement; especially during the 1950's and 1960's. As a nation, we have even enacted legislation guaranteeing racial inclusion by the establishment of the civil rights voting act of 1964, the 13th and 14th amendments of the Constitution, affirmative action, and many other legal protections such as the Fair Housing Act, Equal Employment Opportunity, Civil Rights Title II— outlawing discrimination based on race, color, religion or national origin in public places (including hotels, motel, and theaters) engaged in interstate commerce, and the Civil Rights Title III-- which prohibit state and municipal governments from denying access to public facilities on grounds of race, color, religion, or national origin.

It is necessary to explore whether these legislative measures are truly establishing racial equality in all aspects of American society. According to some states, there is no longer a need for such protection; as a result, some states have begun repealing some of these protections that the civil rights movement of the 1950 and 1960's established. For instance, since the mid 1990's, Arizona, California, Florida, Michigan, Nebraska, New

Hampshire and Washington have abandoned affirmation action policies in the college admissions process. Just recently, the state legislature of Michigan, with the support of the Supreme Court, affirmed its position of voting to abandon affirmative action in college admissions. This idea of the interplay between society, its values, medicine, and disease are affirmed in "What is Social Medicine?" when the authors stated,

> [German physician, who many consider to be the founder of social medicine- Rudolf Virchow-] Investigated an outbreak of typhus in the Prussian province of Upper Silesia. Virchow identified social factors, such as poverty and the lack of education and democracy, as key elements in the development of the epidemic. The experience led him to the concept of 'artificial epidemics' arising in periods of social disruption:
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> Artificial epidemics. . . are attributes of society, products of a false culture or of a culture that is not available to all classes. These are indicators of defects produced by political and social organization, and therefore affect predominately those classes that do not participate in the advantages of the culture. (cited in G. Rosen, From Medical Police to Social Medicine[1]

Has America reach the pinnacle of racial harmony; especially, in our healthcare system? The real question is how we can address racial/ ethnic disparities in the healthcare delivery system. Access to care, underinsured individuals, historical realities and other factors have been considered determinants for racial/ ethnic disparities, not acknowledging that unrealized racialized ideology as the real cause of this disparity within clinical encounters in the United States healthcare delivery system. In this study, I argue that this disparity is based on ideology. The writings of Ignacio Martin-Baro, a Spanish-born Jesuit priest, social psychologist, and creator of the tenets of Liberation Psychology and other liberated theologies/ perspectives can assist us in arresting these unacknowledged

[1] Matthew R. Anderson, Lanny Smith, Victor W. Sidel, "*What is Social Medicine?*," *Monthly Review* 56, no.8 (2005), 28.

processes by making us aware of these biases, and stereotypes. In addition, in this study, I will be utilizing the works of Paulo Freire, a renowned Brazilian educator, of the critical consciousness (*conscientizacao*) as a tool for critical awareness. As part of the tasks of this study, I will present studies that can demonstrate how patients' diagnoses and treatment are affected by healthcare professionals' (physicians and nurses) racial biases and stereotypes (whether or not they are conscious of their behavior). This exploration into the health professions' unconscious processes is important because these biases and negative stereotypes affect the scope as well as the limits of our healthcare services that patient; especially, patients of color, receive.

Ultimately, I hope to raise a concern that must be addressed by the field of medicine. Medicine has pervious systemically study the interaction and interplay between medicine, disease, and society. This aspect of study and form of medicine is called society medicine. Today medicine must look at its history and regain the progressive activism in medicine to address these racial/ ethnic disparities.[2] In addition, there is evidence for social medicine to clearly supports my thesis. There are many factors which influences the patient's health outcomes, such as social, economic, and political determinants. These determinants impact a patient's disease, access to treatment, and health outcomes. As a result, from this concern many have been exploring and examining the social determinants of health. Social medicine could offer a solution to the concerns and challenges of the social determinants of disease, the social aspect of meanings regarding disease, and the responses to these diseases. Social medicine's analyses and methodology can offer the

[2]Anderson, "*What is Social Medicine?,"* 28.

field of medicine an invaluable tool for addressing racial/ ethnic disparities especially in the United States' health care.

Have we really come close to attaining racial equality? There is some evidence that supports such claims such as the 2008 election of the first African-American to the Presidency of the United States of America, as well as the increase of people of color in numerous positions and offices both in private and government structures throughout our society. There are no restrictive policies in terms of where people of color can sit when taking public transportation. Segregating people from particular public locations is illegal. Overt practices reflecting prejudice and bigotry are relics from the past, when Jim Crow laws ruled America.

Nevertheless, despite these advances, America has not achieved the goal of accomplishing racial equality. Racial and ethnic characteristics are still significant factors of concern for many people of color. For instances, in a study, *Cognitive Representations of Black Americans: Re-exploring the Role of Skin Tone*, a Tufts University professor of Psychology concluded through his studies that a person's skin color was ascribed with an increase in racial bias.[3] In the findings of this study, the darker a person's skin color, the more negative the attributes or the perceptions associated with that individual would be. The conclusion that can be drawn from this finding therefore, is that skin color is clearly a determining factor of how people are treated in American society. What were previously overt practices of racial and ethnic discrimination have become more covet processes. This could be illustrated with the current concerns of the police shootings of Black men and

[3]Robin V Smiley, "*Race Matters in HealthCare*," *Black Issues in Higher Education*. 19, no.7 (May 2002), 16.

these questionable actions by white police officers against unarmed as well as armed African-American men. This is also evident even when one explores some aspects of the social interaction of people of color in the United States, especially within healthcare.

Racial and ethnic characteristics can affect a patient's diagnosis and treatment because of the healthcare providers' unconscious biases and stereotypes. Vanessa Gamble discusses this issue as she writes about the distrust between the African- American community and the biomedical community. In her paper, she explores the relationship between the African- American community and the healthcare system after the Tuskegee experiment and other medical misuses. Vanessa Gamble highlighted and underscored how racism affects our healthcare delivery system in a *Los Angeles Times* article, in which she stated,

> When Althea Alexander broke her arm, the attending resident at the Los Angeles County-USC Medical Center told her to 'hold your arm like you usually hold your can of beer on Saturday night.' Alexander who is Black, exploded, saying, 'What are you talking about? Do you think I'm a welfare mother?' The White resident shrugged: 'Well aren't you?' Turned out she was an administrator at [the] USC medical school.[4]

Rethinking the Social History, affirms this idea that if healthcare professionals must obtain a thorough social history of the patients as a result, only then can these professionals explore and examine their own biases. The authors stated,

> To obtain proper social histories, clinicians could be trained in basic and motivational interviewing techniques and challenged to examine their own biases, since unexplored prejudices influence our ability to obtain or act on important information. We also recommend that clinicians attempt to visit the neighborhoods where the majority of their patients live, since such

[4]Vanessa Northington Gamble, *"Under the Shadows of Tuskegee: African Americans and Health Care," American Journal of Public Health.*87, no. 11 (1997), 1776.

> experiences can enhanced clinicians' social perspective and help them understand their patients' "health homes." Such visits might inform clinicians about the people or services in their patients' world that could be organized to help them achieve better health and about the forces working against their engagement in health-promoting or harm-reducing behaviors.[5]

People of color continue to struggle to attain racial and ethnic equality. The perception that racial equality has been achieved is far from reality. In one of the most eloquent public speeches of the 20th century, Rev. Dr. Martin Luther King, Jr.'s *I Have a Dream* speech to an enormous crowd of supporters of the Civil Rights movement at the Lincoln Memorial, in the summer of 1963, spoke of the urgent need for racial equality. He stated,

> We have come to cash this check, a check that will give us upon demand the riches of freedom and the security of justice. We have also come to this hollow spot to remind America of the fierce urgency of now. . . . Now is the time to rise from the dark and desolate valley of segregation to the sunlight path of race justice. Now is the time, to lift our nation from the quicksand of racial injustice to the solid rock of brotherhood. Now is the time! To made justice a reality for all of God's children.[6]

It has been fifty years since Rev. Dr. Martin Luther King, Jr. spoke these words. His message is still very much relevant today. The racial disequilibrium that America is still struggling with to "overcome" echoes of the past experiences of many people of color, indicating that the need for racial equality is critically important.

It has become vividly apparent that racial inequality has affected many aspects of American society, especially our healthcare delivery system, and our response has been

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[5]Heidi Behforouz, M.D., Paul K Drain, M.D., Joseph J , Rhatigan, M.D., *"Rethinking the Social History," New England Journal of Medicine*. 371 (2014), 1278.

[6] Rev. Dr. Martin Luther King, Jr., *"I Have A Dream Speech."*

minimal to say the least. In *Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes*, by H. Jack Geiger, M.D., he states,

> At no time in the history of the United States has the health status of minority populations—African Americans, Native Americans and, more recently, Hispanics, and several Asian subgroups—equaled or even approximated that of white Americans. The health of all American racial and ethnic groups has improved dramatically, particularity over the last six decades, but the paired burdens of excess morbidity and decreased life expectancy for people of color have been noted over several centuries and have proved, even recently, to be stubbornly resistant to substantial change. [He further stated] In 1995, the overall African American mortality rate was 60 percent higher than that of whites—precisely what it had been in 1950.[7]

This notion is further supported in *Social Medicine in the Twenty-First Century*, when the authors stated,

> While an understanding of these large-scale forces remains social medicine's base and one of its most important tasks, this special collection shows the ways in which finer-grained social forces have an equally important effect on health. The different levels at which social factors operate can be considered as four primary domains . . . The third domain is the culture of medicine itself. Health professionals and institutions have their own cultures that also go beyond clinical interactions. Health systems and health research both contain agendas, prejudices, and beliefs that can lead to certain perspective being favored as the most legitimate. Understanding the culture of medicine is essential to understanding health professionals' attitudes toward illness, patients, and treatments.[8]

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[7]H. Jack Geiger, M.D., *"Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes," Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* (Washington D.C.: National Academic Press, 2002), 417.

[8]Scott Stonington, Holmes SM. *"Social medicine in the twenty-first century." PLos Med.3* (2006), 1661.

Responding to these grave inequalities, President William Clinton and the U.S. Congress commissioned a paramount study in 1998, in hopes of exploring and examining the extent of racial/ ethnic disparities. This study by the Institute of Medicine, titled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, clearly establishes the magnitude of the issue of inequality in the healthcare services, as well as many determinants for this disparity. Research illustrates that racial and ethnic disparities are alarming not only because there is disparity in terms of the health status of individuals, but because there is also disparity in the healthcare delivery system, itself. [9] This is evident when the study declares, "The sources of these disparities are complex, are rooted in historic and contemporary inequalities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and patients."[10] In other words, there are social factors which have contributed to racial and ethnic disparities such as the inferior education standards, the lower education status of many people of color, lower paying employment, and underinsurance, as well as historical patterns of segregation and discrimination in society. But, the worst part of this disparity is the unconscious biases and stereotypes affecting patients of color and the healthcare services they receive. The concepts derived from social medicine can assist us in addressing these challenges. Social medicine discourse may be among the most important concepts which can address and challenge the

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[9] Alan R. Nelson M.D., *"Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" Journal of the National Medical Association* 94, no.9 (2002), 666-668.

[10] Brian D. Smedley, Adrienne Y. Smith and Alan R. Nelson, ed. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* (Washington D.C.: National Academic Press, 2002), 12.

global order of health, disease, medicine and the disparities of care.[11] For instance, the social medicine framework can provide the healthcare professionals with an enhanced picture of their patients' lives. This is affirmed by the authors in *Rethinking the Social History*,

> Adopting the social medicine framework, we revised our list of social history topics in an effort to strengthen our therapeutic alliances, better contextualize patients' diagnostic and treatment plans, and improve health outcomes.[12]

The reality of disparities in health care is also affirmed in *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status*, when the author, Thomas Perez, states, "The real implication of the study [Schulman, 1999— *The Effect of Race and Sex on Physicians' Recommendation*] was actually quite sample: doctors are human. Like lawyers, businesspeople, and other professionals, doctors are fallible and may discriminate, consciously or subconsciously. In other civil rights contexts, it has been shown that racial bias can infect the corporate boardrooms, the schoolrooms, and the police precinct rooms."[13] In this article, Thomas Perez, highlights that racial bias can also affect these who get to the operating room.[14]

The study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, provides a clearer picture of the existence of racial and ethnic disparities in

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[11] Scott Stonington, Holmes SM. *"Social medicine in the twenty-first century." PLos Med.* 3, no.e445, (2006), 1661.

[12] Heidi L. Behforouz, Paul K .Drain, Joseph J Rhatigan, *"Rethinking the Social History," New England Journal of Medicine 371,* (2014), 1277.

[13] Thomas Perez, *"The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status," Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*, (Washington D.C.; National Academic Press, 2002), 10.

[14] Thomas, *"The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status,"* 9

healthcare. This report highlighted its findings, its recommendations, and the strategies in hopes of addressing this issue. The study underscores its final report by stating clearly,

> The major findings were as follows: Racial and ethnic disparities in health care exist even when insurance status, income, age, and severity of conditions are comparable, [a]nd because death rates from cancer, heart disease, and diabetes are significantly higher in racial and ethnic minorities than in whites, these disparities are unacceptable. Racial and ethnic disparities in health care occur in the context of broader historic and contemporary social and economic inequalities, and there is evidence of persistent racial and ethnic discrimination in many sectors of American life. Many sources including the health system, health care providers, patients, and utilizations managers may contribute to racial and ethnic disparities in health care. Bias, stereotyping, prejudice, and clinical uncertainty on the part of the health care providers many contribute to racial and ethnic disparities in health care. A small number of studies suggest that certain patients may be more likely to refuse treatments, yet these refusal rates are generally small and do not fully explain health care disparities.[15]

Underscoring how racial/ ethnic group members were treated and to determine whether there was a difference or disparity with regards to medical care, the study, *Racial and Ethnic Differences in the Use of Invasive Cardiac Procedures among Cardiac Patients in Los Angeles County, 1986 through 1988,* was utilized to determine the medical care racial and ethnic group members received. The study notes that it had been already documented that African Americans were less likely to receive certain cardiac procedures. [16] The duration of the study lasted two years in the Los Angeles County in California. The

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[15] Alan R. Nelson M.D., *"Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," Journal of the National Medical Association*.94, no.9 (2002), 666-668.

[16] David Carlisle, M.D., Ph.D, Barbara D. Leake, Ph.D., and Martin F. Shapiro, MD., PhD., *"Racial and Ethnic Differences in the Use of Invasive Cardiac Procedures among Cardiac Patients in Los Angeles County, 1986 through 1988." American Journal of Public Health* 85, no.3 (March 1995), 352-356.

results also indicate that Latinos/ Hispanics and African Americans were less likely to receive certain cardiac procedures such as undergoing angiography and bypass graft.[17] However, Asian Americans were more likely to receive the same number of procedures as white Americans.[18] The authors states, "among studies of inequalities in the use of cardiac procedures, these findings are noteworthy in demonstrating that apparent disparities in receipt of cardiovascular procedures between whites and African American patients were paralleled by differences in rates between Whites and Latinos . . .." [19] This study provides further supporting evidence that racial and ethnic group members receive inappropriate and inadequate medical care when compared to their white counterparts. This notion is further supported in *Social Medicine in the Twenty-First Century*, when the authors stated,

> The stark fact is that most disease on the planet is attributable to the social conditions in which people live and work. The socially disadvantaged have less access to health services, and get sicker and die earlier than the privileged. Despite impressive technological advances in medicine, global health inequalities are worsening. [20]

In *Racial and Ethnic Differences in Access to Medical Care in Managed Care Plans*, a study that examined managed-care plan, to determine where racial/ ethnic group members experience differences in accessibility in comparison to non-managed care recipients

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[17] Carlisle, *"Racial and Ethnic Differences in the Use of Invasive Cardiac Procedures among Cardiac Patients in Los Angeles County, 1986 through 1988."*

[18] Carlisle, *"Racial and Ethnic Differences in the Use of Invasive Cardiac Procedures among Cardiac Patients in Los Angeles County, 1986 through 1988."*

[19] Carlisle, *"Racial and Ethnic Differences in the Use of Invasive Cardiac Procedures among Cardiac Patients in Los Angeles County, 1986 through 1988."*

[20] Scott Stonington , Holmes SM. *"Social Medicine in the Twenty-First Century."* *PLos Med.* 3:e445 (2006), 1661.

provided further evidence of racial/ ethnic disparities in healthcare. The managed-care plans that were utilized here were those that required a patient to sign up with a primary care physician. These primary care physicians were gatekeepers.[21] In addition, these patients would need a referral to visit a specialist. The results were that Latinos/ Hispanics and African Americans were less likely to have access to and use of primary care physicians and specialists in comparison with whites, due to the provisions of their health care plans. [22] This provides further evidence that patients of color receive inferior medical care. This is affirmed when the authors states,

> Hence whites were more likely than Hispanics or African Americans to be in plans with neither a PCP nor a requirement to obtain referrals . . . compared to white Americans, Hispanics and African Americans had worse experiences for almost all measures of access to and use of primary and specialty care . . . Hispanics . . . least likely to have had their last visit with a specialist (22.3 percent) . . . African Americans (25.5 percent) and whites (27.5 percent).[23]

These statistics reveal that most whites Americans have a greater opportunity for obtaining a higher paying job with excellent health insurance benefits that is in juxtaposition to people of color—African-Americans, Latinos and other ethnic group members with lower paying employment as well as inadequate health insurance. This is substantiated in *Dark Ghetto: Dilemmas of Social Power 2nd ed.,* in which William Julius Wilson in the *Introduction to the Wesleyan Edition* states,

> Dark Ghetto . . . made it clear that ghetto behavior, which was said to be ultimately destructive to individuals and families, was at bottom a problem

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[21] J. Lee Hargraves, Peter J. Cumminghan, and Robert G. Hughes. *"Racial and Ethnic Differences in Access to Medical Care in Managed Care Plans." HSR: Health Services Research* 36, no.5 (October 2001), 853-868.

[22] Hargraves, *"Racial and Ethnic Differences in Access to Medical Care in Managed Care Plans,"* 855.

