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DIVIDED

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RACISM, MEDICINE
AND WHY WE NEED TO
DECOLONISE HEALTHCARE

ANNABEL SOWEMIMO

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First published in Great Britain in 2023 by
Profile Books Ltd
29 Cloth Fair
London
EC1A 7JQ
www.profilebooks.co.uk

Published in association with Wellcome Collection

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183 Euston Road
London NW1 2BE
www.wellcomecollection.org

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1 3 5 7 9 10 8 6 4 2

Typeset in Baskerville by MacGuru Ltd
Printed and bound in Great Britain by
Clays Ltd, Elcograf S.p.A.

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A CIP catalogue record for this book is available from the British Library.

ISBN 978 1 78816 920 2
eISBN 978 1 78283 909 5



In memory of Agnes Olabisi Alakija

Details of patient encounters have been altered to protect the confidentiality of both patients and staff.

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PROLOGUE



Protesters throw the statue of slave trader Edward Colston into the Bristol harbour during a Black Lives Matter protest rally in 2020.

At no point in my medical education – nearly a decade of university, three degrees and countless hours spent on the wards – did anyone mention how the legacies of colonialism and racism affect my decisions as a doctor.

Shortly after completing my master's (at arguably one of the world's best public health schools, the London School of Hygiene and Tropical Medicine), I became disillusioned with how healthcare is taught and discussed. I'd spent a year studying sexual and reproductive health, particularly that of countries in the Global South, and I felt that there were gaping holes in many of our discussions. It was the same feeling that I had felt in my undergraduate medical education. I would sit in lectures and listen to senior doctors disparagingly make sweeping generalisations about why some Black people were at risk of high blood pressure and how these patients often did not take their medication. We never discussed the tension between majority white, middle-class doctors and racially marginalised patients. We never discussed how our health institutions have been shaped by imperialism. Nobody challenged these narratives. No one was given the space to do so. The system was heavily weighted in favour of a few. Medicine and healthcare is taught the way it is practised. Only a few bodies have ever historically mattered: usually those of white, male, able-bodied and heterosexual people.

But I wanted to challenge this status quo, to rethink who the true experts may be. As a doctor, I knew that I garnered respect that many others did not, so I founded Decolonising Contraception Collective in 2018, a not-for-profit company with the aim of creating spaces for those working across sexual and reproductive health to discuss health inequalities among marginalised communities and how race affects those accessing care. We dived into the history of our institutions, looked at the mistrust between providers and patients, and how race played out in healthcare. For some, it was quite emotional – we hadn't been able to share our experiences and feelings like this before. As our events became successful, I began receiving messages from young Black women, who wrote that they had never heard people speak about how racism shaped their experiences of healthcare. I knew our work was important and I knew it was helping people, but every now and then I would speak to a medical colleague, and they would say something demeaning. My work was considered a 'little project'. Colleagues told me it was 'edgy' and not 'academically rigorous'. It was clear that this work wasn't a priority to them – and, in some people's minds, it was even a waste of time. As frustrating as this was, I did not care as long as we continued to help our communities and played some role in improving the sexual and reproductive health landscape.

And then, Covid-19 hit. As we entered the first months of lockdown in 2020, we witnessed these issues – of racism, colonialism and mistrust – becoming more vitally significant than ever. I had been writing for *gal-dem* for a few years, and, in the throes of lockdown, I felt it was the right time to begin a regular column on decolonising healthcare. In my first column, I wrote of my experience of encountering a young woman who needed emergency dialysis. Due to her fears about deportation, she hadn't sought medical help until she had kidney failure. The article resonated

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with many – I received direct messages from people sharing their experiences of similar issues. Not everyone was complimentary – a few people suggested I was being overly critical of the medical profession – but it was the messages from young people, particularly medical students who would be shaping the next generation of healthcare providers, that had the most impact on me. My inbox flooded with messages from students across the UK, asking how they might spark similar conversations around the role that colonialism and race played within health at their medical school or if I wouldn't mind speaking at an event. I tried to respond to as many students as possible but I simply didn't have the time. And I realised I had far more to say than one conversation or lecture would allow.

