A PIECE OF MY MIND

Black Lives

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One of my favorite patients is Mr Gardner (not his real name). He lives on the South Side of Chicago, in a region whose residents are predominantly African American, with high levels of violent crime and not a single level I trauma center for adults (though my hospital has proposed to build one soon). In our city, like many others, years of institutional discrimination—in housing, education, and criminal justice—have taken their toll. The distance between Mr Gardner's neighborhood and my own is roughly 5 miles. In my neighborhood, the average life expectancy is 82 years; in his, it is a full decade less.

Now in his early 70s, he had been seeing me in clinic for the past two years. From his medical record, I knew that he would decline a colonoscopy, for reasons he could never quite explain. I would encourage him gently at each visit to reconsider. His answers were always the same—a quick "No," a shrug, or a "Maybe next time."

Regardless, we got along fine, and his medical problems were well controlled. One day, after routine laboratory studies showed an otherwise unexplained iron deficiency anemia, along with a few offhand comments about a change in his bowels, my nudging toward colonoscopy turned into a shove. Of course, the gastroenterologist found a mass, and the biopsy confirmed a diagnosis of colorectal cancer.

After his hemicolectomy, Mr Gardner's wife called our clinic. She requested a quick visit before he was discharged home. I stopped by his hospital room later that day. "Thanks for saving my life, Doc! If you didn't find this cancer … " His voice trailed off. I worried that his future would be complicated—chemotherapy, more colonoscopies, maybe recurrent disease. Whether the surgery would save his life from a potentially preventable cancer was unclear. If he had never gotten an otherwise medically unjustified complete blood cell count, as part of his "routine" labs when he was feeling well, he would have known nothing of his anemia. Nor would he have agreed to proceed with a colonoscopy. Perhaps, if I had found a way to change his mind about screening for colorectal cancer, he would have no visible scars.

I worried a bit about postsurgical complications. I worried a bit more about the potential physical, emotional, and financial burden of chemotherapy. Most importantly, though, I worried that the systemic racism he had experienced during his precancer years would extend to include these years too.

Racial disparities in colorectal cancer have been well described. From 2008 to 2010, adjusted death rates from colorectal cancer per 100000 were highest among black patients, at every level of education, for patients 25 to 64 years of age.[1] Whether these disparities stem primarily from decreased access to screening in minority communities, rather than differences in cancer biology, is unclear. Nevertheless, studies[2] have suggested that disparate racial outcomes in colorectal cancer nearly vanish once equal access to care is guaranteed. Furthermore, patients with higher utilization of primary care have a greater likelihood of receiving a screening colonoscopy and are more likely to be diagnosed with early-stage disease.[3] More importantly, they have reduced colorectal cancer mortality and overall mortality, on average. These findings seem to imply that inequitable access to care could be the fundamental source of otherwise avoidable differences in death from colorectal cancer. It would seem to follow, then, that policy leaders who preferentially obstruct the expansion of health care into minority communities are, in fact, perpetuating a system of racial violence, which, like any other form of violence, leads to loss of life. Whether such actions are justifiable by other financial, political, or policy implications is a separate discussion, which fails to alter the ultimate consequences for the patients we serve.

Certainly our political leaders know the importance of access to care. Certainly they know that patients from different racial groups, on average, have vastly different outcomes from diseases like colorectal cancer. Some of these differences could be prevented with more effective screening or controlled with medications to reduce the burden of otherwise avoidable complications. Certainly they have been told that dramatic variations in life expectancy, which may be driven by differences in access to affordable care, mean that people die younger than they otherwise should. And yet we endure a system in which political leaders endlessly vote to repeal the law that expanded access to care for millions of Americans, without any serious attempts to support a plan with similar goals. In December 2015, the US Senate voted to repeal the Affordable Care Act, joining their colleagues in the House of Representatives, who had previously voted in such a way more than 50 times.

Such actions, shameful as they may be, represent just one of the many manifestations of widespread political racism, hiding in plain sight. Even after the implementation of the Affordable Care Act, a majority of the country's nonelderly black residents live in states with governors who refuse to accept federal money for the expansion of Medicaid coverage.[4] By some estimates, the expansion of Medicaid in these states would cut the percentage of uninsured black Americans by more than half.[4] Perhaps unsurprisingly, surveyed adults overwhelmingly support the individual provisions of the Affordable Care Act, so long as surveyors omit the name of the black president who promotes them.

Do I, as a physician, bear a greater responsibility to speak out against the actions of political leaders who actively undermine efforts to improve access to care?

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Should my desire for apolitical professionalism outweigh the needs of black patients who die as a result of collective inaction? Should I allow policy leaders to perpetuate racial disparities in access to care, while Black Lives Matter protesters are shot in the street? And why should I be so reluctant to outwardly promote an agenda of health care expansion, simply because it may be interpreted as favoring one political party over another? My typical response to these questions is, unfortunately, silence.

All of these thoughts were troubling me as I listened to Mr Gardner's words. I hoped that his access to care had averted an otherwise preventable death. I also hoped that my colleagues and I would find more effective ways to advocate for the medically underserved patients who die in our hospital from chronically undertreated conditions, ongoing structural racism, and seeming indifference from the policy makers who could save them.

On the day the Senate voted to repeal the Affordable Care Act, Majority Leader Mitch McConnell spoke of saving "a middle class that's suffered enough from a partisan law." To justify repeal of this law, which has improved access to care for millions of people of color, by bemoaning the ill-defined but relentlessly cited hardships it might impose on a predominantly white middle class, is as transparently racist as it is cruel. As a physician, I know that the lives of black patients in medically underserved communities matter to me. Our political leaders should act like they know this too.

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Whenever there is lost the consciousness that every man is an object of concern for us just because he is a man, civilization and morals are shaken, and the advance to fully developed inhumanity is only a question of time.

Albert Schweitzer (1875-1965)