[23] Hargraves, *"Racial and Ethnic Differences in Access to Medical Care in Managed Care Plans,"* 863.

> generated by the systematic blockage of opportunities. Although the problem of joblessness, teenage pregnancy, family dissolution, educational failure, violent crime, exploitative sexual relations, drug addiction, and alcoholism are not unique to black ghettos, they are more heavily concentrated there because of a unique combination of economic marginality and rigid racial segregation. Excluded from the stable employment sectors of the economy, inner-city residents have to rely on insecure and dead-end jobs that provide wages insufficient for the purchase of those goods and services that embody the prevailing standard of American life. Racially segregated from the larger society, they more frequently suffer discriminatory practices and encounter contemptuous attitudes from those in positions of social power, even though the latter know that the ghetto poor are forced by their very circumstances to endure super exploitative economic transactions from the private sector and inferior services from municipal authorities.[24]

Yet, another study demonstrates that health care professionals are easily influenced by stereotypes, biases and old age prejudices. *Conscious and Nonconscious African American Stereotypes: Impact on First Impression and Diagnostic Ratings by Therapists,* by Jose M. Abreu, explored the impact of stereotypes of African Americans on mental health professionals and how this affected their diagnosis. This study discovered that healthcare professionals were often influenced negatively based on African American's stereotypes, and these patients were more likely to be seen as hostile and were labeled with wrong diagnoses because of the unconscious biases of the healthcare professionals.[25] Abreu illustrates this result when he states, "the present findings suggest that information

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[24] Kenneth B. Clark, *Dark Ghetto: Dilemmas of Social Power 2nd ed*. Hanover, NH: Wesleyan University Press, 1989. Originally published New York: Harper & Row, 1965, xi.

[25] Jose' M. Abreu, *"Conscious and Nonconscious African American Stereotypes: Impact on First Impression and Diagnostic Ratings by Therapists," Journal of Counseling and Clinical Psychology*,(1999).

related to racial group membership can activate or prime stereotypes, making attributes associated with that stereotype or set of stereotypes more accessible."[26] The finding shows that mental health professionals were exhibiting and working from prejudices based on unconscious stereotypes, highlighting the fact that we are easily influenced by our perceptions and underscoring the notion that treatment protocols are being skewed by stereotypes, biases, and prejudices.

This is again affirming the inequality of medical care as experienced by racial/ ethnic group members with respect to their white counterparts; thus, highlighting the unequal state of our healthcare delivery system. Are we really saying that the cost of white American's lives is more important or are more valuable than the lives of people of color? It seems to me that this issue of racial/ ethnic disparities in healthcare is more than a state of separate but not equal. Is this really happening? In *Race Matters in Healthcare*, Robin V. Smiles, states, "healthcare is our next civil rights issue."[27] Speaking frankly on this issue, his work implies that there is a social justice issue necessitating attention here. There are those who might disagree with this position to whom we must respond, of letting the record show the reality. Whether unconscious or not, research shows that, historically, people of color have and will continue to receive inferior quality of care, if we do not address the issue of race and the multiple forms of racism in our society.

Former President Bill Clinton, in the late 1990's, initiated a very ambitious goal of reducing and eliminating racial/ ethnic disparities in healthcare. He established the "Racial

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[26] Abreu, *"Conscious and Nonconscious African American Stereotypes: Impact on First Impression and Diagnostic Ratings by Therapists,"*355.

[27] Robin V. Smiley, *"Race Matters in HealthCare" Black Issues in Higher Education* 19, no.7 (May 23, 2002), 25.

and Ethnic Health Disparities Initiative" to address this issue focusing on six areas: infant mortality, diabetes, cancer screening and management, heart disease, HIV/ AIDS, and immunization.[28] In addition, Former President Clinton also provided $400 million for the prevention and outreach programs for minorities and other disenfranchised individuals.[29] The unfortunate result of this initiative is that it failed to deliver. The expectation in 1998, was in that the year 2010, we would experience the elimination of racial and ethnic disparities in healthcare. Needless to say, it was a very courageous goal. Four years have passed since the original deadline. Some can argue that the reason why the goal failed to be realize on the elimination of racial and ethnic disparities because it did not address the cause, but rather the symptoms of racial and ethnic disparities. That cause can be attributed to the unconscious infusion of racial bigotry resulting in creating social norms and values that do not reflect attributes of equality in terms of race and ethnicity, especially as it affects healthcare.

Social Dimensions (Values/ Norms)

Understanding how social norms and values are established in a society can probably underscore why racial and ethnic disparities in healthcare exist. Society is comprised of various institutions, including churches, schools, healthcare facilities, and government agencies, including police departments, fire departments, municipal authorities such as Mayors' Offices, Council members, and other City/ Town officials, just

[28] Jennifer Brooks, *"Clinton Announces Racial and Ethnic Health Disparities Initiative." U.S. Dept. of Health and Human Services.* (April 1998), 49.

[29] Brooks, *"Clinton Announces Racial and Ethnic Health Disparities Initiative,"*45.

to name a few. Institutions such as these create, maintain, and reinforce these social values and norms, creating structural injustices. From a sociological perspective, the hospital is one of the many institutions that represent a critical social structure in society and its infrastructures often reflect structural injustices. These various institutions uphold the values and norms of the larger society that often do not include the values of justice and equality for all. This idea is illustrated in *The Church as a Social Institution*. This book tries to define *what an institution is*. The author, David Moberg states,

> Basic human requirements are met in such diverse ways and so many of them are intertwined with one another that it is difficult to determine which one need, if any, is dominant. Nevertheless, social institutions collectively provide the societal framework within which man [humanity] satisfies or attempts to satisfy both organically innate and socially acquired needs. [It further states] All of a society's institutions are intricately interrelated . . . Together they form a syndrome, constellation, or web of net-like interrelationships; when one strand of this web is influenced, the entire web shifts and concomitant modification of the relative positions of the various parts inevitably takes place. No institution can be understood in isolation from others in its society.[30]

It makes sense then that both individuals and the structures of the healthcare delivery system such as: medical clinics, community and teaching hospitals, rehabilitation facilities, and other dispensaries of healthcare services, express the same attitudes and value systems of the larger society.

Demonstrating that these social institutions are the enforcement agents of society's norms and values, in *Sociology 6th ed.*, the authors speaks of the structures and purposes of social institutions as follows:

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[30] David Moberg, *The Church as a Social Institution*. (Cambridge, Mass: 1984.), 27.

> a social institution consists of pattern behavior, and status/ role relationship that fulfill certain basic societal needs. Institutions respond to the fundamental requirements of all human societies by organizing behavior and relationships in a way that satisfies those requirements. The question is what functions do social institutions serve? One is a need to reproduce new members and to teach them the customs, beliefs, and values shared by those who live in their world. [31]

These social institutions establish norms and values, which eventually become unconscious behavioral patterns that are later disseminated to one's offspring and others. These norms/ values are articulated in the medical care received by patients of color via diagnosis and treatment. These social norms and values are manifested through two distinct avenues. The first is through the institutional structures, themselves, by way of policies, procedures, and are institutional ethos. The other avenues that transmit these values/ norms are through the behaviors of professionals in the healthcare industry, including healthcare professionals such as nurses, administrators, nutritionists, physicians, and many others.

It is quite apparent that the racial/ ethnic disparities that exist in healthcare are due to various reasons such as: access issues, underinsurance, inappropriate treatment protocols, environmental discrimination, prejudices, biases, stereotypes, and the inferior quality of care, but, the most pressing problem is the unconscious biases of healthcare professionals. This reality is illustrated in *Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes,* H. Jack Geiger, M.D. states,

> In 1990, the American Medical Association (AMA) took formal note of black-white disparities in health care. While emphasizing the probable roles of socioeconomic status and sociocultural factors and noting the limitations

[31] Calhoun Craig, Donald Light and Suzanne Keller. *Sociology 6th edition*. (New York: McGraw-Hill, 1994), 56.

> of many studies, the AMA also acknowledged that 'Disparities in treatment decisions may reflect the existence of subconscious bias. . . The health care system, like all other elements [institutions] of society, has not fully eradicated this [racial] prejudice.[32]

The desire to eliminate the racial and ethnic disparities in our health care system is an important step to wrestle with. However, these disparities will not change much if the core of the problem is not addressed—this socialization process and the infusion of these biases, stereotypes, and prejudices into our unconsciousness as social norms and values. In other words, if we continue to fail in resolving this dilemma because we have always addressed only one social institution—as if the root of the problem resides only in one particular system—the problem is that these biases, stereotypes and prejudices have become infused into our unconsciousness under the disguise of society's norms and values.

Furthermore, these historical inequalities are based on discriminatory practices, biases, prejudices, and stereotypes that created, and is embodied in racial and ethnic disparities. Racialized prejudices by whites, especially by those in power portions established these historical patterns of behaviors as institutionalized social norms/ values. For instance, during the 19th century, Southern physicians intentionally justified their racial biases and prejudices through the use of pseudo-medicinal methods. This situation became more evident when Dr. Samuel Cartwright initiates and supports his racial bigotry regarding African-Americans and the disorders from which they suffered. He states,

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[32] H. Jack Geiger, M.D.. *"Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes." Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* (Washington D.C.; National Academic Press, 2002), 437.

> Negroes, he explained, were like infants. 'It is well known,' he stated confidently, 'that in infancy, full and free respiration of pure fresh air in repose, so far from being required, is hurtful and prejudicial.' A baby sleeps far better 're-breathing its own breath, warmed to the same temperature as that of its body, and loaded with carbonic acid and aqueous vapor.' Whereas whites outgrow this condition, Negroes have a constitutional predilection towards impure air and instinctively try at all times to prevent the entrance of clean external air into their lungs. Moreover, the vascular system of Negroes was found to be much less developed than in whites, making it difficult to bleed them. 'On cording the arm of the stoutest Negro,' Dr. Cartwright declared, 'the veins will be found scarcely as large as a white boy's of ten years of age.'[33]

After Dr. Cartwright established the notion about African-Americans' physical nature, Dr. A.F. Axson, the president of the Louisiana State Board of Health, claiming further evidence of the physiological differences, states,

> [Dr. A.F. Axson] wrote, they demonstrated that 'freedom to the negro, in the midst of the civilization of the 19th century, is a curse, for it entails upon him insanity as its consequence . . .' these same records showed, however, that as long as he remained in slavery 'the vital energies of the negro' were extraordinary.' [34]

Some may assume that these historically discriminatory practices and views would not have an impact on the lives of people of color as well as on their health status, but they do! These and other historical patterns of racial bigotry give permission to individuals, especially those that belong to the dominant group to espouse consciously or unconsciously ideas that are undergirded with racialized ideology and establishes these ideas as social norms/ values. For instance, in a study entitled, *Unconscious and Nonconscious African American Stereotypes: Impact on First Impression and Diagnostic Ratings by Therapists*,

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[33] John Duffy, *"A Note on Ante-Bellum Southern Nationalism and Medical Practice," The Journal of Southern History*. 34, no. 2 (1968), 269.

[34] Duffy, *"A Note on Ante-Bellum Southern Nationalism and Medical Practice,"*273.

Jose Abreu recognized that racial/ethnic characteristics are still significant factors that can affect a patient's diagnosis and treatment because of the health profession's unconscious biases and stereotypes.[35] As a result, racial/ ethnic disparities in health care exist, due to the social historical realities, as well as these discriminatory practices becoming unconscious social norms/values.

This reality is and should be our continual civil rights struggle. Elimination of racial and ethnic disparities in our healthcare ought to be considered America's first priority in healthcare reform. Based on the comments presented thus far, this research study will wrestle with how as a modern progressive society, can we begin to resolve our blatant past injustices that had and have existed for centuries, as well as our current historical realities which continues to be part of the structures of injustices which deny people of color equality and justice (i.e. The killing of Black men by police officers as well as the continual racial/ ethnic disparities in healthcare.) We must take drastic steps in responding to these grave inequalities.

Currently, many studies have identified multiple determinants for racial and ethnic disparities, but still little has been done to improve this situation. It seems as if we are hoping to discover that one contributing factor that could serve as the panacea for this dilemma. Hence, if it is necessary to look for that one determinant to reduce and eliminate racial/ ethnic disparities, it is important then to begin with objective studies on race and how this reality impacts the clinical encounter for individuals of all races and ethnicities.

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[35] Jose' M. Abreu, *"Conscious and Nonconscious African American Stereotypes: Impact on First Impression and Diagnostic Ratings by Therapists," Journal of Counseling and Clinical Psychology*, (1999), 352.

This persistent issue of racial and ethnic disparities in healthcare, in society, needs a praxis that can address the unconscious behavior of healthcare professionals. What is required is a psychological approach, which not only addresses this disparity, but a praxis that embraces a "preferential option for the poor and the oppressed."[36] In other words, a social science that rejects the notion of objectivity, thus taking an appropriate stance, which supports those who are on the underside of America's historical realities: a psychological method that can transform and redirect society to serve its citizens with the aim of equality, freedom, and liberation, is necessary.[37] Thus, the writing and practice of the Spanish-born Jesuit priest and psychologist, Ignacio Martin-Baro— whose writings on the psychology of liberation—are critical. What is the psychology of Liberation? A more comprehensive assessment and explanation of the psychology of liberation will be presented in chapter 3, as to how this liberative dimension can be used to respond to racial and ethnic disparities in healthcare are looked at more comprehensively.

In chapter 4, this liberative dimension and others are used in hopes of addressing racial/ ethnic disparities in the U.S. healthcare delivery system, I believe it is essentially important and crucial to begin to re-socialize our healthcare professionals (first commencing with doctors) during their medical training both in medical school as well as during their residency programs. First, it must begin by re-designing the medical school curriculum to include a yearlong course which will be utilized to make these medical students aware of their and other's racialized ideology by exploring and examining

[36] This idea of the preferential option for the poor and the oppressed come from Liberation Theology by Gustavo Guitierrez.

[37] Ignacio Martin-Baro, *Writing for a Liberation Psychology*. (Cambridge, Mass.: Harvard University Press, 1984).

literature (i.e., Immanuel Kant, *Of the Different Human Races*, and other writings), studies and historical evidences. Then this discussion can assist these medical students in determining how they should respond, and finally helping these future doctors take clear and decisive actions addressing this racial/ ethnic disparity. These ideas will be fully explored, examined, and explained in greater detail in this chapter, in conjunction with other elements of consciousness raising, what appropriate medical intervention (i.e., Diagnosis, treatment protocols, etc.) is needed, and how these decisive actions, if rooted in experiences of racial/ ethnic patients when they encounter the healthcare delivery system, can possibly reduce racial/ ethnic disparities in the U.S. healthcare system.

In summary, racial and ethnic disparities not only exist in our healthcare delivery system, and our respond to this grave issue has had little impact on the reduction or elimination of this disparity. Furthermore, this disparity is the result of racialized ideology developed through western European thought,[38] and its conquest,[39] the desire for European imperialism and colonization[40] of the New World, and the economic forces [41] at play during the European expansion which have been at work in the global market for the last four hundred years. In addition, this disparity is the direct response of America' social values and social norms. It is important to fully understand this issue that we, as a society, have allowed these biases, prejudices, and stereotypes to interfere with the medical

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[38] See Henry Homes, & Lord Kames *Preliminary Discourse, Concerning The Origin of Men and of Languages*. In addition, see Robert Knox, *The Races of Men: A Philosophical Enquiry into the Influence of Race over the Destinies of Nations* as well as Immanuel Kant, *Of the Different Human Races* and Robert Bernasconi, *Who Invented the Concept of Race? Kant's Role in the Enlightenment Construction of Race*.

[39] Eric Williams, *Capitalism & Slavery*. (Chapel Hill & London: The University of North Carolina Press, 1944), 1994.

[40] Williams, *Capitalism & Slavery*, *1995.*

[41] Williams, *Capitalism & Slavery*, *1995.*

treatment of patients of color. It is my contention that this disparity cannot be reduced or eliminated without the acknowledgement of our unconscious racialized ideology. Not enough has been done to really deal with western Europeans and Americans, non-people of color, as well as some people of color's norms and values regarding people of color and their nature, as well as the level of oppression and repression that people of color continue to encounter and experience. Furthermore, in order for us to commence to reduce and eliminate racial/ ethnic disparities in the U.S. healthcare, we (as a society) need to enhance and refine our medical school education and curriculum to include a robust curriculum that exposes, explains and addresses in concrete and reflective actions this disparity.

Chapter 2- Literary Review— Studies/ Documentation of Racial/ Ethnic Disparities

Racial and ethnic disparities in the U.S. healthcare delivery system seem to be the result of various contributing factors. Studies have established that there are different determinants—lack of access, the quality of care, lack of medical coverage and underinsured individuals just to name a few— which are the causes of racial and ethnic disparities in healthcare. These determinants are the contributing cause for this disparity according to each study and their authors.[42] However, I will argue that these determinants are merely symptoms of unconscious racialized ideology and that these determinants do not go far enough in explaining the widespread racial/ ethnic disparities in the U.S. Healthcare system. Needless to say, I will make the connection between these contributing factors and the real cause—unrealized racialized ideology—as the primary sources of racial/ ethnic disparity. In addition, the latter half of this chapter will tie the real cause to this racial/ ethnic disparity which will further support my thesis; highlighting how this unrealized racialized ideology has become part of the social values and norms in American society. Nevertheless, let us begin first with a vignette and then the presentation of studies documenting the possible reasons for the existence of racial/ ethnic disparities.

One day at the North Central Bronx Hospital, a chaplain visited a patient. He knocked on the patient's room doorframe and the patient welcomed the chaplain, and invited the chaplain in. The chaplain asked if he could sit down and the patient replied, "of course, you can." As the patient and the chaplain talked, the chaplain started to feel

[42] This will not be comprehensive examples and evidence demonstrating the causes and/ or determinants of racial and ethnic disparities as well as the establishment of social values and norms, due to the limitation of space and time.

uncomfortable. The chaplain realized that the patient seemed to be delirious and confused. The chaplain also noticed that the patient's sclera had a yellowish color as well as a yellowish tint to his skin suggesting liver issues. The chaplain continued talking with the patient a little while longer, before he left and reviewed the patient's chart.