I needed to start at the beginning and create something that untangled exactly how and why we have such profound health inequalities. We needed to look at our society and tackle the huge structural shifts that are required if we are truly going to see significant change. Despite the concerns I had of placing myself further in the public eye, I realised that I simply *had* to write this book. We urgently need to address the colonial history of healthcare and how it continues to perpetuate health inequalities. This is long overdue. Over the last couple of years, Covid-19 has brought most of the world to a grinding halt, and we all, now, have to acknowledge the role that healthcare institutions have in determining how we live our lives, and the real power that medical professionals yield. We can no longer deny that health inequalities and uneven power relations exist. This is most apparent in the poorest areas of the world. Black communities globally have been disproportionately affected by Covid-19 and have disproportionately died of the virus. Poorer countries have failed to secure adequate Covid-19 vaccinations. We must start to question precisely why this is the case. We need to make sense of

the health inequalities we see. We need to address the racial inequalities in medicine. Only then can we hope to build a system that is more equitable for everyone.

Divided is the culmination of years of both learning and unlearning things that I thought to be true about myself, medicine and health. I had to unlearn the race science and colonialism that runs to the very core of medicine. Race science, the pseudoscientific belief that empirical evidence exists to justify racism, continues to be part of healthcare today. Our understanding of health has been shaped by European colonisation and race science. We must unravel this. Through conversations with academics, activists and other health professionals, as well as my own experiences, I want to examine this story: the story of race and health. Across the world, race science is used to justify racism. In the United States, which exerts significant scientific and pharmaceutical influence globally, race science was (and is) used to justify segregationist policies. I often hear colleagues say that ‘science is objective’. But that is simply not true. Even science is influenced by social contexts. And when much of our scientific understanding originates in deeply racist, colonialist contexts, we must challenge it.

Covid-19 has reminded us that everyone’s health is connected, something we often conveniently choose to forget. Given recent events, if we all don’t examine the deep-rooted biases within our health institutions and spaces, health inequalities may actually worsen. But there are some people already challenging us to reimagine how we think about our bodies and our health. Almost twenty years ago, Linda Tuhiwai Smith, now Professor of Indigenous Education at the University of Waikato, penned *Decolonizing Methodologies*, drawing attention to the way that many of the methods used within Western-based research were formulated as part of imperialism, to support theories of

white supremacy. Drawing on her own experiences as an indigenous Maori researcher in New Zealand, Smith discusses how cultural communities were disposed of and new ones installed, fundamentally remodelling both their understanding of themselves and their relationships with each other. She underlines how decolonising goes beyond the academic: how the very act of researching one's own communities is a move towards self-determination.

Decolonising means different things to those in academic institutions and those working within grassroots community organisations, but there is some overlap: a desire to unravel the role of European colonisation, to examine how systems of race, class and gender have been shaped by this history and how we move to establishing a more equitable society. For some academic historians, decolonisation has traditionally meant the process by which countries become independent from colonial rule.¹ While many countries formally ended their colonial relationships several decades ago, these effects still resonate and are enacted on the global stage today, perpetuating white supremacy.

On 9 March 2015, fifteen years after Smith's book, Chumani Maxwele, a political science student, picked up a bucket of excrement, walked onto the campus of the University of Cape Town and threw the bucket at a bronze statue of Cecil Rhodes, proclaiming, 'Where are our heroes and our ancestors?' This act started a wave of conversations, and led to Black South African students forming the Rhodes Must Fall (RMF) movement. RMF sought to draw attention to the colonial conquests and segregationist policies of Cecil Rhodes. The presence of Rhodes iconography can be a harsh reminder of the persisting racial inequalities within South African society – as well as an indication that Rhodes's colonial ideas are still accepted. Apartheid – a system which saw Black South Africans confined to ghettos and

outlawed any interracial mixing – ended in 1990, but the legacy of this terrible system remains. Black South Africans still have a life expectancy fifteen years lower than their white counterparts, driven by infectious diseases such as HIV and tuberculosis, both closely associated with poverty.² The ripples of this movement are still being felt, as more and more students and academics begin to take seriously the effects of colonialism and Empire within their institutions.

In the UK, similar campaigning sprang up at the University of Oxford in November 2015, when a 300-strong protest called for the removal of a Rhodes statue at Oriel College. Protesters argued that the statue was a glorification of British colonialism, and that educational institutions failed to adequately educate on the violence and subjugation associated with the expansion and maintenance of the British Empire.³ RMF has become symbolic of the fall of white supremacy, a way of highlighting the perpetuating ideas of colonialism within our educational and academic spaces. We have to understand past atrocities in order to challenge the invasive and prejudicial beliefs that still remain ingrained in our society. But some people feel threatened by these conversations on our colonial history.

