Medicine for All? by N'joula Agnes Baryoh and Ngozi Katharina Odenigbo from https://blackinmedicine.de

1 What is the problem / the void?

After the terrible events of the Second World War, the General Assembly of the United Nations met and declared human rights with the Charter. In 1948, three years later, the various articles of the resolution not only defined human rights, but also the protection against disadvantage and discrimination on the basis of race, thus condemning racism. Nevertheless, there was no fundamental change in ideologies after the war, certainly also due to personnel continuities, for example in medicine and teaching.

Historically, great philosophers and scientists such as Kant, with the introduction of his "race theory" and the establishment of a racist scale of values, as well as Hegel, one of the most influential thinkers of modern philosophy, who also had a great influence on European intellectual history and consequently on world history through his work, had shaped these patterns of thought. Another scholar and writer, Arthur de Gobineau, wrote a four-volume essay in the mid-19th century on the inequality of the human races - which he categorised into white, yellow and black and in which he attempted to justify the superiority of the "Aryan" human race. The National Socialists later used this work, among others, to legitimise their ideology - Gobineaus' ideas can even be found in part in Adolf Hitler's "Mein Kampf". The "racial ideology" had found its way into medicine by the middle of the 19th century at the latest. The so-called Social Darwinists, who established the law of nature with the thesis of "survival of the fittest", and later the even more radical racial hygienists and eugenicists, not only held the view that there was a genetic superiority of the white "race", but also substantiated and disseminated this theory pseudo-scientifically.

This racial ideology in turn was the root and at the same time the justification for, for example, the atrocities committed by colonial tropical physicians (more on this later). Even today, Black people and people of colour suffer from existing stereotyping and discrimination in the context of healthcare. This results in unequal medical care. Black patients often report that their pain was not taken seriously in the context of their medical care. For women*, it was often the situation surrounding the birth of a child. Here they were denied their pain. They reported that the analgesic therapy was not sufficient. "You're African, you must be able to do it." This is a sentence that a Black woman with a migration background from Hamburg, who works in the healthcare sector herself, had to listen to while she was in labour. After an incorrectly administered epidural anaesthetic, she was still suffering from severe pain during the birth and asked for more painkillers. She was denied this with this very statement. Some people may regard such experiences as coincidental. However, if we look at the history of medicine, it becomes clear that Black people have been denied the ability to feel pain and that Black bodies have been used as objects of experimentation for centuries. If we focus on the history of gynaecology, we cannot avoid the name James Marion Sims (1813-1883). Sims was an American physician and surgeon, the so-called "father of modern gynaecology". He is known for developing a surgical technique to repair the vesicovaginal fistula, a condition in which urine leaks through the vagina. He is also known for the "Sims speculum", a gynaecological instrument for examining the vagina. His work was deeply rooted in the slave trade. By treating the human property of slave owners, the aim was to maintain the enslaved women's ability to produce and reproduce. From 1845 to 1849, James Marion Sims tested surgical techniques on enslaved

African-American women - mostly without their consent and without anaesthesia. Enslaved women were used as human test subjects. These experimental surgeries were unethical and cruel and caused immeasurable harm to dozens of enslaved women. One young enslaved woman, Anarcha Weskott, suffered from a rectovaginal or vesicovaginal fistula. She received 30 operations by Sims. The first when she was pregnant at the age of 17, and others until the fistula was finally closed. Another enslaved woman, Lucy, suffered from incontinence since the vaginal delivery of her child. Lucy had to undergo operations in extreme pain while dozens of doctors looked on. Another woman named Betsy had similar experiences to Lucy and Anarcha Weskott, and it is now known that the surgery was not consensual. Forcibly handcuffing women before operations was not uncommon.

The "Mothers of Modern Gynaecology" is a movement of protest against the violent methods of Sims, the so-called methods of Sims, the so-called "father of modern gynaecology". The aim of the movement is to honour the contributions to science made by Lucy, Anarcha and Betsy: "If you've ever had a Pap smear, you have Anarcha, Lucy and Betsey to thank." The statue of the doctor James Marian Sims stood in New York's Central Park until April 2018. Its removal was achieved through the work of a commission set up in 2017 to evaluate the statue Science has not fulfilled its role as a critical corrective for centuries. Rather, academic disciplines such as botany, (tropical) medicine, geography, anthropology, ethnology and linguistics have laid the foundations for the exploitation of human life. Although there is no biological basis for the division of people, the notion of "race" and the categorical distinctions ascribed to it have shaped the modern world in fundamental ways. Our perceptions and realities are still structured by the concept of race today.

Racism was established as a social system of order. It became the justification for the dehumanisation of Black people, which became effective in the transatlantic slave trade and in the colonisation of large parts of the world. Doctors such as Claus Schilling, Eugen Fischer or better-known, important names such as Rudolf Ludwig Karl Virchow, Robert Koch etc. committed numerous crimes against Black people in the age of German colonialism through their medical work, legitimised by science. Accordingly, dealing with racism in medicine means, on the one hand, coming to terms with the colonial legacy and, on the other hand, promoting Black perspectives in medicine makes it possible to raise awareness of discrimination in the healthcare system, as well as inclusion analogous to our globalised world in development policy work, whether in North-South or South-North contexts.