The patient was a 42 year old dark skinned Puerto Rican male. His diagnosis was advanced cirrhosis of the liver. The patient was an alcoholic and the years of alcohol abuse resulted in his medical condition. As the chaplain read through the doctor's note, he realized that the patient needed a liver transplantation, if the patient was going to live.

The question for consideration; however, should a patient with high-risk behavior be given a transplantation of a liver? Most of us would agree that every patient deserves basic medical care; however, transplantation of a liver to an active alcoholic seems to be a misuse of resources, including the procedure itself, the liver, and the medication needed for the longevity of the patient's life, the healthcare professionals needed for the operation and many other unforeseen expenses. Liver transplantation for patients with high-risk behavior such as alcoholism, is still a very controversial issue. In cases like this, should a patient's race and/ or ethnicity be a consideration as to whether or not he/she receives a new liver? Most people would assert *no*, it should not be a factor. But what is of concern is the patient's high-risk behavior, that is, the abuse of alcohol in this case. Should the patient's social economic status (SES) be an issue? No. Again, it is the patient's high-risk behavior that should be the determining factor.

What if another patient who has the same medical condition (that is, the high-risk behavior as well as the medical diagnosis of alcoholism) in addition to cancer? Should that patient be given a transplantation of the liver? What do you say? Let us say that the

patient is white, should he or she receives a liver transplant? What if the patient is white, has money, and some notoriety, should he or she be given a liver transplant? Most people would deny this patient the liver transplant, due to their high-risk behavior. However, this very incident has happened. How do we justify this?

In 1995, a New York Yankee centerfielder needed a liver transplantation. He was placed on the liver transplant list in Dallas, Texas. Within forty-eight (48) hours, he received a liver. He then underwent the liver transplantation surgery. At the time of the transplantation, the typical wait for a liver was one hundred eighty-three (183) days. Just two months after the liver transplant, the patient died. The patient had liver cancer; in addition, he had hepatitis, and alcohol-related cirrhosis of the liver. The patient was Mickey Mantle. He was white, his economic status was affluent, and his notoriety was not in question. This may be over simplified, but this case clearly demonstrated that there might be preferential treatment for patients who are white, wealthy, and famous. If you think that is just one incident, what do you do with the double transplantation of a liver and heart for Governor Robert Casey (D-Penn) who in 1993, received both transplants just one day after being informed of his condition. Also, let's not forget "Baby Jesse," who received an organ donation half way through the Phil Donahue show, as the parents pleaded for help. It was later discovered that the very organ donated to this California couple for "Baby Jesse" should have gone to another infant.[43] These real-life examples demonstrate that our biases, prejudices and stereotypes do affect our medical decisions and *can* contribute to racial and ethnic disparities in our U.S. healthcare delivery system.

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[43] Marcia Chambers, *"Tough Questions about Transplants raised by New Heart for Baby Jesse,"* (Special to the New York Times. Published: June 15, 1986), 5.

Let us now review the literature and the evidence of the possible reasons for racial/ ethnic disparities in the U.S. Healthcare delivery system.

In *Pathways to Access: Health Insurance, The Healthcare Delivery System, and Racial/ Ethnic Disparities, 1996-1999,* the authors attempted to discover and explain racial/ ethnic disparities in healthcare from the perspective of access to and use of healthcare services, in the hopes of detailing the sources of these disparities.[44] The study utilized Medical Expenditure Panel Survey (MEPS) as well as Area Resource File (ARF) data in the hopes of identifying key components to the issue of racial/ ethnic disparities that exist in the United States healthcare system. With the data from MEPS, the authors are able to collect data on healthcare use and spending, access to care, health status, health insurance coverage, demographic and socio-economic characteristics and employment and job characteristics for U.S. citizens who are not institutionalized at least permanent in healthcare facilities.[45] In hopes of examining/ exploring external factors that are endemic to a particular individual or communities, whether it is an urban or suburb, or rural area or where the neighborhood caters to Caucasians, or African-Americans or is highly populated by Hispanics or Asians. It is the combination of these data sources which provided the authors with factoring leading to racial/ ethnic disparities; as well, as unexplained factors.[46]

To supplement these data sources, the authors also used MEP Access to care supplement which looked at access and the usage of medical services. This supplement

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[44] Samuel Zuvekas, and Greggs S. Taliaferro. *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999." Health Affairs*. 22, no. 2 (March/ April 2003),140.

[45] Zuvekas, *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999,"* 141.

[46] Zuvekas, *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999,"*141.

examined whether a person has a usual source of care; by asking "is there a particular doctor's office, clinic, health center, or other place that the individual usually goes when sick or in need of health services?" [47] In an attempt to further understand issues of access, subjective family measures were taken in order to get a clear picture. These subjective measures are designed to acquire the family's experience with ambulatory care. These measure explore, "(i) Whether family reported that any family member had difficulties or delays or did not get needed healthcare, and (ii) whether family was satisfied with their ability to get medical treatment when needed.[48] In addition, Samuel Zuvekas and Greggs S. Taliaferro, the authors, explore factors outside studies of healthcare to further shed light on these disparities by examining employment provided insurance; since according to the authors, employment provided healthcare insurance is the main avenue that U.S. citizens are granted access to the healthcare delivery system.[49]

The findings in *Pathways to Access: Health Insurance, The Healthcare Delivery System, and Racial/ Ethnic Disparities, 1996-1999*, were mixed. In other words, it found that the racial/ ethnic disparities gap did not increase within the timeframe of 1996 to 1999. Nevertheless, they also concluded that the gap did not diminish, even though MEPS Access to Care supplement measure reflect that African- Americans reported in not having difficulties with access to healthcare while Hispanics reported as having difficulties with

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[47] Zuvekas, *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999,"*142.

[48] Zuvekas, *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999,"* 142.

[49] Zuvekas, *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999,"* 140.

access as well as not being satisfied in terms of their ability to get medical treatment.[50] Furthermore, statistical data clearly demonstrate the opposite of what African-Americans reported, as it shows that African-American children had thirty-five percent use of an ambulatory visit, Hispanics children had a sixty percent utilization compared to a seventy-six percent for white children from 1996 to 1999.[51]

In addition, this study has demonstrated that health insurance coverage played a role in explaining racial/ ethnic disparities in the U.S. healthcare delivery system; however, there are also other contributing factors to this disparity. The authors' state:

> For example, these differences explained 53 percent of the black-white disparity in having usual source of care, with local area demographic and economic indicators twenty-eight (28) percent, income seventeen (17) percent and demographic characteristics sixteen (16) percent being the most important factors, while education explained little. Simply meaning that health insurance coverage can not only explain the racial/ ethnic disparities in healthcare, but that it does provide a glance into the complexity of our healthcare disparities with regards to racial/ ethnic group members.[52]

Samuel Zuvekas and Greggs S. Taliaferro further claimed that the increase in access to healthcare insurance will certainty begin to address racial/ ethnic disparities by reducing this disparity. This is affirmed when the authors state: "Clearly, health insurance is important. Differences in insurance coverage explain up to one-third of Hispanic-white disparities and two-fifths of black-white disparities in having usual sources of care. Increasing health insurance coverage would no doubt increase access for all Americans and

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[50] Zuvekas, *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999,"*144.

[51] Zuvekas, *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999,"*144.

[52] Zuvekas, *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999,"*145

reduce racial and ethnic disparities."[53] In addition, the study clearly presents that external factors contribute to racial/ and ethnic disparities, whether or not access employment-related insurance is increased. This is supported when the study states: "Our analysis suggest that the disparities in access to employment-related coverage for blacks can be traced to lower employment among single blacks and lower marriage rates. For Hispanics, the lower levels of employment-related coverage . . .. the types of jobs that both single and married Hispanics hold are much less likely to offer insurance than is true for jobs held by other ethnic groups, which further contribute to disparities in access to health insurance". [54]

Although I agree with the authors that increased health coverage will provide greater access to healthcare, I cannot fully accept their overriding assumption that racial/ ethnic disparities will be reduced. Even their study, *Pathway to Access: Health Insurance, The Healthcare Delivery System, and Racial/ Ethnic Disparity, 1996-1999*, suggests that other external factors are contributing to this disparity. The reason is because ethnic bias transcends these structures. For instance, in a study called *Access to Health Care: What a Difference Shades of Color Make*, the author asserts, "Gaining access is difficult for people of color because the United States health care system is based on a white male paradigm. This paradigm explicitly highlights race, ethnicity and sex, and implicitly, economic status, due to the dominance of white males in employment positions of power and high

[53] Zuvekas, *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999,"*150.

[54] Zuvekas, *"Pathways to Access: Health Insurance, The Health Care Delivery System, and Racial/ Ethnic Disparities, 1996-1999,"*150.

compensation". [55] This is further affirmed in *"Race and Discretion in American Medicine,"* where the author declares

> Variations in medical spending account for only a small portion of population-wide class and race-related differences in health status: life expectancy, infant mortality, and the incidence of many diseases correlated much more closely with income, education, environmental conditions, race and ethnicity. Racial disparities in health care access arise in large part from socio-economic disadvantage and consequently unequal affordability of medical coverage and services. [56]

The main culprit is the ideological belief that whites are superior to all others. This ideological belief is embedded within American's social norms and value.

In another study, *Medicaid Manage Care and Racial Differences in Satisfaction and Access*, the objective of this study was to explore how African-Americans in comparison to whites who thrived under managed care (MC) versus traditional fee-for-services (FFS) healthcare providers to determine whether manage care can reduce or eliminate racial and ethnic disparities in the U.S. Healthcare. This study took a structural analysis position with regards to how healthcare organizational systems can either hinder or benefit certain racial groups; specifically, African-Americans from accessing healthcare services. The authors, Greg Greenburg, William P. Brandon, Nancy Schoeps, Lynne R. Tingle, and Laure D. Shull explored two aspects of African-Americans and their

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[55] Gwendolyn Roberts Majette, *"Access to Health Care: What a Difference Shades of Color Make," Annals of Health Law*. Loyola University Press, Chicago, IL, 2003; 12 (1),122.

[56] M. Gregg Bloche, MD, JD., *"Race and Discretion in American Medicine," Yale Journal of Health Policy, Law, and Ethics.* Vol. 1, (Spring 2001),455.

experiences with the healthcare delivery system. First, they examined how African-Americans were able to access care. Second, they investigated whether African-Americans were satisfied with the quality of this care, in the hopes of exploring if managed care can assist in lowering racial and ethnic disparities by altering healthcare delivery system's ethos. Authors Greg Greenburg, Williams P. Brandon, Nancy Schoeps, etc. acknowledged that there is data documenting the fact that African-Americans have difficulties accessing health care services, but there is little to no evidence examining whether managed care, in comparison to fee-for-services, can lead to reduction or increased racial and ethnic disparities in the U.S. Healthcare system.

The methodological approach that this study undertook was a telephone survey in two North Carolina counties, Mecklenburg and New Hanover counties, only with Medicaid recipients.[57] In addition to these telephone interviews, only one hundred and twenty-nine face-to-face interviews were also included for those who did not have a telephone in the demonstration group— Mecklenburg County. Two surveys were conducted in each county. In Mecklenburg County, the first survey was in October 1996 to January 1997. In New Hanover county, the first survey was conducted in November 1996 to February 1997. The second survey for both counties, Mecklenburg and New Hanover, were done in the Fall/ Winter of 1998 to 1999.

This study focused primarily on Medicaid recipients within the above mention counties, Mecklenburg and New Hanover. Within Mecklenburg County, Medicaid recipients were mandated to enroll into HMOs. There were five HMOs to choose from

[57] Greg Greenberg, Brandon, William P., Schoeps, Nancy, etc. "*Medicaid Manage Care and Racial Differences in Satisfaction and Access," Journal of Health Care for the Poor and Underserved.* vol. 14, no. 3 (2003), 353.

and one federally qualified community health center. Mecklenburg County was considered to be the demonstration group. New Hanover County, the other county, was considered to the controlled group. The Medicaid recipients in this county were enrolled into primary care case management (PCCM). The reimbursement rate was very similar to traditional fee-for-services.

The findings in *Managed Care and Racial Differences in Satisfaction and Access* were surprisingly obvious to most healthcare professionals who are aware of the racial/ ethnic disparities in our healthcare system. According to this study, African-Americans did not receive any advantage or disadvantage from the implementation of a managed care healthcare system in terms of access.[58] After the implementation of the managed care in the demonstration group, that is, in Mecklenburg County, whites and African-Americans' access improved. Despite this finding, the study also presented the need for improved access for African-Americans.[59] This is presented when the authors state: "For example twenty-four (24) percent of African-Americans' in the study remained without a regular doctor's visit or source of healthcare in 1998".[60]

In addition, for New Hanover County (the control group), in 1996, in terms of racial differences, two (2) out of the three (3) direct measures of access showed significant differences between whites and African-Americans; whites having better access to health

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[58]Greenberg, *"Medicaid Manage Care and Racial Differences in Satisfaction and Access,"* 366.

[59]Greenberg, *"Medicaid Manage Care and Racial Differences in Satisfaction and Access,"* 359.

[60]Greenberg, *"Medicaid Manage Care and Racial Differences in Satisfaction and Access,"* 359.

care services.[61] Furthermore, the study also indicated that two (2) out of the three (3) realized measures of access a much greater improvement as was evident for whites rather than African-Americans.[62] To fully understand what is meant by the pervious statement regarding realized measure of access, the study defines realized measure of access as, first, received care within 6 months, second, one or more visits to a doctor's office and third, the use of an Emergency room. In retrospect, the study concluded that there was no significant inequality. Nevertheless, it has become evident that under both systems, fee-for-service and managed care, the need for greater improvement for African-American in terms of realized access is critical.[63]

Moreover, the study demonstrated that for African-Americans, managed care did not positively influence access, yet, whites saw a significant improvement in both systems. This is affirmed when the authors state: "In fact, for two of three realized measures of access, the data clearly illustrate that African-Americans' access to healthcare relative to whites' declined in that [Mecklenburg] County, as well as in the control county."[64] Over and above, the authors further claimed, "MC's (Managed Care) lack of effect on racial differences in access to quality health care is clearer with respect to the measures of satisfaction. We found no significant differences between the two-racial groups with regards to satisfaction with any of the four observation points. . .. However, it must be

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[61]Greenberg, *"Medicaid Manage Care and Racial Differences in Satisfaction and Access,"* 361

[62]Greenberg, *"Medicaid Manage Care and Racial Differences in Satisfaction and Access,"* 361

[63]Greenberg, *"Medicaid Manage Care and Racial Differences in Satisfaction and Access,"* 363.

[64]Greenberg, *"Medicaid Manage Care and Racial Differences in Satisfaction and Access,"* 368.

reiterated that with regards to the major question of this paper, whether MC affects African-Americans' access to quality care, all four types of analyses of the satisfaction measures indicated a negative answer." [65]

The authors contradict themselves. They cannot have it both ways. On the one hand, they argue that there is no significant negative impact on African-Americans under a managed care system, especially with regards to satisfaction with their medical care. On the other hand, they stated that their research suggests that under either system, managed care or Fee-for-Services, that African-American patients do not benefit in terms of access. This is illustrated when the authors state: "Most important, we have shown here that racial differences in access to health care services (but not of satisfaction with their services) exist under both FFS or MC."[66] Furthermore, they stated that there needs to be more research on why African-Americans experience trouble with issues of access. It becomes clear to me that whether or not specific groups of people are satisfied with their medical care is important; needless to say, the real question is whether or not these groups of racial/ ethnic members are experiencing issues of access which tend to be more of an important aspect in determining racial/ ethnic disparities. I agree with most people, that quality of care is vital; however, if access is limited, then no matter how great the care, maybe, disparities exist. The only aspect about which I agree with the authors' of *Medicaid Managed Care and Racial Differences in Satisfaction and Access*, is when they state: "If discrimination in health care delivery exists, whether intentional or not, and if we wish to eliminate it, we

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[65]Greenberg, *"Medicaid Manage Care and Racial Differences in Satisfaction and Access,"* 368.

[66]Greenberg, *"Medicaid Manage Care and Racial Differences in Satisfaction and Access,"* 369.

need a complete understanding of its sources and mechanisms of operation, not just the knowledge that it exists."[67]

Yet, in another study, *Access to Health Care: What a Difference Shades of Color Make,* the author's primary focus was to present the major issues of racial/ ethnic disparities in the United States Health Care delivery system. Author Gwendolyn Roberts Majette takes a comparative analysis of racial/ ethnic disparity and infer that the main determinant is access to health care. As a result, she illustrates the barriers to health care. The author begins by exploring four aspects (affordability, availability, usability and acceptability) which clearly illustrate issues of access for racial/ ethnic group members.

In the first aspect, affordability, the author informs us that health care in America is expensive and in order to access healthcare, one must be employed because health insurance is connected to employment. This is affirmed when the author states: "Because health care is expensive, the main determinant to accessing health care is the availability of insurance. In the United States, availability of insurance is almost inextricably tied to employment."[68] Gwendolyn then asserts that most people of color, especially those of immigrant status, have lower paying occupations which result in lower quality of health care insurance. The author further informs us that another barrier to insurance is immigrant status, meaning simply that even if an immigrant has legal resident status, he/ she is still not able to get medical services under Medicaid, a publicly funded program.[69]

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[67]Greenberg, *"Medicaid Manage Care and Racial Differences in Satisfaction and Access,"* 370

[68]Gwendolyn Roberts Majette, *"Access to Health Care: What a Differences Shades of Color Make" Annals of Health Law*.123.

[69]Majette, *"Access to Health Care: What a Differences Shades of Color Make,"*124.