In response to growing decolonising movements around the world, many conservative commentators have argued that they are an attack on freedom of thought and speech. In 2020, Daniel Hannan, a former Conservative Party Member of Parliament for the European Union, wrote an article for the *Daily Telegraph*, claiming the RMF was ‘too silly for words’ – although he still seemed to think an entire article should be devoted to the topic.⁴ Hannan stated that ‘Cecil Rhodes is commemorated by Oriel because he left money to the college. Accepting that money in 1902, and honouring the benefactor, doesn’t mean endorsing his opinions today.’

He advised students to simply ‘move on’.

The problem, of course, is that it is very difficult to simply ‘move on’ when you see the prejudicial ideas of colonialists, like Rhodes, still embedded within institutions and being subtly enacted within our daily lives. Although not everyone agrees with the methods the RMF movement has taken, it has done more to educate a generation of students on the legacy of Rhodes and other white supremacists than the educational systems we currently have in place. William Hutton, the principal of Hertford College, Oxford, argued that a decision to move the statue means ‘treading carefully’, and that ‘Rhodes cannot be expunged from the history of Oxford, Britain and South Africa. What’s more, Rhodes cannot be regarded as a lone wolf, an especially abhorrent racist; the importance of race and breeding as explanations of good character were widespread within western culture in the late 19th and early 20th centuries.’⁵

Hutton is not wrong. While Rhodes was integral to the colonisation of South Africa, he was far from alone in his beliefs on white racial superiority. Over the last decade, I have been unlearning much of my medical education, and discovering the origins of scientific racism in European colonial expansion. When I speak to healthcare professionals, most, like myself, are so knackered from their day jobs that they never really interrogate the foundations on which their medical knowledge and guidelines are built. We are taught to celebrate measurement tools like the body mass index (BMI), created by Belgian mathematician Adolphe Quetelet, which tells us whether we are a ‘healthy’ body weight. But few of us are aware of some of the prejudicial beliefs that fuelled its invention and why there was a desire to establish a measurement for the ideal body type in the first place. Ideas that were driven by a desire to justify white superiority and colonialism still shape and inform our society and science.

A YouGov poll in 2016 found that 44 per cent of British people were proud of Britain's colonialist history, while only 21 per cent regretted what happened.⁶ It confirms what many already know to be true: the legacy of British and European colonialism is, at best, poorly understood by many – and, at worst, still openly celebrated. The establishment of RMF inspired many, including myself, to start exploring the effects of imperialism and colonialism on our own work, and once I started looking, what I learnt was staggering.

Of course, part of the problem is that European colonial history is so badly taught that most people do not understand just how much of society has been shaped by it. At school, we were taught to celebrate the British Empire, instead of to challenge it. Mainstream publishers have, on the whole, overlooked our stories. Phenomenal books have existed, on the fringes of the publishing industry, like *Heart of the Race: Black Women's Lives in Britain*, published in the early 1980s, which explored the experiences Black women in Britain face, particularly in navigating health and social care. In recent years, a number of bestselling books have shown that there is more and more demand to understand the complex history of race and colonialism, especially in the wake of the Black Lives Matter movement. *Black and British: A Forgotten History* by David Olusoga filled a much-needed gap in understanding the history of Black British communities, raising awareness on how the significance of 'Blackness' has consistently altered over the last few centuries. Reni Eddo-Lodge's multi-award-winning and *Sunday Times* no.1 bestseller *Why I'm No Longer Talking to White People About Race* was a breakthrough when it was published in 2017: she expertly simplifies the very specific type of racism that must be endured by so many Black British people. Having spent many years enjoying Akala's music, I was particularly pleased to read his account of growing up in England and navigating the educational

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system in *Natives: Race and Class in the Ruins of Empire*, where he credits the role of Black supplementary schools in ensuring he received a well-rounded education and built his self-confidence. And in 2019, Angela Saini's *Superior: The Return of Race Science* helped shed light on how the invention of race science continues to be weaponised to maintain racial divides. These books, and their successes, have opened the door for many more voices within mainstream publishing, as well as demonstrating a growing interest in books that address race and identity.