2 What needs to change?

A study carried out in the USA in 2016 with American medical students in the USA in 2016 found that 40% of students believed that black people had thicker skin and were less sensitive to pain. 12% of the students even believed that Black people had fewer nerve endings and were therefore able to withstand more pain. Furthermore, another phenomenon, the adultification of Black children and adolescents, leads to poorer analgesic care for the younger patient group. Adultification denies Black children the notion of innocence and vulnerability. Systemic racism and prejudice force Black children into social, emotional and physical adult roles before they are even adults. Another study from 2012 found a link between the unconscious racial bias of paediatricians and the bias of paediatricians and the way they treat pain in a simulated African-American or white child. Simulated African-American or white teenager after surgery: With As the strength of the implicit bias of the doctors in favour of the white teenager bias in favour of the white teenager, the likelihood that they

would prescribe the Black teenager Black adolescent* with an appropriate painkiller. In addition, a meta-analysis of over 20 years of studies addressing many causes of pain in numerous areas found that Black or African-American patients were 22% less likely to receive pain medication than white patients. These are alarming figures, as medical students will one day become practising doctors or those already working as professionals have long had responsibility and decision-making power over other people, including Black patients. With the existence of such beliefs, it is easy to understand why Black people repeatedly experience that their pain is not taken seriously.

The violent statement of the attending physician to the above-mentioned Black woman from Hamburg while she was in labour here in Germany "You are African, you can bear it" is a continuity in the history of the dehumanisation of Black people. A continuity of the attempt to justify one's own atrocities in the context of enslavement and the experimental trials on children, women and men, Black bodies. It cannot be viewed in isolation from a racist colonial continuity. The reappraisal of discriminatory convictions and structures inevitably includes the the study of medicine, as the example above makes clear. It requires critical examination of the curriculum taught during the degree programme. There is a lack of awareness of racism as a determinant of health and illness, not only in teaching but also in practice. Teaching about this, i.e. the mechanisms and consequences of the experience of racism on health, is of enormous importance in order to enable equal access for all patient groups in the German healthcare system. It is now scientifically proven that trauma and stress triggered by racism, so-called "racial related stress", makes people ill and leads to a clinical picture that is similar to post-traumatic stress disorder. There is now even an internationally recognised ICD code for cataloguing "racial trauma" in medicine. In Germany, this is the additional designation Z. 60.5: Target of hostile discrimination and persecution.

It is a first, but big step in making this problem visible at a higher level (e.g. health insurance companies) and forces the assumption of responsibility, e.g. also financially, because as the examples and results in this and the previous section show, almost all study results come from the US context. Here in Europe, there is still scientific work on the topic of anti-Black racism in medicine in the UK.

In Germany, the Afrozensus 2020 study, jointly conducted by Each One Teach One and Citizens for Europe, was the first comprehensive study to shed light on anti-Black racism in the healthcare system, among other areas. With the "Blackness in Medicine" campaign, the Black in Medicine association has for the first time started to create a database to document incidents of anti-Black racism in the context of the German healthcare system. It is important, even if the US context is somewhat different in terms of the migration history of the African diaspora, to draw on these findings, as Black people of African origin and descent are already suffering greatly from the effects of anti-Black racism in this country, as the findings of the German Centre for Integration and Migration Research (DeZIM), as well as the current study by the EU Agency for Fundamental Rights (FRA) "Being Black in Europe" show. Because the root of the discrimination and racism that Black people experience, both in the USA and here in Europe and not to forget on the mother continent - as I call Africa or the Global South, as others call it - is and remains the same.

In this context, it should not go unmentioned that students* and specialists in social and medical professions are deployed to various countries in the Global South via secondment programmes. On the one hand, this is without a critical examination of the individual motivation; on the other hand, the development-policy institution and its structures and thought patterns must always be scrutinised. Here, for example, it is common practice that staff, regardless of their specialism, are

often strictly prohibited from having personal contact with so-called "locals" and are even punished for doing so. . It literally cries out for critical whiteness workshops, e.g. to investigate one's own white saviour or white superiority complex.

3. how can something change?

As healthcare professionals, we must not only individually and collectively face unpleasant questions unpleasant questions such as: Who is doing research with a supposedly "objective" view? Who is researching with what interest? Who are the research subjects? In what tradition do we learn? Where does our knowledge come from? Why do certain groups of people perhaps have fears or reservations about medicine? etc.? Clinical research with specific questions is needed, both in the form of qualitative and quantitative studies. This is the only way to improve healthcare for BIPOC in the long term. But in general, Germany is behind the USA in terms of conducting clinical trials, with Spain leading the way. We not only have to honestly question our own positioning and privileges as private individuals or institutions to make the epistemic violence visible. Another necessary step would be active listening. This means providing resources and creating spaces must be created where those affected and their experiences can be voiced and recorded in writing (e.g. and recorded in writing (e.g. complaints management on racism). On the one hand, this is the only way to record the perspectives of those affected without judging those who are not affected and, on the other hand, it makes it clear that these are not isolated cases.

Intercultural competence, as well as diversity and racism sensitivity, i.e. the ability to to recognise different (man-made) structures of inequality (such as skin colour, ethnic origin, sexism, heteronormativity colour, ethnic origin, sexism, heteronormativity, classism, ableism, etc.) that exist in our society should be a firm prerequisite for obtaining a training or study qualification in the degree in the healthcare sector. The same applies to the "onboarding" of full-time staff or volunteers in development policy work. Furthermore, regular further training should be obligatory in the course of professional life in order to ensure consistent knowledge transfer and confrontation with existing stereotypes. Supporting instruments for this could be anti-discrimination centres and the appointment of anti-racism officers in all state medical associations and healthcare institutions. (please note: the equal opportunities officer is NOT the same as an anti-racism officer). This also enables the referral of healthcare professionals and patients to qualified counselling centres in the event of experiences of racism in the context of healthcare, which in turn represents an important support measure for taking legal action if necessary.

Critical Whiteness seminars at medical faculties, hospitals and healthcare institutions as part of quality assurance should also be considered. Just as there are standard operating procedures (SOPs) in medicine, standards for behaviour and responsibility in this area should also be defined and established. After all, it is our responsibility to recognise and name violent connections and colonial continuities in science as well.

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