Moreover, the author demonstrates that another barrier is availability of health care providers in urban communities of color. In *Access of Health Care: What a Differences Shades of Color Make,* Gwendolyn claims that maintaining health care facilities as well as sufficiently trained physicians of color is extremely difficult. Regarding health care facilities, the author clearly illustrates that health care facilities are faced with economic hardships simple because these facilities are situated within communities that are economically deficient and disenfranchised, simply meaning that these health care providers' clienteles are poor and are disproportionately uninsured. This notion is affirmed when the author states: "Consider, for example, the June 25, 2001 closing of DC General Hospital, located in the Southeastern quadrant of the District of Colombia, an area that is characterized by poverty and poor health status . . .. [the] closing [of] the hospital as a cost-cutting measure, in spite of the fact that the hospital saw over half the trauma cases in the District and provided the bulk of uncompensated care (36%) to DC residents." [70]

Another challenge illustrated by Gwendolyn is that health care providers in communities of color, are physicians of color. Notwithstanding, the author demonstrates that there is a shortage of physicians of color and their enrollment is declining; as a result of challenges to the affirmative action program initiated by medical schools to increase the enrollment of people of color. Why is enrollment of people of color in medical school important? According to the author, over sixty-six (66) percent of physicians in urban communities of color are physicians of color. This notion is affirmed when Gwendolyn states:

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[70] Majette, *"Access to Health Care: What a Differences Shades of Color Make,"*126.

> Studies show that 'minority doctors open practices in minority neighborhoods in far greater numbers (nearly three-to-one) than do whites.'[71]. . . Additionally, recent court challenges to the use of race as an admission criterion to colleges and universities, such as the case of Hopwood v. Texas, adversely impacted the numbers of minorities enrolling in medical school. For example, between 1994 and 1996, enrollment of African American students in medical school declined 8.7%, and enrollment of African Americans in Texas' public medical school alone dropped 54%. This trend is likely to exacerbate the existing disparity between minority physicians and the number of minorities within the United States population. [72]

The study continued to further demonstrate barriers to healthcare by asserting the need for cultural sensibility and communication. According to the author, "Access difficulties are compounded by the fact that prospective patients may refuse to visit health care providers who are racially or ethnically different from them. Establishing a trusting and productive provider-patient relationship between persons who share different values, beliefs and languages is difficult."[73] In addition, experiencing a language barrier is critical because communication issue arises. This idea is affirmed when Gwendolyn states:

> Communication between patients and physicians is more problematic for Hispanics (33%), Asian Americans (27%), and African Americans (23%) than for Caucasians (16%). . . the inability to communicate can be a complete barrier to care, or it may cause misdiagnosis and inappropriate treatment of the patient's symptoms. A recent survey revealed the following communication problems among minority patients: '(1) the doctor did not listen to everything that the [patient] said, (2) the patient did

[71]Majette, *"Access to Health Care: What a Differences Shades of Color Make,"*130.

[72]Majette, *"Access to Health Care: What a Differences Shades of Color Make,"*131.

[73]Majette, *"Access to Health Care: What a Differences Shades of Color Make,"*135.

> not fully understand the doctor, or (3) the patient had questions during the visit but did not ask them.'[74]

The final barrier presented by *Access to Health Care: What a Difference Shades of Color Make*, is discrimination. Gwendolyn's study clearly eludes that health care professionals are affected by racial/ ethnic stereotypes and prejudices. This is affirmed when the author states: "the study found that patient's race and socioeconomic background influence physicians' perceptions. According to the study, physicians rated African American patients 'as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, and less likely to participate in . . . [treatment] than white patients.' "[75] As a result, physicians are less likely to provide sufficient time and energy to patients of color because of their prejudice, this is affirmed in the statement, "The van Ryan and Burke study reveals that nonobvious consequence of a physician holding negative perceptions about ethnic minorities is that the doctor is less likely to recommend treatment, or less likely to put effort into discerning the true nature of the patient's problem."[76]

Although I agree with Gwendolyn Roberts Majette up to a point, I cannot accept her overall conclusion that racial/ ethnic disparities are the result of access to health care; whether that issue is a by-product of affordability, availability, usability and acceptability. The author brings out and presents these factors as determinants which enlist one to believe

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[74]Majette, *"Access to Health Care: What a Differences Shades of Color Make,"*135.

[75] Majette, *"Access to Health Care: What a Differences Shades of Color Make,"*137.

[76]Majette, *"Access to Health Care: What a Differences Shades of Color Make,"*137.

that racial/ ethnic disparities are the result of access. However, when one truly reflects on what the author is saying, one could then see that access to healthcare is a symptom of another dynamic that she characterizes as discrimination.

Notwithstanding, I must emphasize that racial/ ethnic disparity in the United States healthcare delivery system is the result of unrealized racialized ideology which is embedded into every aspect of the American's psyche, and America's society values and norms. Again, the author just casually describes this dynamic as "discrimination." Gwendolyn Roberts Majette just briefly suggests this idea, when she states: "Discrimination in the health care system is merely a reflection of the discrimination that exists in American society. Racial discrimination persists in several important aspects of American life such as mortgage lending, housing, employment, and criminal justice."[77] However, Gwendolyn Roberts Majette doesn't take the idea far enough because if she did, she would arrive at the conclusion that in order for discrimination to be as widespread as she states, it must somehow transform itself from a perception into part of American society's norms and value system.

In *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, this important study was designed to assess the effects of race and sex of the patients' treatment recommendation by physicians.[78] A recorded interview with actors portraying patients who experienced chest pain to determine whether or not they had a

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[77]Majette, *"Access to Health Care: What a Differences Shades of Color Make,"*.136.

[78] Schulman, Kevin A., Jesse A. Berlin, William Harless, Jon F. Kerner, Shyrl Sistrunk, Bernard J. Gersh, Ross Dube, Christopher K. Taleghani, Jennifer E. Burke, Sankey Williams, John M. Eisenberg, and Jose J. Escarce. *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization." The New England Journal of Medicine.* vol.340, no. 8 (2002), 618.

myocardial infarction, and whether they needed further testing, or undergo a cardiac catheterization procedure.[79] Seven hundred and twenty primary care physicians evaluated the recorded interview. In addition to the recorded video, physicians were also provided with the results. One of three stress tests with thallium (moderate inferolateral ischemia, moderate anterolateral ischemia, and multiple severe ischemia defects).[80] The physicians were also given electrocardiography with non-specific T-wave changes with each stress test. And, then the physicians took a 10-item scale, the 10-item scale was designed to assess physicians' judgement of the emotional, intellectual, and communication characteristics of the patients.[81]

Eight actors were given a script, so they could record these interviews portraying patients to present to physicians; these interviews represented each possible combination of race, sex, and age.[82] The interviews were all recorded at the same location. The camera was not moved, and the physicians were told that they were participating in a study that examined clinical decision-making. But the physicians were not told that they were to be evaluated to assess whether race and sex impacted their clinical decision-making.[83] The authors used a multivariate regression analysis to determine the effects of race and sex of the patients on physicians' treatment recommendation.

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[79]Schulman, *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,"*618.

[80]Schulman, *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,"*619.

[81]Schulman, *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,"* 619.

[82]Schulman, *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,"*619.

[83]Schulman, *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,"*619.

The findings were that both men and whites were more likely than women and Blacks for further treatment such as cardiac catheterization.[84] In addition, Black women were less likely to be referred for cardiac catheterization than white men.[85] Using univariate analysis, the authors discovered that the race and sex of the patient were significantly associated with the physicians' decision about whether these patients should be referred for further cardiovascular treatments.[86] This critical study, *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,*" was not important because of the impact of racial/ ethnic disparities that these patients experienced, but rather, that physicians were seen as being influenced by racial/ ethnic prejudices, and stereotypes. This is affirmed when the authors state:

> Our finding that race and sex of the patient influence the recommendations of physicians independently of other factors may suggest bias on the part of the physicians. However, our study could not assess the form of bias. Bias may represent overt prejudice on the part of physicians or, more likely, could be the result of subconscious perceptions rather than deliberate actions or thoughts. Subconscious bias occurs when a patient's membership in a target group automatically activates a cultural stereotype in the physician's memory regardless of the level of prejudice the physician has.[87]

I wholeheartedly endorse and agree with Schulman's study, *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization* that physicians are

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[84]Schulman, *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,"*622.

[85]Schulman, *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,"*622.

[86]Schulman, *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,"*623.

[87]Schulman, *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,"*625.

affected by the racial/ethnic prejudice, bias and stereotypes which can determine a physicians' recommendation for treatment. It is these biases which create and cause this racial/ ethnic disparity in the United States healthcare. This is affirmed when the author claims: "They suggest that decision making by physicians may be an important factor in explaining differences in the treatment of cardiovascular disease with respect to race and sex."[88] Even with the controversy of this study, whether or not Schulman's study clearly demonstrated that physicians exhibited bias of any form was questioned. According to the study, *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health*, it did not suggest that physicians' clinical decision making was compromised by any form of biases, prejudices, or stereotypes. This is affirmed when the author states: "The problem, of course, is that only black women were referred less often. The race of the patient in combination with her gender led the physicians to refer the black women less often. Did this, in itself, constitute racial bias, or gender bias, or neither, or both? This was the controversy that rapidly surrounded the Schulman study."[89]

However, the author then presented that this study was used again with some changes, such as two (2) out of the one hundred and forty-four (144) interviews were used and shown to medical students with no training and, again, the result indicates that bias is present. This is affirmed when the author states:

> Overall, the medical students saw no difference in the needs of the two patients . . .. However, the students were significantly more likely to attribute the white male patient's symptoms to angina than those of the

[88]Schulman, *"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization,"*625.

[89]Donald A. Barr, *Health Disparities in the United States: Social class, Race, Ethnicity, and Health,* (John Hopkins University Press, 2008), 206.

> black female. As discussed by the authors, 'If patient race and sex influence physician recommendations about treatment, then our study indicates that these biases may be present at the earliest stage of medical training. . .. Thus, differences in diagnosis and health state rating may derive from preformed ideas brought to medical training. These biases may not be conscious but still influence clinical decision.'
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> As with the Schulman study, these results suggest that an unconscious form of bias, affecting their perceptions of blacks and women, may affect the reasoning and decisions of both medical students with little clinical training and physicians with substantial clinical experience.[90]

There is no doubt in my mind, that these latent biases are embedded deep in our unconscious behavior, and they arise when they are triggered. The importance of this study is that it connects the idea that biases, prejudices, and stereotypes can easily influence and alter our thought patterns and behaviors whether consciously or unconsciously. This suggests that when these biases become unconscious behaviors they then transcend from being right or wrong behaviors to become part of society's norms and its value system. This idea is affirmed when the author, Donald A. Barr, quotes Unequal Treatment: "Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients' insurances status and income, are controlled. The sources of these disparities are complex, are rooted in historic and contemporary inequalities, and involve many participants at several levels, including health systems, ..."[91] Just as the studies in this chapter have demonstrated whether its issues of access to healthcare, or whether we implement managed care or Fee-for-service, or whether health insurance is restricted or unrestricted, the one common denominator

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[90]Barr, *Health Disparities in the United States: Social class, Race, Ethnicity, and Health* ,207.

[91]Barr, *Health Disparities in the United States: Social class, Race, Ethnicity, and Health*,200.

remains. That is, people of color do not receive the same services, nor are treated the same as their white counterparts.

As I have already presented briefly in this chapter, racial/ ethnic disparity is wide spread throughout our healthcare delivery system and there have been attempts to address this disparity by seeking to identify the source of this disparity. I believe that the racial/ ethnic disparities in our healthcare delivery system indicate that these biases, prejudices and stereotypes have become embedded and reinforced within our social values/norms.

These prejudices and biases have become embedded into the American psyche, which helps to shape American's norms and value system. This notion is affirmed when Donald A. Barr states: "In the middle of the twentieth century, overt racial discrimination was the norm in many parts of the United States. Blacks were not permitted in many hospitals and clinics meant for whites. Black doctors, fully licensed and certified, were not permitted to join the staff of white hospitals. The discrimination was conscious, and it was intended."[92] These norms and value system have been established over centuries since the establishment of the America colonies. This is affirmed in *The Color Complex: The politics of Skin Color Among African Americans*, where the authors state:

> Miscegenation, or race mixing, became widespread as Europeans, Africans and Native Americans mixed their seed and substance to produce a kaleidoscope of skin tones and features. But these primary race grouping differed sharply in their civil liberties and political freedoms. Subtle variations in appearance took on enormous consequence in meaning, especially among Negroes. Against a backdrop of love and rape, politics

[92]Barr, *Health Disparities in the United States: Social class, Race, Ethnicity, and Health,*201.

> and war, and, ultimately, power and privilege, attitudes about skin color evolved in America.[93]

The reasons why these biases, prejudices and stereotypes were established was so that white landowners would have cheap labor so that they could carve out their existence in a new land- America. This is affirmed when the authors write:

> It became apparent that the English would have to find some other source of cheap labor if their settlement was to become permanent. Dutch traders provided the answer. They brought Africans to Virginia from Santo Domingo in the West Indies, where Negroes had been enslaved on sugar plantations since the 1500s.[94]

The authors go even further:

> In the upper South, including Virginia and Maryland, legislators decided that any person with even a drop of Black blood would have the same legal status as a pure African. This early statute became the basis of today's 'one-drop rule' (also called the one-drop theory) of racial identity, which has its origin in racist concern about the contamination of the White gene pool; no matter how White looking or White acting someone of mixed ancestry is or how little Blackness is in a person's genetic makeup, that person is considered Black.[95]

It has become apparent that our norms/ values are associated with skin color and ethnic makeup has translated into the way we operate in the United States, since the beginning of the colonial settlement. Even the passing of laws was designed to take these biases, prejudices, and stereotypes and make them into norms and establish a clear value system

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[93]Kathy Russell, Midge Wilson, and Ronald Hall. *The Color Complex: The Politics of Skin Color Among African Americans*, (New York, Doubleday Publishing, 1992),9-10.

[94]Russell, *The Color Complex: The Politics of Skin Color Among African Americans*,13.

[95]Russell, *The Color Complex: The Politics of Skin Color Among African Americans*,14.

where Whites were at the top and everyone else was a tool for use by the White colonists. It was these practices that created within the American psyche a color hierarchy; simply meaning that white skin was better and provided more opportunities than dark skin which resulted in discrimination. This notion is clearly affirmed when the authors claim:

> White leaders knew that if sexual relations with Africans continued unchecked, ethnical questions about slavery would surely follow. As early as 1622, a little more than two years after the first Africans had arrived, Virginia legislators passed the earliest antimiscegenation statutes. Most of these laws implied that Africans were a lower life form than Europeans; ... As the number of free colonial mulattoes grew exponentially, they were increasingly treated as outcasts, visible reminders of the state's failure to keep the races apart. Neither fully White nor Negro, mulattoes lay outside of the social order. Certain rights, like holding property, running for office, and voting, were reserved exclusively for Whites and denied to Negroes. Free mulattoes required legal definition, preferably in a way that would maintain the status quo. How they came to be classified did much to create the color-caste system that lingers in America today.[96]

Because of centuries of establishing norms/ and a value system, along the line of racial/ ethnic makeup, which provided preferential option for Whites in America; how could we not expect this to taint our social institutions, such as the healthcare delivery system.

Let us continue by establishing a clear understanding of racial discrimination. First, let's us begin by defining *discrimination,* the *Webster's Third New International Dictionary unabridged edition* as "the act, practice, or an instance of discriminating categorically rather than individually." It further defines, *discrimination* as "the according of differential treatment to persons of an alien race or religion (as by formal or informal restrictions of imposed in regard to housing, employment, or use of public community

[96]Russell, *The Color Complex: The Politics of Skin Color Among African Americans*, 4.

facilities) and/ or the act or practice on the part of a common carrier of discriminating between persons, localities, or commodities in respect to substantially the same service."[97] The Institute of Medicine refers *discrimination*, "to differences in care that result from biases, prejudices, stereotypes, and uncertainty in clinical communication and decision-making."[98] The manner in which the Institute of Medicine is using this definition clearly not only includes intentional acts but underscores unintentional actions as well. This definition that the Institute of Medicine uses for *discrimination* seems to be robust in nature in that it allows for slight differences, but also addresses systematic structures in our society that may cause disparities in addition to individual contributions.

Another critical term that must be defined is *racial/ ethnic minority group member*. The *Webster's New International Dictionary unabridged edition* defines *racial* as "of relating to or based on a race or existing or occurring between races."[99] The Institute of Medicine defines *racial/ ethnic minority group* by using the federal government classification which "the revised standards established five categories for 'racial' groups (American Indian or Alaskan native, Asian, Black or African-America, Native Hawaiian or other Pacific Islander, and white), and two categories for 'ethnic' groups (Hispanic or Latino and Not Hispanic or Latino)." Furthermore, the Institute of Medicine acknowledges the difficulties with the use of this definition regarding race and ethnicity but states that the

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[97] Philip Gove, Babcock ed., et al. *The Webster's Third New International Dictionary Unabridged Edition,*(Springfield, Mass: G. & C. Merriam Company, 1968), 1207.

[98]Brain D. Smedley, Adrienne Y. Smith and Alan R. Nelson, ed. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* (Washington D.C.: National Academic Press, 2002), 246.

[99] Philip Gove, Babcock ed., et al. *The Webster's Third New International Dictionary Unabridged Edition.* (Springfield, Mass: G. & C. Merriam Company, 1968), 1209.

use of this definition is necessary due to the common understanding and usage as well as the fact that this is already in use by researchers. Nevertheless, it is important to be aware that the Institute of Medicine and most people are using a definition that is embedded with racist notions. Hence, the real dilemma is that this racial classification is plagued with racialized ideology supported by racism, biases and stereotypes, thus establishing the foundation for systematic discrimination infused into our common knowledge perpetuated by our socialization process.

In summary, it is quite evident through the studies cited above that various determinants have been explored and presented to explain our current racial/ ethnic disparities in the United States Healthcare delivery system; nevertheless, these determinants are real symptoms of the hidden problem. The real problem is that we have not really dealt with our past biases, stereotypes and prejudices; as a result, these biases, stereotypes, and prejudice have now become a part of our social norms and value system. And until we really deal with this issue effectively, we will never be able to reduce or eliminate racial/ ethnic disparities in our healthcare system. For me, this raises some very critical questions. First, is it possible to reduce racial/ ethnic disparities in healthcare? If not, then, can we live with the idea that we, as a society, are forever fettered to our racialized past ideology?