One of the last in-person panel discussions I did before Covid-19 lockdown measures came into place in March 2020 was with Reni Eddo-Lodge on reproductive health in the UK. It was focused on Black women and reproductive health, hosted by the (amazing) charity Bloody Good Period. Reni reflected on her own experiences with great honesty, speaking about the difficulty of navigating healthcare as a Black woman. Audience members added to the discussion on mental and reproductive health. Some recounted facing the same issues their mothers and grandmothers had. They wanted to know why the health system didn't seem to work for Black patients and, ultimately, why racial inequalities remained so stark. It became clear to me, at that event, that there remains so much mystery about medicine and health, particularly among those that are racially marginalised and in financial difficulty. Medicine has, historically, been the domain of middle-class white men, and while the medical profession has become more inclusive, this history inevitably is embedded in our mindsets, systems and processes.

I didn't – initially – pay much attention to history as a medical student. But I remember the first time I realised our history affects our current practice. We were in a lecture on joint conditions. My mind sometimes wandered during lectures, but suddenly this lecturer mentioned something that piqued my interest. He spoke

about ongoing efforts to rename eponymous syndromes, such as Reiter's disease (a condition which causes inflammation of the joints, now called reactive arthritis), that had originally been named after Nazi scientists. Hans Conrad Julius Reiter was a doctor integral to the Nazi Racial Hygiene Programme, which involved the forced sterilisation and euthanasia of Jewish communities, Roma Gypsy communities and people with disabilities, among others. What is it like to receive the diagnosis of Reiter's disease, when it is named after a person who tortured people like you? The lecturer painted Reiter as a lone wolf, a single rogue doctor: he didn't explain where these ideas on race science had emerged, or how widespread they were. But these individuals were not rogue, they were following a well-trodden path of scientific exploitation and race science that was established as part of European expansion from as early as the seventeenth century.

And so, spurred on by these snippets of passing information and moments of realisation, I started to explore the history of medicine within my own specialty, sexual and reproductive health. I wanted to find out more about its history, and how this affected current practices. As a medical student and later an SRH trainee, I occasionally heard colleagues and patients express prejudicial views – Black people are hypersexual, they would say, or Asian men don't have a high sex drive, or even Black people labour more easily in childbirth. I remember an awkward encounter with a young white woman who was keen to inform me that she only had sex with Black men because they had large penises, had a high sex drive and so performed well in bed. I tried to challenge the generalisations she had made but it was a short consultation, and this was clearly an idea that had formulated over several years. I wanted to understand where these ideas came from and to shed light on how these ideas led to poor health today. As a sexual and reproductive health doctor,

the racial disparities in my own sector are striking, particularly among the Black community: Black women are four times more likely to die in childbirth in the UK,⁷ 80 per cent of women accessing HIV services are non-white,⁸ infertility-causing sexually transmitted infections like gonorrhoea and chlamydia are ten times more prevalent in some Black communities.⁹ The reasons for these racial disparities are multi-factorial, but usually linked to social deprivation and economic inequalities. And while these sociocultural contexts are frequently dismissed and overlooked, the historical context is entirely absent from our conversations.

As healthcare professionals, we're often so focused on learning new clinical information that there isn't time to consider the wider flaws within our healthcare systems. For example, we are aware that young Black men are ten times more likely to be diagnosed with schizophrenia than their white counterparts but are very rarely diagnosed with depression. But nobody stops to consider how racial tropes on aggression might come into play here (I dive into this in Chapter 7). Global health is entirely defined by neocolonial relationships, where the world's poorest countries remain indebted to governments and wealthy donors in the Global North (as I discuss in Chapter 9). This was clearly illustrated during the pandemic, as countries who helped manufacture huge quantities of the Covid-19 vaccination, and took part in clinical trials, then struggled to acquire adequate numbers of the vaccine for their own population.

When I started my *gal-dem* column in early 2020, I set out to broaden understanding on how colonialism, race and healthcare interact. I could never have imagined that the combined tragedy of the Covid-19 pandemic, with so many lives being lost disproportionately from racially marginalised backgrounds, and the renewed focus on Black Lives Matter, would place a sharp lens on racial inequalities in healthcare. The topic had

been neglected for far too long. To overcome a global pandemic, countries and communities needed to operate collaboratively and the health behaviours of some of the world's most marginalised communities mattered greatly. Low vaccine uptake among Black communities has become a particularly contentious issue; Black communities are more likely to work in low-paid, public service roles with high exposure to the virus, making us more vulnerable to contracting the virus. Vaccine hesitancy among this same group remains high. A long-established distrust of the medical profession has become ever more apparent.

In June 2020, the decolonising movement was pushed into the limelight again, as protesters marched in Bristol town centre, toppled a statue of Sir Edward Colston, a slave trader, and dragged it into the sea. Within the next few days, every major news channel and newspaper was covering the incident and the history of Colston. Removing Colston's statue wasn't a new idea: since the 1990s, activists and academics have campaigned to ensure that there is adequate education on Bristol's links to the transatlantic slave trade; this has led to a permanent exhibition in one of Bristol's museum spaces.¹⁰ Over the years, there have been multiple petitions from Bristol citizens asking that Colston's statue be removed and replaced with something unifying rather than divisive, but these calls for action have been ignored.¹¹ Campaigners were told that Colston's legacy was not important, and that there was a lack of motivation to contextualise the statue or his legacy. But this all changed as 2020 unfolded; the clip of the murder of George Floyd, which circulated on social media and was viewed by millions each week, sparked a wave of Black Lives Matter protests across the world. Overnight, people who had previously had little awareness or interest in colonial history suddenly knew far more about Colston and his slave-trading past than long-standing campaigners could have hoped for. Now that

more people are waking up to the most unpleasant part of Britain's history and how it continues to shape the world around us, we need to develop ways to contextualise and rebalance the inequality it has helped establish.

At the same time, the Covid-19 pandemic was sweeping across the globe – first identified in Wuhan, China, it then spread rapidly across Europe, impacting Italy and then much of Western Europe, including Britain. Throughout April 2020, each morning brought fresh speculation from TV and radio, as policymakers and scientific experts debated how Britain may be affected by Covid-19, and which communities needed protecting. I saw first-hand how neocolonial narratives continued to play out within discussions of health. There were those who speculated that Black people may somehow be immune to Covid-19, due to the lower caseload in sub-Saharan Africa and assuming colonial myths that Black skin denoted exemption.¹² It appeared far easier for social commentators to believe that *all* Black people had innate immunity, rather than credit the preparedness of some African countries due to their handling of previous pandemics such as Ebola, or even consider whether the warmer climate might make a respiratory illness less likely to thrive. Then there were those senior government ministers who leaned into the narrative of 'survival of the fittest', arguing that we should not implement any lockdown measures as 'only' the elderly and those with 'pre-existing' health conditions would be affected. These dangerous narratives hurt everyone and were wildly inaccurate in any case. But as the pandemic unfolded, it was clear that there were other communities who were being severely impacted: racially marginalised communities, those living in deprived communities, those with low-paid jobs and those who were unable to work from home. Most of the time, these groups overlapped. Within the first few months of the pandemic, many nurses who had

migrated to the UK from the Philippines had lost their lives due to Covid-19. A significant number of them had been directly recruited to work here, enticed by better salaries and greater security for their families. For the first time, people inside and outside medicine were confronting some uncomfortable truths regarding health inequalities – notably, that it is impossible to disentangle the state of someone’s health from the socio-economic conditions of their life.

As the death toll of Covid-19 rose, it became obvious that the burden of this disease was not evenly shared. The first twenty members of the National Health Service (NHS) staff who passed away all belonged to the category Black, Asian and minority ethnic (BAME) – that is, non-white people. Academics, TV pundits and politicians twisted themselves in uncomfortable circles to explain how, scientifically, we could account for why those of predominately non-European ancestry appeared to be disproportionately experiencing worse Covid-19 outcomes. There was considerable time and money spent researching the idea that all BAME people had a genetic flaw, making them more susceptible to Covid-19, despite high death rates among groups possessing vastly differently origins.

Rather less attention was paid to the structural inequalities that led to poorer health, and even less was devoted to discussing how the healthcare community responds to the needs of different communities. Belly Mujinga’s story encapsulated this. Mujinga was a Transport for London worker, who died of Covid-19 shortly after being spat at alongside her colleague Motolani Sunmola. According to staff at the station, Mujinga had not been provided with any PPE, not even a mask, despite requesting to work in an enclosed space due to her respiratory issues. Instead, she was made to work on the concourse with no protection. On 21 March 2020, she was working at Victoria

Station when a passenger approached her, told her he had the virus, then spat at her. She was taken ill with Covid-19 and died in Barnet Hospital on 5 April. In the wake of protests, Mujinga became the face of the Black Lives Matter movement in the UK. We don't know whether the attack was racially motivated, but Mujinga's story represents a historic dynamic among Black diasporic communities in the UK. Protesters argued that Mujinga's case highlights how little has changed since the sixties, when people travelled from the Commonwealth, particularly the Caribbean, to support public services, yet struggled to access these same services themselves. Why were staff in frontline professions not provided with adequate PPE? A fundraising page was set up to donate money for Mujinga's children. In the wake of the protests around George Floyd, Mujinga and the Colston statue, academics and medical professionals began to pay attention. There were more articles on racial health inequalities in leading medical journals like the *Lancet* and *British Medical Journal* than before.