In order to deal with this racialized ideology, we need tools of liberation that are able to break the chains that hinder both the individuals who are not aware of their biases, stereotypes, and prejudices as well as those that are recipients of racialized ideologies.

Chapter 3- Liberation Psychology

Reflecting on what I have presented in the previous discussions (racial/ ethnic disparities have been caused by biases, prejudices, and stereotypes as well as now these biases, prejudices, and stereotypes have been infused into America's social norms/ value system), I am gripped by anxiety and a sense of being overwhelmed; however, I must continue seeking a solution to this issue—racial/ ethnic disparity in the U.S. Healthcare delivery system. For the past centuries, people of color have resisted the existing social condition, that is, the oppression and repression of people of color because of biases, prejudices, and stereotypes. We, as a society, have made some small improvements and advancements over time, but the cost has been very high; for example, the killing and the murder of innocent people and activists who attempted to protest against the injustices that people of color received. Repression was used to ensure the continuous social hierarchy. There have been countless rebels against such cancerous social condition; these countless efforts have utilized various strategies and techniques to achieve their ultimate goal—freedom. These strategies have ranged from national demonstrations, to armed conflict, to non-violent protests, to marches, and also everything in-between. Nevertheless, the reality is that I have no choice, but to continue to fight for justice and freedom from an oppressive situation.

What is needed are tools that can assist us in engaging racial/ ethnic disparities in the U.S. Healthcare delivery system which are based on unrealized racialized ideology. In addition, these tools must be able to function on multiple levels (corporate/ individual) simultaneously as well as engage those that are oppressing and the oppressed. These tools

must be able to awaken people. They must be able to make people aware of their situation and others, as well as to be grounded in genuine actions. The tool that I am proposing first is the work of Ignacio Martin-Baro's Liberation Psychology. Additionally, the work of Paulo Freire of making individuals aware of their social condition by educating themselves better, known as Paulo Freire's concept of *conscientizacáo* (critical consciousness), to speak to the structures in the medical profession as well as American social norms/ value system. The goal is simple—the reduction and the eventual eradication of racial/ ethnic disparities in the U.S. healthcare, and the surgical removal of the cancerous disease of unrealized racialized ideology disguised as racial/ ethnic biases, prejudices, and stereotypes from America's social norms/ value system. In other words, the deconstruction of racism, biases, and stereotypes not only in the U.S. healthcare delivery system, but also within the America's norms/ value system. The question that arises is how can this be done?

Contemplating on my experience as a chaplain and my training with patients with a multitude of medical conditions; for example, patients with leukemia and lymphomas, patients suffering from Thoracic Surgeries, patients with Pulmonary Cancer, pain and palliative care patients, general oncology patients, Bone Marrow patients, Geriatrics patients, and Heart Disease patients (CCUC, Thoracic Step-down, ICU and Step-Down) just to name a few; I know of the importance and the urgent need for emotional, spiritual and psychological support that these patients require. Over the years, I have searched for a psychological approach that can speak to patients from their social location and emotional vulnerability. Hence, I encountered a psychological approach that can engage and address the rampant racial/ ethnic biases, prejudices, and stereotypes that continue to mutate and

adapt to time and society's attempts to eradicate these toxicants and cancerous ideas, labels, and beliefs that seem to plague our healthcare delivery system.

What I discovered was Community Psychology and Liberation Psychology. Let's begin with Community Psychology which seems to have the same interests of Liberation Psychology, that is, the serving of the disfranchised and these who are outside of the status quo. Community Psychology emerged out of the tumultuous times of the 1960's in the United States, in the hopes of focusing on people's life and within their communities as well as fight for social justice.[100] This idea is affirmed in *Community Psychology Practice: Expanding the Impact of Psychology's Work* by Tom Wolff when he writes: "The vision for the field of community psychology, as adopted by the Society for Community Research and Action (SCRA), Division 27 of the American Psychological Association, is to 'have strong, global impact on enhancing well-being and promoting social justice for all people by fostering collaboration where there is division and empowerment where there is oppression.'"[101]

Furthermore, much like Liberation Psychology, action is a key concept in Community Psychology, the appropriate action is critical. In *Community Psychology Practice: Expanding the Impact of Psychology's Work*, Tom Wolff, the author states: "The field demands the capacity not only to study issues, but also act to make the world a better place. . .. the founders understood the need to combine academic theory, research, and field practice. Practice translates research, values, and principles into meaningful actions;

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[100] Tom Wolff, *American Psychologist. Community Psychology Practice: Expanding the Impact of Psychology's Work.* (November 2014), 803.

[101] Wolff, *American Psychologist. Community Psychology Practice: Expanding the Impact of Psychology's Work*, 804.

practice is the means through which community psychology impacts communities and organizations. This is how community psychology practice 'walks the talk.'"[102]

In conjunction with appropriate actions, Community Psychology emphasizes key concepts such as the ecological perspective, preventive care; social and system change, the empowerment of residents; and multidisciplinary approaches.[103] In addition, to these key concepts is the idea that community psychology is working to influence and move social systems in the direction of these concepts.[104] However, this raises serious questions for me. Questions like knowing that this system of society is designed to benefit the dominant group and their benefactors, how can community psychology influence these systems to change? How can one change the system of American norms/ values which are embedded with racial/ ethnic biases, prejudices and stereotypes? For me, therefore Liberation Psychology is the preferred source for the reduction and elimination of racial/ ethnic disparities in the U.S. healthcare delivery system.

We need a psychological approach that not only studies society but also engages society to transform it. Liberation psychology is a psycho-social process that engages its citizens in hopes of liberating them from social structures that oppresses and represses certain groups of people by those who are in position of power or those who are the benefactors of a system that grants and reward them just because they are aligned with the dominant group members.

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[102]Wolff, *American Psychologist. Community Psychology Practice: Expanding the Impact of Psychology's Work*, 804.

[103]Wolff, *American Psychologist. Community Psychology Practice: Expanding the Impact of Psychology's Work*, 805.

[104]Wolff, *American Psychologist. Community Psychology Practice: Expanding the Impact of Psychology's Work*, 804

Let's answer and address first why Liberation Psychology? Why is this unknown psychological therapeutic approach important for the United States? What is so important about Liberation Psychology? In hopes of responding to the social needs of its citizens, Ignacio Martin-Baro developed Liberation psychology in direct response to what was happening in El Salvador—bloody civil war—the rich and powerful versus the majority of the people—deemed unworthy.

Psychology as Ignacio Martin-Baro saw it must be liberated from the influences and tenets of Eurocentric notions. This is affirmed in the *Writing for a Liberation Psychology*, when the authors states: "In my opinion, the roots of the misery of Latin American psychology are sunk in a history of colonial dependency—not the history of Ibero-American colonization, but rather the neocolonialist 'carrot and stick' imposed upon us a century ago. The 'cultural stick' that continually prods our people finds in psychology yet another tool with which to mold minds. It also finds in psychology a valuable ally for soothing consciences when explaining the indisputable advantages of the modern technological carrot."[105]

This notion is also affirmed in *Liberation Psychology as the Path Toward Healing Cultural Soul Wounds*, when the author stated: "Multicultural scholars have described the various ways that the mental health professions have been an instrument of oppression from their earliest days when the power of the Church was passed on to the new priest of the society (i.e., mental health professionals) who could impose their will on people from diverse cultural groups under the guise of being healers. Operating from culturally biased

[105]Ignacio Martin-Baro, *Writings for a Liberation Psychology* (Cambridge, Mass.: Harvard University Press, 1994), 20.

views of mental health and what are considered to be appropriate intervention strategies, these professionals perpetuate various forms of injustice and institutional racism by imposing helping paradigms that are often incongruent with the worldviews, values, beliefs, and traditional practices that have been used to promote the psychological well-being of persons in diverse groups."[106]

This lead us to the question of how Liberation Psychology can be used? Well, first, if we liberate psychology from the centuries-old ideologies that have been infused into racial biases, stereotypes, and prejudices, we can begin using psychology in a new direction, a direction that realizes and recognizes the connection between an individual and their social location. Usually psychology has placed little attention to the social realities of its patients, assuming that an individual is not influenced by their environment. This idea is affirmed in the *Writings for a Liberation Psychology*, when the author states: "Moreover, psychology has often contributed to obscuring the relationship between personal estrangement and social oppression, presenting the pathology of persons as if it were something removed from history and society, and behavioral disorders ass if they played themselves out entirely in the individual plane." [107]

In addition, this new direction allows Liberation Psychology, to related personal existence with a personal social existence. This new direction allows people to see the dynamics between individual control and collective power; as well as between the

[106]Eduardo Duran, Judith Firehammer & John Gonzalez, *"Liberation Psychology as the Path Toward Healing Cultural Soul Wounds," Journal of Counseling & Development*, (Summer 2008. vol. 86), 288.

[107]Ignacio Martin-Baro, *Writings for a Liberation Psychology*. (Cambridge, Mass.: Harvard University Press, 1994), 27.

liberation of each person and the liberation of a whole people.[108] As a result, this helps people see the unconscious and/ or conscious experiences holding them back from their existential goals and personal happiness.[109] For example, if an individual who experienced oppressive conditions with their parents, cannot, as adults, see the possibility of how these experiences have held them back from their personal happiness. Furthermore, this new direction can aid in the direct confrontation with the social structures that oppress them, depriving them of control over their own existence and expecting nothing from life.[110]

The next dimension of Liberation Psychology is the idea of a new epistemology, that is, a new way of seeking knowledge. This new knowledge must be acquired and obtained from "below"; that is, from the oppressed themselves, rather than knowledge being imposed on the oppressed by others who have no idea of what it means to be oppressed. This idea is affirmed in the *Writings for a Liberation Psychology*, when the author stated: "Note that we say "from" the illiterate and the unemployed, "from" the tenant farmer and the woman in the market, not "for" them. This is not a matter of thinking for them or bringing them our ideas or solving their problems for them."[111] This idea offers the possibility of a new way of dealing with racial/ ethnic disparities. This would be very interesting to see how the oppressed (people of color) would engage this disparity. What would they propose to resolve this issue?

This new way of developing truth and knowledge does not mean that all pervious knowledge must be discarded; it simply means that this knowledge must be relevant and

[108]Martin-Baro, *Writings for a Liberation Psychology*, 26.
[109]Martin-Baro, *Writings for a Liberation Psychology*, 27.
[110]Martin-Baro, *Writings for a Liberation Psychology*, 27.
[111]Martin-Baro, *Writings for a Liberation Psychology*, 28.

revised it from the perspective of the oppressed, rather than assume that it is suitable for everyone regardless of social location. This is supported in the *Writings for a Liberation Psychology*, when the author states: "To take on a new perspective obviously does not mean throwing out all of our knowledge; what it supposes, rather, is that we will relativize that knowledge and critically revise it from the perspective of the popular majorities. Only then will the theories and models show their validity or deficiency, their utility or lack thereof, their universality or provincialism. Only then will the techniques we have learned display their liberating potential or their seeds of subjugation."[112]

As a result, Martin-Baro clearly emphasizes that if Latin American psychology is to aid its citizens, it first must be liberated, and it must then redesign its theories, and practical tools from the perspective of the people it was designed to help. This idea is affirmed when the author states:

> We have to redesign our theoretical and practical tools, but redesign them from the standpoint of the lives of our people: from their sufferings, their aspirations, and their struggles. . . . therefore, if Latin American psychology wants to get started on the road to liberation, it must break out of its own enslavement. In other words, to achieve a psychology of liberation demands first that psychology be liberated.[113]

This idea is also affirmed when the author wrote:

> The psychological oppression that ensues from these practices results in various forms of injustice that are typically inflicted unintentionally by counselors who are genuinely interested in helping clients from diverse groups and backgrounds to realize new and untapped dimensions of their humanity. Rather than promoting the collective dignity and psychological liberation of clients in these diverse cultural populations, Western counseling interventions are inadvertently used to promoting the types of

[112]Martin-Baro, *Writings for a Liberation Psychology*, 28.
[113]Martin-Baro, *Writings for a Liberation Psychology*,.25.

> social control and conformity that are necessary to sustain the existing political/ economic/ social status quo.[114]

The final element is the pursuit of a new praxis. This praxis must determine and understand that knowledge is limited, and this limitation is imposed by reality itself. In other words, perspective determines what we see and how we see it as well as our reality.[115] In the *Writings for a Liberation Psychology*, the author explains this idea:

> Thus, to acquire new psychological knowledge it is not enough to place ourselves in a new praxis, an activity of transforming reality that will let us know not only about what is but also about what is not and by which we may try to orient ourselves toward what ought to be. . . . only through participation do we get the voluntary and living rupture of the 'asymmetrical relationship of submission and dependence implicit in the subject/ object binomial'. [116]

Why is it necessary for psychology, to first seek and be liberated before it can really help its citizens? The simply reason is that psychology and its structures is part of the status quo which is designed to aid and assist in maintaining the social structures as is; as a result, it aligns itself with the dominant group. This is clear when the author states:

> Among the criticisms most often made of psychologists in Central American countries is that the majority devote most, if not all, of their attention to the well-to-do social sectors, and as such, their work tends to center on the personal roots of the problem- a focus that causes them to ignore social factors. The social context is thus converted into a kind of natural phenomenon, an unquestioned assumption, before whose 'objective' demands the individual must seek, individually and even 'subjectivity,' the solutions to his or her problems. With this focus and with this clientele, it is no surprise that psychology is serving the interests of the established social order, as a useful instrument for reproducing the system.[117]

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[114]Eduardo Duran, Judith Firehammer & John Gonzalez, *"Liberation Psychology as the Path Toward Healing Cultural Soul Wounds," Journal of Counseling & Development*, (Summer 2008. vol. 86), 289.

[115]Ignacio Martin-Baro, *Writings for a Liberation Psychology*, (Cambridge, Mass.: Harvard University Press, 1994), 28.

[116]Martin-Baro, *Writings for a Liberation Psychology*, 29.

[117]Martin-Baro, *Writings for a Liberation Psychology*, 38.

Nevertheless, once psychology liberates itself, it can serve the interest of society to create a just and humane social structure to ensure that everyone becomes part of society. In order words, psychology become a gateway and functions as a vehicle to ensure fair and equal treatment of all its citizens.

In order to break psychology free, according to Martin-Baro, psychology must return to its root- observing behavior and look at the consciousness. In doing this the author in the *Writings for a Liberation Psychology* believes that psychology can re-gain a clearer understanding of individuals and their context. The author believes that the consciousness is where individuals engage their knowledge within social context and begin to develop their identity; as a result, this knowledge acquired through this engagement process establishes a personal and social realities. This reality (this newly acquired knowledge) is really a praxis (engagement) with the world (their social realities) before it becomes a thought.[118] This consciousness is really a psychosocial process, it becomes a reality that represents an understanding of oneself, and one's history as well as it represents a social representation of an individual and their relation to their society.[119]

This then takes us to the idea that psychology must re-assert itself back into society with the idea of awakening people's critical consciousness—the *conscientizacáo* (critical consciousness of its people). This concept of *conscientizacáo* was developed by a Brazilian sociologist and educator, Paulo Freire, who through his literary process and education assists people (individuals) in not only learning how to read but helped them

[118]Martin-Baro, *Writings for a Liberation Psychology*, 39.
[119]Martin-Baro, *Writings for a Liberation Psychology*, 38.

(illiterate) engage their social realities as oppressed people in the hopes that they would be able to engage society and transform it. This is affirmed when the author stated:

> Conscientizacáo is a term coined by Paulo Freire to characterize the process of personal and social transformation experienced by the oppressed of Latin American when they become literate in dialectic with their world. For Freire, literacy does not consist simply in learning to write on paper or to read the written word; literacy is above all learning to read the surrounding reality and write one's own history.[120]

Simply meaning that the oppressed must begin to engage their world and strive for freedom from chains that oppress not only their bodies, but also their spirits. The real question is how can this critical consciousness be accomplished?

To expand our understanding further, *conscientizacáo* is the awaking of our consciousness after a dialogue with others in regard to our social realities. It is this dialogue and the dynamics behind it that simulate a discussion in our present situation and how it affects us. This dialogue between the leaders and the participators offers both sides the possibility to learn from each other in the hopes of obtaining liberation. This is supported in *Education, Liberation and the Church* when the author states: "The educator and the people together conscientizes themselves, thanks to the dialectical movement which relates critical reflection or past actions to the continuing struggle."[121] Once we begin to obtain this critical consciousness, this new awareness must lead to actions. It is these actions which are the catalyst to transforming our present situation; as a result of these actions and the effects of our actions, we must again return to dialogue to ensure that our actions are not only genuine but that the desired results are what we sort after. This is clearly illustrated

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[120]Martin-Baro, *Writings for a Liberation Psychology*, 40.

[121] Freire, Paulo. "*Education, Liberation and the Church," Religious Education.* vol. 79, no. 4, (Fall 1964), 528.

in *Education, Liberation and the Church* when the author stated: "Thus, there is a unity between practice and theory in which both are constructed, shaped and reshaped in constant movement from practice to theory, then back to a new practice."[122]

Now let's explore the intricate details of the dialectic process of *conscientizacáo*. First, we must understand that this process is always evolving, and this dialogue is an encounter between individuals, engaged by the world, to name their social realities. This dialogue is a social event which is collaborative. This idea is evident in *Paulo Freire's Liberation Pedagogy*, when the author states:

> Dialogue is an encounter, a close encounter, a social encounter . . . Dialogue is not just conversation; it is dialectic and reflective . . . . Freire calls his classroom a 'culture circle'; for him to speak of 'collaborative learning' would be redundant: there is no other kind. Learning is necessarily collaborative.[123]

What is really happening in this process of conscientizacáo is an education of liberation. What does this mean? It's simply the awaking of people's critical consciousness, is the realignment of people's understanding of their lives and within the social realities that they exist in. This critical consciousness is political not because it is designed to awaken people, but it aids them in their understanding of their lives as well as how society interacts with them. This is illustrated in *Education, Liberation and the Church*, when the author stated:

> Education for Liberation does not merely free students from blackboards just to offer them projectors. On the contrary, it is concerned, as a social praxis, with helping them in their objective reality. It is therefore political education, just as political as the education which claims to be neutral,

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[122]Freire, "*Education, Liberation and the Church,"*, 527.

[123]Ann E Berthoff, *"Paulo Freire's Liberation Pedagogy", Language Arts vol. 67*, no 4, (Apr. 1990), 363.

> although actually serving the power elite. It is thus a form of education which can only be put into practice systemically when society is radically transformed.[124]

In closing, the hopes of reducing and eliminating racial/ ethnic disparities in the U.S. healthcare delivery system, it is important to use a psychological tool that can liberate not only itself from Eurocentric notions of racialized ideologies, but also society. As a result, Liberation Psychology is one of the key concepts which can assist us in responding to this grave issue—racial/ ethnic disparities in the U.S. healthcare delivery system.

Unfortunately, Community Psychology is not really a viable option because community psychology attempts to address injustices within the system. Needless to say, society cannot be transformed if a small part of the system is challenged. The way to true liberation is a radical break so as to completely change the system. This radical break starts from the standpoint of love for self and others. For example, just like in human relationships, in order to break free from one partner, the other partner must completely leave in hopes of severing the ties. The hope of cutting ties would liberate one partner from the other; as opposed to having a dialogue, so that both are liberated. But, in reality, this breaking free is a process; it is a very painful process, but offers an opportunity to re-assert one's intentions, one's goal, and one's desires. Both parties have this opportunity but usually both individuals do not seize this opportunity and its benefits because the one that first initiates the break up usually begins from an inappropriate departure point, usually out of anger, or injury.

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[124]Paulo Freire, *"Education, Liberation and the Church". Religious Education.* vol. 79, no. 4, (Fall 1964), 528.

That is why Liberation Psychology must make use of *conscientizacáo,* in hopes of coming to the awareness of one's oppressive situation and how this has impacted one's life; as well as how one views life, people, and how one responds to traumatic experiences. For instance, looking at an individual who experienced trauma while growing up, that individual must look inside themselves in hopes of examining how they react to life's situations and experiences, especially with another person. Does this individual simply discard people, lovers, friends without a regret? Does this person really process what happened? Does this person really understand or is aware why they reacted to the situation? Are they reacting from a past traumatic experience or do they simply discard people and experiences because they are too injured/ wounded to deal with the real issue—themselves? But this exploration into themselves must be done in a dialectical process in order to obtain liberation.

Therefore, critical consciousness is an important aspect of the transformation process for society because this dialectic learning enables one to critically analyze the situation with others in dialogue which leads to genuine actions and then back to reflection and then back to action; in the hopes of responding with a loving presence rather than from a presence of anger, pain or suffering.

In this critical consciousness, the process must not be altered in anyway because the alteration of the process then creates an obstacle to this freedom. For instance, a mother who experiences her own traumatic events based on her skin color (she is a very dark skinned individual), not only from society but from her father's family (who were lighter skinned individuals). Throughout her life she learned to discard people with no remorse because that is how she was treated by her family and her community. If this process of

critical consciousness is altered, then an obstacle (non-awareness/ lack of freedom) is very likely to occur. Using this same situation, the daughter eventually also learns to discard feelings, and people who injured or cause her suffering without really processing or becoming aware of herself, and how she was altered by her mother's experiences and the way her mother raised her which continued the traumatic cycle from mother to daughter. This is further illustrated in *Education, Liberation and the Church*, when the author states:

> be it in Latin America or elsewhere, be it at the hands of the shrewd or naïve, constitute an obstacle rather than an aid to the liberation process. It becomes, on the other hand, an obstacle because, in emptying conscientizacáo of its dialectical content and this making it into a panacea, it put it, as we have seen, at the service of the oppressors. On the other hand, it creates an obstacle because such idealistic disfiguration leads many Latin American groups, especially among youth, to fall into opposite error of mechanical objectivism. In reacting against the alienating subjectivism which causes this distortion, they end up denying the role of consciousness in the transformation of reality and therefore also denying the dialectical union between consciousness and the world. They no longer see the difference between such things as class consciousness and the consciousness of class needs. Between the two there is a sort of dialectical gap which must be bridged. Neither subjectivism nor mechanical objectivism is able to do this.[125]

Finally, in hope of transforming society with regards to racialized ideology, Liberation Psychology as well as *conscientizacáo* must be utilized in establishing an atmosphere where freedom/ liberation of the oppressed and the oppressor are simultaneously being achieved.

[125]Freire, *"Education, Liberation and the Church,"* 527.

Chapter 4- Addressing Racial/ Ethnic Disparities in the U.S. Healthcare-Ethic of Dignity, Ethic of Solidarity and Medical School Curriculum

Before I begin to present an essential and critical curriculum for medical schools, this writer feels that he needs to justify the reason why such a curriculum needs to be developed, besides the idea that racial/ ethnic disparities exist. This issue leads us to deal with the task of judging the situation. Now that we have analyzed and examined the present situation of racial and ethnic disparities in our healthcare delivery system as well as the biases and stereotypes held by medical professionals,' what is left is to engage this task. It is the desire of this writer to develop a strategy that can possibly address this issue. In the development of a strategy to deal with the historical-reality of racial and ethnic discrimination, one must be able to see the reality as it is, our awareness that can lead one to making an adjustment. That is, the formation of this judgment pertaining to racial and ethnic disparities in the medical profession raises a fundamental question, regarding whose morality are we going to replicate? It is clear that different people offer various levels of moral standards. As a result, as a pastoral care leader, I am left without a framework that offers honorable and incorruptible principles towards which we can direct our concerns and energies. It is clear that whatever moral standards are established must be outside of us, but with achievable goals. Therefore, I will use biblical resources which hopefully can provide this attainable goal. The biblical text that I will utilize is the parable of the Good Samaritan located in the Gospel of Luke, chapter 10 verses 27 to 39. I have come to the understanding that I must use that which I know and have used in my life to set these standards, and for me that has been the Holy Bible.

Most people will now really begin trembling because I said the B word—the Bible. It is clear that not every person believes in God, Jesus, the Holy Spirit, the Quran, Mohammad, the Jewish text or the Christian text. Moreover, non-believers will say that religion (especially Christianity) has been the greatest culprit in starting disputes, killings, and wars, and to that I say, yes, that is true in some cases. I am not defending organized religion against the bloodshed with which it has been associated I do believe that the conflicts, with which the Christian church has been associated have always been based on the political ambitions and agenda of religious leaders and/or the belief that everyone must believe in my God and in my belief system. My understanding is that Jesus offered a way of life and faith that embraced anyone who seeks to love and offer compassion to people—not to evangelize the entire world's population. That is, I am not here to covert anyone to my understanding of God or my religious tradition but Jesus (the son of God) taught and helped me to understand an ethic of love that goes beyond what I understand love to be. I am here to offer a possible strategy in developing a way for medical school to emphasize a kind of care for society. Nevertheless, by surpassing the obvious, the Bible also offers us the greatest and attainable moral standards. I will use this source (the Bible) as a means to setting a moral standard, not as a tool for evangelizing non-Christians, but to an understanding of a God, not of their choosing.

Now that evidence has been presented, demonstrated and illustrated with regards to the root cause of racial and ethnic disparities in the healthcare delivery system and medical profession, that is, indirect and direct discrimination with regards to medical treatment, medical procedures and protocols and standard of care, we must begin to address this process of awareness. Our next task then is to probe the bible as a resource to learn how

to engage this disparity. This paradigm requires that we ask the preceding fundamental and important question, what does God have to say about racial and ethnic disparities in healthcare? But, before we begin, this writer wants you (the reader) to know that this research project is trying to fulfill a very simple edict, that is, "to know God is to do justice." This idea is affirmed in Micah 6:8 when it states,

He has told you, O mortal, what is good; and what does the Lord require of you but to do justice, and to love kindness, and to walk humbly with your God? [126]

This text clearly indicates the importance of God's requirement that good be present in our lives. In addition, the text, Luke 10:29-37, presents to the reader a model that addresses the racial and ethnic disparities besides stereotyping, prejudges, and discrimination. It is this very text that provides us with the tangible illustration of why we are required to contend with this horrific and appalling situation of racial and ethnic disparities in our healthcare system that Jesus believed necessitated a special teaching.

The Model of the Good Samaritan

First, I will present the scripture, and then a partial exegesis will be offered as well as providing some gleam of our next task and obligation. In the Christian scripture, in the Gospel of Luke 10:29-37, Jesus is asked a question regarding who is my "neighbor"? Jesus thus engages a conversation with a teacher of the law, providing us a view of who our neighbor is and how we should conduct ourselves:

> But wanting to justify himself, he asked Jesus, "And who is my neighbor?" Jesus replied, "A man was going down from Jerusalem to Jericho, and fell

[126]Micah 6:8 (NRSV)

> into the hands of robbers, who stripped him, beat him, and went away, leaving him half dead. Now by chance a priest was going down that road; and when he saw him, he passed by on the other side. So likewise a Levite, when he came to the place and saw him, passed by on the other side. But a Samaritan while traveling came near him; and when he saw him, he was moved with pity. He went to him and bandaged his wounds, having poured oil and wine on them. Then he put him on his own animal, brought him to an inn, and took care of him. The next day he took out two denarii, gave them to the innkeeper, and said, 'Take care of him; and when I come back, I will repay you whatever more you spend.' Which of these three, do you think, was a neighbor to the man who fell into the hands of the robbers?" He said, "The one who showed him mercy." Jesus said to him, "Go and do likewise."[127]

In this text, we are given a clear example of how we, as human beings, are to care for those who desperately need help. In this parable, the two individuals (the priest and the Levite) have passed by an injured person without much distress. It was the third individual, a Samaritan, who was moved to compassion and bandaged the wounds of the beaten traveler. We would hope that most people would not pass by an injured person. We would have definitely brought the beaten person to a place where medical treatment would be provided. Today, most people would not pay for these individuals' medical needs, nor promise to pick up the medical costs. Fortunately, we are rarely placed in this situation. But, this parable goes far beyond the medical needs of this person. We are usually concerned with the Jewish teacher of the Law who asks the question, or his intention. We miss the nuances of this story. This parable is really addressing a simple and more complex issue. Whom do we love as our neighbor?

Jesus is using a contemporary story of his time to illustrate a simple message. With this story of the Good Samaritan, we must listen to the message behind the words that really is at the heart of the parable. So, when we examine this biblical source we must locate the

[127]Luke 10:29-37 (NRSV)

essence of this parable. It is this essence of the story which has social ramifications. It highlights the social boundaries and limits during Jesus' time. In addition, the story rejects all kinds of justification and reason for society's premise for establishing the caste system, whether based on class, race, ethnicity or the like. This story challenges society and how society has constructed such boundaries. First, we must understand that during Jesus' life time, the prevailing racial and ethnic stereotypes occurred between the Jews, Gentiles and the Samaritan. At some point, this difference in terms of treatment was based on religious concepts of cleanliness and uncleanliness with regards to religious status. Nevertheless, this notion eventually was transformed to meet humanity's desire to manipulate and retain power. The Jewish notion of that which is clean or unclean became associated with certain individuals, labelling them as inferior and; as a result, power, privilege, and control became the rewards for religious leaders. Hence, since some of the context has been set; let's continue to take a closer look at what the parable is trying to illustrate.

In this parable, we have a priest and a Levite, who simply passes by this beaten person. Normally, we would assume that a priest would at least show some compassion and offer aid to this person. But, to our dismay, he does not even break his stride as he (the priest) continues his journey. Likewise, the Levite (let's say the associate minister) does the same. Despite that, it is a Samaritan, one who would not usually even be permitted to speak to a Jewish person according to the social regulations, who is moved by compassion and provides aid and further assistance.

Now, let's analyze this portion of the parable, there are several questions that need to be answered. The first question is why are the first two individuals described by their title juxtaposed with the third individual who is identified by his ethnicity? The next question

to ask is, is there a message that must be explored when these two characters are contrasted with the other? The third and final question is what is the importance of Jesus saying, "Go and do likewise"?

In answering these questions, we must begin with the characters' identity and the differences between them in the parable. The priest and the Levite are described by their titles. It seems that Jesus is using the notion of title for its significance and its meaning. Because of this title of Priest and Levite, we (people) would expect these individuals to do that which is just and right. For instance, when we explore our healthcare professionals, we would assume that these individuals are good and have the best intentions of servicing those of us who are ill. We would not expect them to disfranchise these patients because of their racial/ ethnic background. In other words, the essence of these individuals is that their title implies persons of goodness. The understanding of this idea of goodness relates to having the moral high ground in comparison with others. This is affirmed in a *Dictionary of Theological Terms,* when the author defines "goodness" as follows:

> moral excellences in relation to God. Creation and humanity have "goodness" in that they are created by God, who is supreme Good. Their ethical actions are assessed in relation to God and the degree to which they are "like God" in doing what is genuinely good. [128]

Unlike the Priest and the Levite, the Samaritans were seen by Jews as unclean, outcasts, and idolaters, by Jews and probably by most other people as well. The parable already sets up the conflict between good and evil, that is, what society defines as good and evil. In

[128] Donald K. McKim, *Westminster Dictionary of Theological Terms*, (Louisville, Kentucky: John Knox Press, 1996), 119.

addition, we can also see that the Samaritan is defined as evil based on his ethnicity, his cultural background, and as well as his social customs. It is this racial and ethnic profiling that should alarm and alert us because this group of people is being judged by their ethnicity. It is this judgment which then set up specific infrastructures which relegate these individuals to an inferior status. This notion of racial and ethnic disparities is then embedded into society's infrastructures ensuring that these individuals are then situated in society and treated by society accordingly. For example, these individuals and groups of people are then not invited to be full participants in society and are designated to hold an inferior status. This status is then used against them throughout the institutions that are established by a society. Eventually, this notion becomes a permanent part of society's national identity as well as society's psyche. I wondered what kind of psychological damage these Samaritans suffered because of this label or the notion of the propensity to be violent that most people associated with Samaritans. Again, just to highlight this idea once more, Samaritans, because of established stereotypes, are seen and judged by their ethnicity not by their character. Dr. Martin Luther King, Jr. would say, "They were judged by the color of their skin, [rather than] by the content of their character." [129]

It must have been shocking for first-century listeners, to know that which was labeled as evil, inferior, devoid of light, lazy and unintelligent as having the moral fiber in offering mercy and then acting with such moral fortitude as to take care of the beaten traveler and even providing financial support. In our society certain groups of people (African-Americans, Latinos, and other groups) and individuals (homosexuals, transgender and

[129]Martin Luther King, Jr., *Why We Can't Wait*, (New York: Mentor Books, 1963), 35.

others) which have been discriminated against because of ethnicity, socio-economic status, class, sexual orientation, or by their gender. Of course, that is why there are racial and ethnic disparities in our healthcare delivery system besides our society's biases and stereotypes. It would seem then that this parable can really speak to our own life situations. It is also an example of how a society categorizes people into an asymmetrical relationship based on ethnicity, race, religion, class and other factors which society defines as inferior, less than, and other notions which degrade humanity. But this parable shows us a strategy that can be employed to contend with such a society. This leads us to the one of the questions of this chapter: What is the moral standard that will remedy this situation? In establishing this moral standard, we cannot forget the final question that was asked earlier: What is the importance of Jesus' saying, "Go and do likewise?"

Contemplating these disparities in the medical profession, we are immediately confronted with issues of morality as well as maybe questionable mortality.[130] Strictly speaking from the moral basis of a religious understanding, it is then clear from this vantage point that our engagement with this world should be predicated on particular moral principles. It is this understanding that should regulate our interaction within society and other cultural and religious contexts. Furthermore, as we engage in the 21st century, it is even more indispensable that our moral foundation is founded on the understanding of love. A moral comprehension of love which contains the idea that love has no prejudice with regards to color, sexual orientation, religious heritage, cultural significance and understanding. For instance, in the context of the Judeo-Christian context, one of the

[130] Brian D. Smedley, Stith & Nelson, ed. *Unequal Treatment Confronting Racial and Ethnic Disparities in Healthcare,* (Washington D. C.: National Academic, 2003), 3.

building blocks for the doctrine of love is recorded in Matthew 22: 34-40. It is in this passage that Jesus is questioned by a Jewish canonical lawyer of the Torah. Jesus' responded to the lawyer's question,

> which commandment in the law is the greatest?" Jesus answer was, ". . . .'You shall love the Lord God with all your heart, and all your soul and with all your mind.' This is the greatest and first commandment. And a second is like it. 'You shall love your neighbor as yourself.' On these two commandments hang all the law and the prophets. [131]

It is this text, that most Christians understand establishes the doctrine of love and who we are to love. Furthermore, it is this comprehension that unites us as a society; especially, a society that claims to be the moral example for the world. It is this emphasis on this doctrine of love or theology of love which is embraced by most Christians; however, we have placed conditions on who we will love, based on racial and ethnic criteria, or economic criteria or sociable acceptance rubrics that fit into a particular image or understanding. Therefore, we as human beings have failed to live up to this notion, that is, *to love thy neighbor as thyself,*[132] which is the moral standard for which I believe we should strive.

With regards to the moral standard that needs to be the premise of our lives and our society, that moral standard that is outside of ourselves, but only an arm's reach away. One must go back to the passage before this text in Luke 10:27:

"You shall Love your God with all your heart, and with all your strength, and with all yours mind; and your neighbor as yourself." [133]

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[131]Matthew 22: 34-40 (NRSV).
[132]Matthew 22:40 (NRSV).
[133]Luke 10:27 (NRSV).