Like the UK, the US was similarly affected: in cities like Chicago, with a big Black population, higher losses were reported during the first wave of the pandemic compared to white Chicagoans. Other hard-hit countries, such as Brazil, showed large deaths tolls particularly among their poorer Black communities living in the favelas. Yet in some sub-Saharan African countries, using strategies learnt during the Ebola outbreaks, they were able to report far fewer Covid-19 cases.¹³ But mainstream media continued to claim that race was a biological reason for poor Covid-19 outcomes. Of course, so-called 'BAME' groups in both the UK and US are not a homogenous entity: these groups possess vastly different ancestry for a variety of reasons, such as migration, colonisation and population mixing. The only thing binding them together is the classification as non-white. The idea

that something biological binds together all non-white groups, a group which itself has changed over the centuries (as I'll discuss in the next chapter), is so routine within science that the lunacy of it all goes relatively unchallenged. And what is considered biologically normal is the average white, male body, with every other body being measured in proximity to that. This all has its origins in colonial science. We must understand this history, to make sense of how these ideas are regurgitated today.

On 21 January 2021, during the third lockdown in England, Home Secretary Priti Patel declared during a breakfast interview that the UK now had the highest death rate from Covid-19 in Europe, partly because 'some ethnicities are more susceptible to death'.¹⁴ This is not true. There is no conclusive evidence to support the claim that *all* racially marginalised groups are more susceptible to dying from Covid-19. What we do know is that they have been dying in far higher numbers, much like those seen among white working-class communities.

Instead of examining the structure of our healthcare institutions and spaces, attention turned again to genetic causes. Was there one biological gene that all non-white people shared? Was it because they were more likely to be obese or have blood pressure concerns? Perhaps it was their shared lack of vitamin D? While some of these things may play some role in worse Covid-19 outcomes, they are clearly not the main culprits. Rather, those who are racially marginalised are more likely to live in overcrowded housing, often juggling multiple lower-paying jobs to make ends meet and less likely to find the time to attend doctor's appointments. Long before Covid-19, health research has consistently prioritised the biological rather than the social, despite mounting research that this drives the greatest health disparities. Many of my peers would rather discuss the elusive silver bullet – a faulty lung receptor – than confront the fact that a

significant proportion of the racial disparities are due to the racism present within our society and the history of race science within our practice. Of course, we cannot divorce the motivation for medical interventions from the capitalist motivations of the pharmaceutical industry; creating medicines, particularly those that target a specific demographic, has become a lucrative business. In 2005, BiDil, the first medication targeting African Americans for high blood pressure was launched, but it later emerged that the data to support its use was scanty, and even the targeted group ‘African American’ had been poorly defined. Pharmaceutical cures are, of course, important. But as medical professionals, our job is to look at all the possibilities. At times, when we do not know the exact diagnosis, we must treat different things simultaneously in the hope that one of them will make our patient better.

In *Divided*, I offer an alternative diagnosis. We are at a moment of reckoning. As a global community, we must establish a detailed understanding on how colonialism and race science operate within healthcare if we are to achieve more equitable health outcomes. It is very tempting to simply plaster over the cracks of racial inequality, such as a recent suggestion made by policymakers that Black women be offered an induction of labour earlier than their white counterparts, to help counter the higher maternal death rate in the UK. But in this book, I want us instead to ask *why* – why, for instance, are Black women dying disproportionately during pregnancy? What is the historical series of events that have led to this? For too long, health inequalities and racial inequalities have been attributed to some deficient behavioural or biological flaw among marginalised communities, with minimal reflection on the wider healthcare system in which they have emerged.

Divided provides one perspective on how colonialism, race

and healthcare interact. I want to examine how ‘Western medicine’, as it is commonly referred to, has been shaped through colonial thinking and ideas of race science – and, hopefully, how shifting our perspectives may reduce health inequalities.