In clarifying the moral standard that this writer proposes, I will re-state this standard. One can read this text as a moral standard to be read as "*Love your neighbor as you love yourself*." This is stated in Mark 12: 39

> The second is this, 'You shall love your neighbor as yourself.'
> There is no other commandment greater than these. [134]

The moral standard that I propose establishes a framework that offers an honorable and incorruptible principle on which we can reach and on which we can rely. The only concern that I would have with this moral principle is that not every person loves themselves, so I would include the following idea. That we should love our neighbor more than we love ourselves! I would hope that his inclusion would not be relevant because my hope, my desire and my belief are that everyone should love themselves but, in my experience, is that some people's love is ill-formed. Now that we have established a framework, that is, "*Love your neighbor as you love yourself or more than you love yourselves*," we can see why this Samaritan acted with such compassion and bandaged this traveler's wounds. In addition, taking care of him and paying money for his lodging with the promise to return to settle any other expenses for this injured traveler. We can clearly comprehend that Love is and can be merciful as demonstrated by the Samaritan, thus, leading to the importance of Jesus' statement, "Go and do likewise." In this parable, the lawyer clearly can distinguish between acts of mercy so the he is able to answer Jesus' question. But, it does no Godly good to know the answer without putting it into praxis. That is the reason Jesus says, "Go and do likewise." So, Jesus requires us to put love into practice as well as defining everyone is our neighbor and, as a result, no one can select who are our neighbors.

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[134]Mark 12:39 (NRSV).

The potentiality of the power of love can be illustrated by Kwasi Issa Kena in *40 Days, in the Wilderness: Meditations for African-American Men*, when he writes for the 27th Day, entitled "Love Is All Around Us"

> Love is a force.
> Amen!
> Martin Luther King, Jr. believed in the power of agape,
> God's unconditional, uncompromising love."
> Yessuh!
> Love draws a man and a woman together, no matter what the distance or the obstacle.
> Say it!
> Love purses injustice and demands recompense.
> Preach on!
> Love stands while others cower.
> Well!
> Love promotes peace without a pistol.
> Uh huh!
> Love wrapped itself in human flesh, came down, and dwelt among us. . . .
> Victor listened to fragments of Reverend Bertram's sermon before drifting into his own thoughts. How does this love thing play out in real life? He wondered. Martin's dream got him killed. Men and women come together, but a lot of them don't stay together. Jesus was there for the disciples, but I can't see him. If love is so strong, it ought to make the six o'clock news . . . . . Reverend Bertram's sermon rose to a crescendo, snapping Victor back to reality. "Love is like an unstoppable army. Let's call the roll from love's ranks. Patience! Kindness! Hope! Perseverance! Trust! All present and accounted for, sir. Listen, there can be no arrogance or evil here. No, sir! There can be no grudges or selfishness here. No, sir! So you see, my brothers and sisters, love is a mighty force." Amen![135]

Using this moral standard and this newly acquired awareness with regards to addressing racial and ethnic disparities in our healthcare delivery system and the indirect and direct discrimination by our medical professionals, we must clearly say in one loud voice that this is an injustice. The next thought is where do we go from here? Knowing and awareness

[135]Kena Issa Kwasi, *40 Days in the Wilderness: Meditations for African-American Men*, (Nashville: Abingdon Press,1998), 93.

are just some of the pieces of the resolution in examining and analyzing the situation, but the final piece after judging the situation, is that of liberating action. This leads us to our next task which is acting on awareness and judgment to create a strategy to address a situation. The situation in our life time, beside discrimination that seems to be rampant in our society, are the racial and ethnic disparities that exist in our healthcare delivery system. Just imagine every patient in our healthcare institutions being this beaten traveler, who has been robbed by those who have discriminated against them and left them half dead because the person's dignity has been stolen and he has been stripped of his/her humanity because of the color of his/her skin or because of his/her socio-economic status or because of his/her sexual preferences or because of his/ her gender. In your life journey towards Jerusalem, which one of the three travelers do you choose to be? The Priest? The Levite? Or the Samaritan?

Liberating Actions— In Hopes of resolving Racial/ Ethnical Disparities in the U.S. Healthcare: (Use of Ethical Principals)

In this final chapter, we focus on liberating actions, as the next preceding task after seeing (awareness) and judging the situation. In this aspect of the model, we are required to carefully and deliberating tailor actions of liberation in response to the issue at hand. For the purpose of this research project, the issue is the prevailing concern related to racial and ethnic disparities in our healthcare system. The question becomes how are we to respond? It is clear now that after being able to see the reality of this disparity and its root cause, in addition, in the previous pages, we discussed and listened to the words of God with regards to this situation and the setting up of a moral standard. That is, we must love

all those patients as our neighbors. The difficult task of acting is now knocking on our doors, and we must open it, if we are to put in praxis this moral standard as well as adhering to this newly integrated framework of pastoral care. It is this model which is forcing us to deal with the ramifications of our analysis, and its social origins, in terms of racial and ethnic stereotypes and biases. First, we must establish ethical principles that can police our behaviors. Then we must establish concrete and tangible structures which can commences our response to this appalling and distasteful situation of racial and ethnic discrimination and disparities in our medical establishments. At the end of this chapter, the writer illustrates the following tasks to ensure that this hermeneutical process is completed. In the establishment of these liberating acts, medical schools will begin their arduous journeys of development of its care of society by creating a new way of educating medical students.

Let us begin with the creation of ethical principles which can commence this process of liberating actions. If you are asking yourself what would these ethical principles really do? I would paraphrase what I once heard Dr. Martin Luther King, Jr. speaking to his critics on the civil rights issues as well as advocate for a bill for the protection of African-Americans. He said: I might not be able to legislate people to love me, but I can surely legislate their behavior so that killing me (Negroes) is a crime. So, my reply is the same, I might not be able to legislate medical professionals and the healthcare delivery system to love me, but we can establish ethical principles of conduct to facilitate medical treatment to be as dignified as possible.

Knowing and realizing the stated disparities with regards to racial and ethnic groups in the medical profession, it seems as if these disparities lead one to ask the question. What are the ethical principles which could address these racial and ethnic disparities? In

addition, can these ethical principles aid in the strengthening the formation of the much-needed moral paradigm? As stated earlier, the moral and the ethical principles that this research proposes seem to go hand in hand with a significant portion of the doctor's Hippocratic oath which affirms to do no harm nor engage intentional injustice. It is this moral criterion which must be reinforced by establishing these ethical principles. There have been several key principles which seem to hold very important significance for me. These ethical principles included Dignity and Solidarity:

The Ethical Principle of Dignity

First, let us begin with the ethical principle of Dignity. It is the comprehension of this ethical principle of dignity which should offer guidance to our moral fiber, especially in the healthcare field in which we are engaged in human suffering. It is in this critical moment, when people are suffering, that we should be the most compassionate. Not only should we be guided by the ethics of dignity, but also by the clear understanding that when people look for medical assistance, that they are not looking from the perspective of a selfish reason. Chances are that they are seeking medical attention because of illness or injury. Guided by the ethical principle of dignity, all medical personnel should remember that the institution (hospitals and other medical facilities) in which they are employed is there to serve them (the patient), rather than to exist to make a profit or for the institution to be served. Of course, these medical institutions need to be financially viable, but this viability doesn't preclude dignified medical care. Unlike most other institutions, the historical development of most hospitals has a foundation in charitable existence. In other words, these very institutions originated because of charitable acts, rather than motived by

profit or money. Within this ethical principle, it becomes clear that our interaction should be based and motived on the idea that we are here to serve others rather than to be served. Because of racial and ethnic disparities in our current healthcare system, it is clear that patients are being label with stereotypes, prejudgments are being made as well as patients are being discriminated against, whether consciously or unconsciously. Patients and their illness, disease and/or injury are not being served appropriately or ethically. Based on this research, one could only imagine the numerous times patients encounter these racial and ethnic biases without their knowledge. I wonder how many people of color enter a hospital's emergency room and these patients have to deal with racial and ethnic discrimination, based on stereotypical biases of being treated solely for their injuries. This concern illustrated is in Thomas E. Perez's writings *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status* in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, when he states:

> According to Dr. Calman, until and unless physicians develop the capacity to confront their own stereotypes, it will be difficult to prevent conscious or subconscious bias from interfering with the physician-patient relationship. Dr. Calman's thesis is consistent with those put forward by Dr. Vanessa Gamble, former vice president of the Association of American Medical Colleges, and a frequent contributor on issues of race and medicine. In a 1997 article, Dr. Gamble wrote about race and medicine, and discussed a newspaper story reporting on an African-American woman who went to the emergency room of a county hospital in Los Angeles for treatment of a suspected broken arm. According to the article, interns, who were white, asked her to position her arm 'like she would have a beer on a Saturday night.' The patient responded: 'Do you think I'm a person on welfare?' 'Well aren't you?' was the response. The patient was actually an administrator at the University of Southern California Medical School. Dr. Gamble used this experience to discuss the role of discrimination in health

> care, and examine the forces at work that would enable a physician to basically look at a person and conclude they are on welfare.[136]

As a result of this incident, it is clear that this situation violates the understanding of the principle of dignity. The sole reason why this physician was present in this situation was there to provide medical attention/ medical treatment instead of providing his or her bias. But, the real concern is how did this perception affect the medical treatment she was given? The ethical principle of Dignity upholds the idea that everyone has the right to shelter, food, education, employment and medical care. In addition, that these rights should be the basis of what an institution should strive for in their daily interactions with people. In the simplest form, these very institutions should be the means that serve the real end– the entire collection of humanity. This ethical principle has been proposed by the National Conference of Catholic Bishops, in their book, *Economic Justice for All*. It is this text that the idea of dignity and its significance are presented. This idea is demonstrated when the author states:

> All human beings, therefore, are ends to be served by the institutions that make up the economy, not means to be exploited for more narrowly defined goals. Human personhood must be respected with a reverence that is religious. . . When we deal with each other, we should do so with the sense of awe that arises in the presence of something holy and sacred. . . Similarly, all economic institutions must support the bonds of community and solidarity that are essential to the dignity of persons. Wherever our economic arrangements fail to conform to the demands of human dignity lived in community, they must be questioned and transformed.[137]

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[136] Thomas Perez, *"The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status," Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*, (Washington D.C.; National Academic Press, 2002),634.

[137] National Conference of Catholic Bishops. *Economic Justice for All*, (Washington D.C..: Catholic Bishops Conference 2000), 30.

Even though this text is speaking to our economy's infrastructures, one can also deduce that institutions must serve humanity by this concept. It is this framework that addresses these institutions which are self-serving. It is from these ethical principles that we can also contend and propose an option for the poor, because if our neighbor is poor then we are obligated to provide not only medical treatment, but also the means to ensure continuous medical care.

The Ethical Principle of Solidarity

The next ethical principle is Solidarity. It is apparent that the disparities that exist in the healthcare industry and its connection to racial and ethnic groups are caused by this unrealized racialized ideology which establishes symptomatic causes. These factors are economics, discriminatory practices, genetic predispositions as well as environmental causes. In the hope of addressing several of these symptomatic causes, there must be ethical principles which help facilitate our awareness of our interconnectedness with the world and one another. I believe that it is this ethical principle of Solidarity which could begin to provide us some direction in addressing a number of these factors. For example, it is probable that the ethical principle of solidarity can help motive individuals to rise with fervent voices against the proliferation of environmental incinerators and other hazardous industries which seem to always be in racial and ethnic neighborhoods. It is these industries which seem to increase the already vulnerable health conditions of most racial and ethnic group members. It is the hope that this principle can assist in the reformation of the basic human value with regards to caring for others in a more global matters, especially as the

present economic system continues to establish its foothold in a global context. As this ethical principle begins to assist the people (the masses) in caring for others; ultimately, it will strengthen the moral standard—Love your neighbor as your love yourself.

Once we begin to centralize the idea of "love thy neighbor as thyself," it will become apparent that the racial and ethnic disparities in the healthcare industry of the United States could be minimized and eliminated, especially when using the ethical principles of Dignity and Solidarity. Furthermore, because of these ethical principles, one can see that the moral dimension of our humanity will be strengthened– that is "Love thy neighbor as thyself."

At I conclude the ethical principles for the preceding section— the creation of a medical curriculum which emphasizes an education for critical consciousness, I am left with mixed feelings—feelings of hope, feelings of vulnerability, renewed feelings of passion for justice, feelings of apathy, feelings of courage, as well as feelings of fear, amidst numerous other feelings. The reason for these mixed feelings is because usually those at the top of asymmetrical relationships are where the power is typical held. Those with the position and power do not easily relinquish position and power without considerable force. In today's society, it seems as if people are so trapped by their daily obligations that it seems impossible for people to respond to such a divisive subject as racism and racial and ethnic disparities. Most people of the dominant groups are consumed with their defensive mechanism of denying racial and ethnic discrimination such that they are unable to see or just refuse to see. I thank and praise God for giving me the purpose and the strength to speak with validity without much concern about the repercussions. If left up to my own virtues, as a human being, I would probably cower like so many others. However, with God, I could do all things.

I have presented to you that racial/ ethnic disparities in the U.S. healthcare delivery system exist, as well as the psychological tools (Liberation Psychology and *conscientizacáo*) that can aid in the reduction and hopefully, elimination of this issue—racial/ ethnic disparities. It is now time to clearly illustrate how these psychological tools can be utilized within a U.S. healthcare system.

First, there many moving parts to the U.S. healthcare system so the most important aspect of this process is to place these tools where we can maximize the benefits as well as the best possible results; therefore, our departure point should be medical education. What is essential is the development of a medical curriculum that enhances not only awareness of the existence of racial/ ethnic disparities, but also raises that it the students' critical consciousness with regards to their own personal biases, stereotypes, and prejudices. Furthermore, we need to select the most appropriate candidates for the curriculum, simply meaning that the curriculum should be tailored to first year medical students. The reason being that first-year medical students are the best candidates because they are just beginning their careers; therefore, they are more eager to be their best and become the most effective physicians. After exposing the 1st year students, the next process is to reconnect with students in their 3rd and 4th years. First, they will be given a refresher course so that they can integrate this learning with their clinical training. This idea is illustrated in *Innovative Health Care Disparities Curriculum for Incoming Medical Students*, when the authors states: "Nonetheless, our course is innovative in that in the first health disparities course for Task Force goals, it used a variety of teaching modalities, and it occurred early in students' medical school careers. [Furthermore] The timing of the course before the

start of medical school rather than during the school year allowed students to learn the content with fewer competing demands on the students' time and attentions."[138]

In addition, to maximize patients' health, healthcare professionals can use social medicine curricula to address complex social issues. This idea is affirmed in *All Health is Global Health, All Medicine is Social Medicine: Integrating the Social Sciences into the Practical Curriculum*, when the authors stated,

> Social medicine is the systematic study of the relationships between society, disease, and medicine, incorporating the quantitative (e.g., economic, demography, epidemiology) and qualitative social sciences (e.g., anthropology, history, political sciences) to understand how micro- and macroscopic social factors influence human disease and its distribution worldwide. Social medicine recognizes that physicians must engage with social realities outside the clinic or hospital to optimize human health.[139]

Taking this idea, a little further, the authors stated,

> Medicine is inextricably embedded in social contexts. Physicians need to understand the social determinants of disease, the changing social meanings of disease, the diversity of health care behaviors and practices, and the social factors that influence treatment effectiveness. The goal of the course is to make social medicine concepts tangible and applicable to real-world clinical settings. [140]

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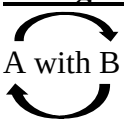
[138]Monica B. Vela, M.D., Karen E. Kim, MD, Hui Tang, MS and Marshall H Chin, MD, MPH. *"Innovative Health Care Disparities Curriculum for Incoming Medical Students. Addressing Teaching and Training Gaps," J General Internal Medicine*, (Department of Medicine; University of Chicago, 2010), 1031.

[139] Jennifer Kasper, MD., Greene, JA, MD., Farmer, Paul, MD., Jones D., MD., *"All Health is Global Health, All Medicine is Social Medicine: Integrating the Social Sciences into the Preclinical Curriculum." Academic Medicine*. vol. 91, no. 5, (May 2016), 628.

[140]Kasper, *"All Health is Global Health, All Medicine is Social Medicine: Integrating the Social Sciences into the Preclinical Curriculum,"* 629.

Second, the course must not be in the format of a traditional graduate course with the instructor imparting information to the 1st year medical students. The curriculum must be careful to follow the process of critical consciousness, simply meaning it must be within the dialectic learning process; and not only the usually teaching modalities.

In addition, the relationship between leader and participants must be changed. The relationship should be to express equal power dynamics; in order words, there should not be an asymmetrical relationship. For effective dialogue to occur, the participants should be able to conceptualize that they can change the world. This idea is emphasized in *Education for Critical Consciousness,* when the author Paulo Freire states;

> Our method, then, was to be 'based on dialogue, which is a horizontal relationship between persons
>
> **Dialogue**
>
> 
>
> A with B = communication/ interconnectedness
>
> Relation of "empathy" between two poles who are engaged in a joint search.
> Matrix: Loving, humble, hopeful, trusting, critical.
> When two poles of the dialogue are thus linked by love, hope, and mutual trust, they can join in a critical search for something. Only dialogue truly communicates.[141]

Furthermore, the traditional role must be altered to ensure effective critical consciousness. In other words, there is no teacher but a coordinator of the discussion. In addition, there are no students, but only learners or participants. This is clearly illustrated in *Education for Critical Consciousness,* when the author states:

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[141] Paulo Freire, *Education for Critical Consciousness,* (A continuum Book The Seabury Press; New York 1965), 45.

> Through this project, we launched a new institution of popular culture, 'a cultural circle', since among us a school was a traditionally passive concept. Instead of lectures, dialogue; instead of pupils, group participates; instead of alienating syllabi, compact programs that were 'broken down' and codified into learning units.[142]

This is clearly evident and illustrated in *Innovative Health Care Disparities Curriculum for Incoming Medical Students*, when the authors present: "Several teaching modalities were employed: didactic learning lasting 50-60 minutes, 20 minute lectures on specific disease important in Chicago's South Side community, small group discussions led by two faculty members, and poster session workshops led by the resident teachers that utilized a teach-back method designed to help student s recognize their roles in teaching others about health disparities."[143]

Unlike Liberation Psychology, these teaching modalities cannot achieve the stated goals and objections of understanding of subconscious bias, and stereotyping that occurs between the clinical encounter (patient and physician).[144] The reason why is because the dialectic process is changed. Critical consciousness could only be achieved as stated earlier in chapter 3, as illustrated in *Education, Liberation and the Church*:

> Hence conscientizacáo whether or not associated with literacy training, must be critical attempt to reveal reality, not just alienating small-talk. It must, that is, be related to political involvement. There is no conscientizacáo if the result is not the conscious action of the oppressed as an exploited social class, struggling for liberation. What is more, no one

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[142]Freire, *Education for Critical Consciousness*, 42.