As both a practicing clinician and academic, I am continuing to learn and look for solutions. *Divided* is the culmination of my journey so far. After several years of lecturing medical students as well as facilitating ‘outreach’ projects for racially marginalised groups, I felt compelled to write this book – so many of the questions that I am asked by students, my peers and members of my community can’t be fully answered in a lecture or at an event. I remember a medical student picking up on a point I had made regarding the contraceptive patch: why are they only produced in a single shade of salmon, which is clearly unsuitable for most skin tones? To answer this question comprehensively, I had to delve into why whiteness is centred in our medical research and even how our medical technologies are created. This book is part of my journey to understanding some of the racial problems that lie at the heart of medicine and what we can all do to start to remedy them. I hope it will encourage those that work within healthcare or are just embarking on their career to challenge more and blindly accept less. For those that are simply interested in understanding more about healthcare, I wish to shed light on some of the greatest complexities and contradictions in the system. If the years of living through a global pandemic have taught us anything, it is that few things are fixed, many things are mutable, and if we collectively push hard enough then we can move towards change.

I hope that this book will encourage more people to consider areas that desperately need to be reimagined and improved upon. *Divided* is a story of unlearning, with three key areas of focus. Firstly, I will examine how the idea of a ‘normal’, healthy

body is understood through the legacy of the transatlantic slave trade and European colonisation. Secondly, I will explore the ways in which science, medicine and healthcare continue to reinforce inequality by abiding to those same systems of understanding. And finally, I will delve into stories of individuals and organisations that are building a better vision for healthcare.

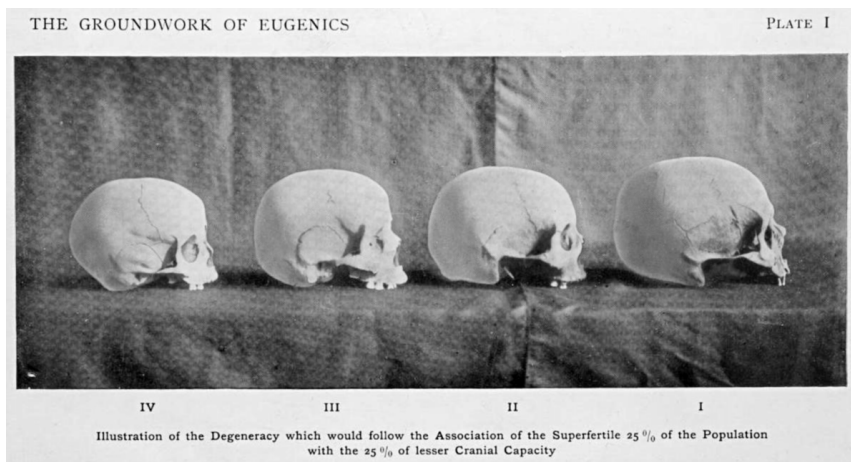
Within this book, I will utilise the term ‘racially marginalised’ to refer to groups that are racialised as non-white within predominantly white majority countries. On occasion I will use the terms Black or people of colour, where appropriate given the context of the questions, research or interview at hand. Within the UK, the term BAME is frequently used within research and policy to denote those racialised as non-white; this is also used by some activists as a coalition term in the fight against racism and so I will use this term within those contexts. Often, when I refer to racial disparities in various fields of healthcare, I use the terminology of the studies I cite.

I also want to acknowledge that much of the scientific research that I draw on in this book ignores the additional barriers that those who are gender non-conforming face when accessing healthcare. Most studies fail to account for these communities, reinforcing the idea that they do not exist. We must begin to incorporate gender non-conforming individuals into our research to ensure that they can access the healthcare that they deserve.

I’ve written this book through the lens of my experiences of being educated within a British medical system as a Black British doctor, working in the NHS and the huge privileges this affords. In sharing my story, and the story of race and health, I hope to shine a light on those who are sidelined within our current medical system and to begin a conversation on overcoming barriers to equitable healthcare today.

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COLONIALISM, RACE AND HEALTH



An illustration from *The Groundwork of Eugenics* by Karl Pearson, 1912. This intends to demonstrate the ‘degeneracy’ that would follow if those with ‘lesser’ cranial capacity had children with those who were considered ‘superfertile’.