[143]Monica B. Vela, M.D., Karen E. Kim, MD, Hui Tang, MS and Marshall H Chin, MD, MPH. *Innovative Health Care Disparities Curriculum for Incoming Medical Students. Addressing Teaching and Training Gaps," J General Internal Medicine*, (Department of Medicine; University of Chicago, 2010), 1029.

[144]Monica, *"Innovative Health Care Disparities Curriculum for Incoming Medical Students*," 1029.

> conscientizes themselves, thanks to the dialectic movement which relates critical reflection on past action to the continuing struggle.[145]

Finally, such a curriculum must not be relegated to inappropriate and inadequate time slots. I learned a long time ago, the degree of importance of an issue is determined by the time and space given to a specific issue/ concerned. For example, an issue that is relegated to a non-specific and permanent slot in a school curriculum is usually an indication of not being taken seriously or cared about. In addition, a liberation of psychology curriculum would not be considered an elective course but should be a mandated course because of the urgency need for critical consciousness of health care professional especially physicians. This idea is evident in *Innovative Health Care Disparities Curriculum for Incoming Medical Students*, when the authors wrote,

> Our study has several limitations. First, self-selection by mere interested and motivated students might have favorably skewed our results. . . . . The University of Chicago is now requiring this course for all first-year medical students in the week immediately after orientation.[146]

At this point of the study, I will present some sample lesson plan for the medical school which will emphasize the use of critical consciousness, Liberation psychology and key components of social medicine.

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[145]Paulo Freire, *Education, Liberation and the Church. Religious Education*, vol. 79, no. 4 (Fall 1964), 528.

[146]Monica B. Vela, Monica B. Karen E. Kim, MD, Hui Tang, MS and Marshall H Chin, MD, MPH. *"Innovative Health Care Disparities Curriculum for Incoming Medical Students. Addressing Teaching and Training Gaps". Journal of General Internal Medicine.* (Department of Medicine; University of Chicago, 2010), 1031.

Sample Learning Plan[147]

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— The Inequalities of Human Races by Author de Gobineau

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

[147]I would like to extend my gratitude to Dr. Dawn Digrius for the ideas and materials in regard to racialized sciences and its development in Eurocentric history which I learned through a course called racialized science. Because of these ideas and materials, I created these lesson plans.

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

1. How would you treat patients with the above reading? Is the medical treatment appropriate?
2. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
3. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Sample Learning Plan

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— Who invented the concept of Race? Kant's Role in the Enlightment Construction of Race by Robert Bernasconi

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

Readings—

Dialectic Process

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

4. How would you treat patients with the above reading? Is the medical treatment appropriate?
5. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
6. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Sample Learning Plan

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— The Classification of Races by Immanuel Kant

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

Readings—

Dialectic Process

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

7. How would you treat patients with the above reading? Is the medical treatment appropriate?
8. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
9. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Sample Learning Plan

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— Of the Different Human Races by Immanuel Kant

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

Readings—

Dialectic Process

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

10. How would you treat patients with the above reading? Is the medical treatment appropriate?
11. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
12. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Sample Learning Plan

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— The Race of Men: A Philosophical Enquiry into the influence of Race over the Destinies of Nations by Robert Know

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

Readings—

Dialectic Process

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

13. How would you treat patients with the above reading? Is the medical treatment appropriate?
14. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
15. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Sample Learning Plan

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— drapetomania by Dr. Samuel Cartwright

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

Readings—

Dialectic Process

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

16. How would you treat patients with the above reading? Is the medical treatment appropriate?
17. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
18. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Sample Learning Plan

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— Studies— Liver transplantation, Access to healthcare and Access to healthcare Insurance

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

Readings—

Dialectic Process

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

19. How would you treat patients with the above reading? Is the medical treatment appropriate?
20. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
21. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Sample Learning Plan

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— Medical Waste Incinerator in urban neighborhood

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

Readings—

Dialectic Process

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

22. How would you treat patients with the above reading? Is the medical treatment appropriate?
23. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
24. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Sample Learning Plan

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— Under the Shadow Tuskegee

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

Readings—

Dialectic Process

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

25. How would you treat patients with the above reading? Is the medical treatment appropriate?
26. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
27. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Sample Learning Plan

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— Medical Apartheid by Harriet A. Washington

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

Readings—

Dialectic Process

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

28. How would you treat patients with the above reading? Is the medical treatment appropriate?
29. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
30. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Sample Learning Plan

Objectives:

Raising Critical Consciousness of 1st year medical school student.

Reading— Seeing Patients: Unconscious Bias in Healthcare by Augustus A. White

Specific Goals:

Raise the awareness of specific racialized ideology in medical students and how these ideologies could impact the clinical encounter

Teaching Method:

Readings/ Studies /

Engage the students with the readings/ studies within a Dialectic process

Length of time:

3months 2 twice a week- each class will be 50-60 minutes

Process/ Procedure:

Readings—

Dialectic Process

Students and instructor sit in circle and have a discussion on the readings and studies.

Questions to consider:

31. How would you treat patients with the above reading? Is the medical treatment appropriate?
32. After years of practice with the above medical understanding, can you easily change mind, behavior and attitude?
33. With modern medical understanding, how do we rectify the current situation?

Assessment:

After each class, the selected students will do a presentation on previous week's reading and conclusion discussed in class.

Conclusion—Racial and Ethnic Disparities—A Component of Our Morality Impasse!

Summarizing the research for this dissertation, it is clear that unfortunately, racial/ ethnic disparities in the U.S. healthcare delivery system not only exist, but it seems as if this issue is increasing with no end in sight. In chapter 1, I have been able to illustrate that there is no equitable distribution of medical care in the U.S. healthcare system between that which is available to white/ Caucasians and that offered to people of color (Black Americans, Latino/ Hispanic Americans, Asian Americans, Native Americans, and many others). In addition, I suggest that the reason for this inequality is based upon assumptions regarding race and how medical historical evidence have clearly demonstrated this idea of racial/ ethnic biases, prejudices, and stereotypes.

In chapter 2, the literature review, I have presented various studies also affirming the notion that racial/ ethnic disparities exist in the U.S. healthcare delivery system, as well as the various determinants that each study endorses is the primary cause of this issue. Furthermore, it is also apparent that this issue of racial/ ethnic disparities exists according to many studies because of employment status, managed care versus traditional fee-for-service, as well as other factors such as limited medical facilities in rural and urban neighborhoods. Needless to say, I have concluded that the real culprit in the case of racial/ ethnic disparities in the U.S. healthcare delivery system is the embedded racialized ideologies that are unrecognized in our society's value and norms.

In chapters 3 and 4, I present the psychological tools needed to resolve this issue: Liberation Psychology and *conscientizacáo* (critical consciousness) as suggested by Paulo Freire. These tools which can assist us in becoming aware of our society's biases, prejudices, and stereotypes. In addition, I have demonstrated how these psychological

tools can begin to aid our awareness by integrating these psychological tools in our medical school's curriculum first targeting first-year medical school students. Let us continue by wrestling with the question of what is at stake?

At stake is the moral superiority of our health care as well as the perceptions of America regarding this quandary. In essence, it becomes our moral imperative to address these racial and ethnic disparities in our healthcare delivery system. The reason that America's health care delivery system needs to be regenerated is because studies have proven that racial and ethnic disparities exist, and these data point out how lives are being affected by prejudices, biases and stereotypes. It is quite simple when analyzing the data just to see words and numbers rather than human lives, but the reality is that these numbers represent people; They represent human life. Moreover, even one preventable death in our health care system is a moral blemish on our social reality; in this case however, millions of lives are impacted. What is demanded then is a fair and just health care system that addresses this moral impasse!

It is clear that people know about the data and its implications. That is, racial and ethnic disparities exist. Perhaps what is needed then is for me to be candid. What is needed is radical change! If we (you) already know about the data, then why is there not a concerted effort made to resolve it? Contemplating this situation, it appears somewhat pathological that people know about the data and the studies, but they continue to allow subtle biases or prejudicial behaviors to impact the health status of people of color. Paulo Freire expresses this idea in a very different way, not so much as pathological but, misleading one's intention—a travesty. This can be illustrated in the study of Freire, entitled *Pedagogy of the Oppressed*, when Paulo Freire states, "To affirm that men and

women are persons and as persons should be free, and yet to do nothing tangible to make this affirmation a reality, is a farce."[147] Is education needed? Yes, at some level. What I feel is needed is a direct confrontation, of course, non-violently. Well, how can this be accomplished?

During the civil rights movement of the 1950s and 1960s, television was utilized to show America the violence inherent in the continual practice of segregation by those who enforced the status quo; these images pricked the conscience of White-Americans. This newly acquired awareness led to transformative actions that eventually ended segregation as an overt social process. One may argue that perhaps what is needed is a boycott of all medical services to bring this issue to the forefront. I am not so sure! This approach would prove to be too costly. That is, we are already suffering and dying because of the racist notions and assumptions that are associated with Blacks of all shades—African-Americans as well as Latinos.

This brings us to what is needed to draw attention to this issue. What Reverend Dr. Martin Luther King, Jr. did was to raise the conscious and unconscious behaviors of America's caste system and how it operates, which has been embedded into the American social fabric. The question is how do we do this today? The answer is by utilizing a methodology that can bring to bear all of its resources to raise the unconscious racist ideology or what Freud would call "the perverse", in the hopes of effectively eliminating this unconscious process in all White-Americans. It is these subtle and unconscious biases that not only reinforce this disparity, but also enable most White-Americans to claim that

[147]Paulo Freire, *Pedagogy of the Oppressed,* (New York: Continuum, 1993), 45.

they are not racists. However, they are color-blind. Why color-blind? Are you truly color-blind? Why is it that White-America prefer to be color-blind rather than simply acknowledge my color—Black? What images does this conjure up for you? I am aware that everyone has been affected by racism; including people of color but focus on America and their racist propensity due to their socialization process in a society that values white people over and against Blacks of all shades.

Returning back to our focus, how then do we change the unconscious behaviors of White-Americans; especially, the unconscious bias that gushes forth. What comes to mind is Paulo Freire's idea of "*conscientizacáo*", the making aware of one's situation, the reawakening of one's awareness—making the unconscious conscious! Paulo Freire uses this pedagogical tool to engender the illiterate people of Brazil to participate in the awareness and transformation of their social location as well as their oppression.

One must remember however, that social norms and values are reinforced by social institutions. This is illustrated in a sociological perspective found in *Sociology 6th ed.*, in the hopes of demonstrating that social institutions are the enforcement agents of society's norms and values. It states: "consist[ing] of pattern behavior, and status/ role relationship that fulfill certain basic societal needs. Institutions respond to the fundamental requirements of all human societies by organizing behavior and relationships in a way that satisfies those requirements . . . What functions do social institutions serve? One is a need to reproduce new members and to teach them the customs, beliefs, and values shared by those who live in their world."[148] This idea is further emphasized in "Racial and Ethnic

[148]Craig Calhoun, Donald Light & Suzanne Keller, *Sociology 6th Edition* (New York: McGraw-Hill, 1994), 97.

Disparities in the U.S. Health Care industry: The Dialogue between Liberation Theology and Pastoral Care,"[149] when the author claims that a hospital is a micro-institution of our society (See Figure1).[150] Thus, these various socialization processes reinforce society's biases, stereotypes, prejudicial behavior as well as their discriminatory practices. These processes eventually become unconscious behavioral patterns which are later disseminated to one's offspring. In other words, from a sociological point of view, we have failed because we have always addressed one social institution—as if the root of the problem is the health care system—the problem is White-America and its propensity for its unconscious biases.

[149]Victor L. Algarín, *"Racial and Ethnic Disparities in Health Care in the U.S. Health Industry: The Dialogue between Liberation Theology and Pastoral Care,"* (STM Thesis, Drew University, 2007), 12-13.

[150]Algarín, *"Racial and Ethnic Disparities in Health Care in the U.S. Health Industry,"*13.

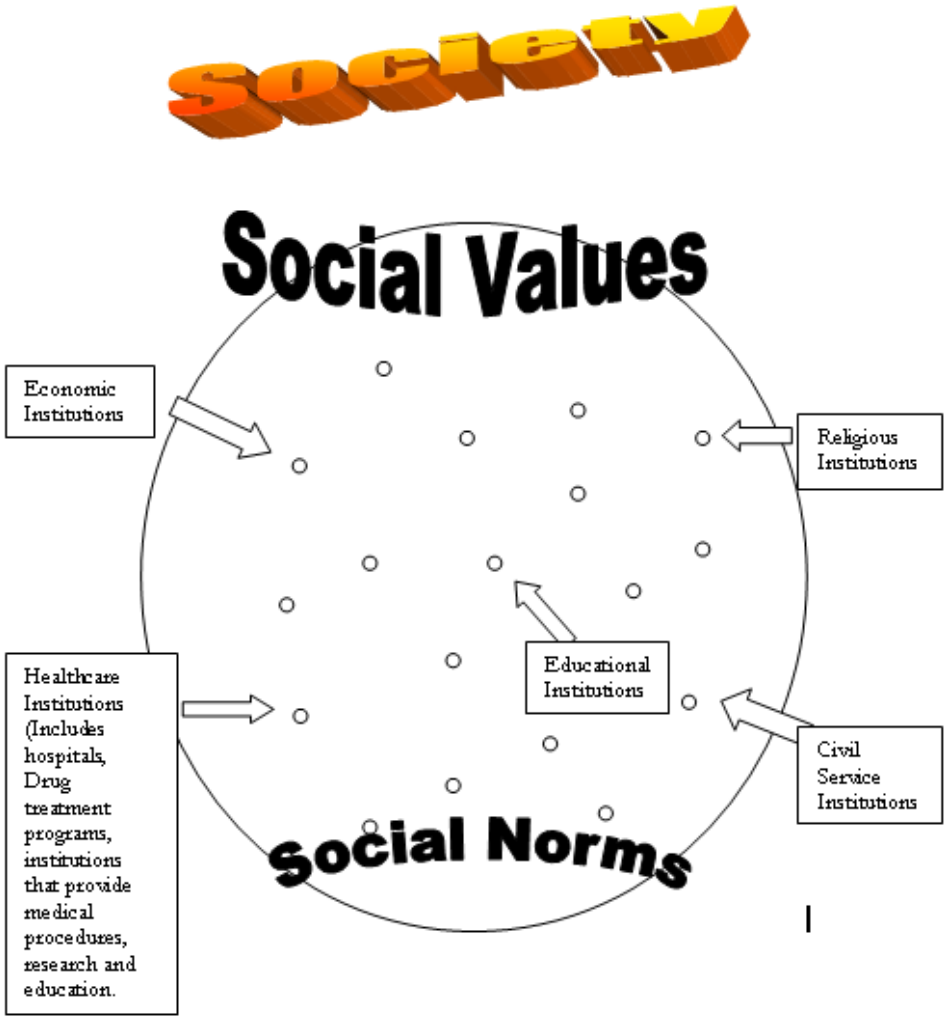

Figure 1.
In this illustration, we can see that every institution in our present society participates in organizing our behavior and relationships that subscribe to the values and norms of our society. From a sociological perspective, every member and every institution has a role and responsibility to ensure that we affirm our society's values and norms.

In the hopes of drawing some conclusions about the essence of this research project, it is quite apparent according to various studies that racial and ethnic disparities exist due to various reasons such as: prejudices, biases, stereotypes, inferior quality of care,[151] inappropriate treatment protocols,[152] environmental discrimination as well as access issues, but the most pressing problem is the unconscious biases of white-Americans and their

[151]Brian D. Smedley, Adrienne Y. Smith and Alan R. Nelson, ed. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, (Washington D.C.: National Academic Press, 2002), 35.

[152]Smedley, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, 35-37.

collective unconscious.[153] The desire to eliminate the racial and ethnic disparities in our health care system is an important step to wrestle with; however, things will not change much if the core of the problem is not addressed—the socialization of white-Americans that contains unconscious prejudices. I liken this dilemma to the well-known biblical story of Jacob wrestling with the angel of God. As Jacob wrestled with the angel of God all night long, Jacob is touched by the angel who then departs. As Jacob wrestled with the angel of God, the angel's touch dislocates Jacob's hip, thus signifying that, Jacob was blessed because he lived as well as saw the face of God. The emphasis of this study is not only on the blessing of a new and radical health care system, but that the idea of struggling all night long can be the source of our blessing. In other words, we must "struggle all night long" to address this crisis in our health care delivery system, which at some point in time, engages the moral quandary of our society.

Furthermore, it is these historical inequalities which were based on discriminatory practices, biases, prejudices, and stereotypes that created and which are embodied in racial and ethnic disparities. This is affirmed in the *Report of the National Advisory Commission on Civil Disorders*, as it seeks to find answers to the question of what were the factors which caused the riots in the United States of America during the 1960s. The special introduction to this report written by Tom Wicker of the New York Times, states,

> …that it was necessary to go beyond these concepts to the root question of white racism—of white refusal to accept Negros as human beings, social and economic equals, no matter how they might feel about Negro 'civil rights.'. . . 'what white Americans have never fully understood—but what Negros can never forget—is that white society is deeply implicated . . .

[153] See Carl Jung

> White institutions created it, white institutions maintain it, and white society condones it.'[154]

Addressing only one social institution barely touches the surface of the problem, which the statement of Tom Wicker clearly declares, "White institution**s** created it, white institution**s** maintain it, and white society **[as a whole]** condones it." Hence, a theory of justice must be injected into all aspect of [white] social institutions as a whole.[155]

[154]Tom Wicker, *"Special Introduction" Report of the National Advisory Commission on Civil Disorders* (Washington D.C.: Government Printing Office, 1967), vi.

[155]Wicker, *"Special Introduction" Report of the National Advisory Commission on Civil Disorders,* v

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