How COVID-19 Exposes the Isolation of Minorities in America

Home to the United Nations Headquarters, over one million Asian Americans, and 800 languages, New York’s diverse nature is an attractive force for many cultural-seeking Americans. However, celebrated as ‘the city that never sleeps,’ New York City, New York, has come to an eerie, abrupt halt amidst the coronavirus pandemic. The once-thriving Chinatown neighborhood is now vacant, with customers driven away by a xenophobic fear that eating Chinese food will lead to contracting the virus. Despite the population being composed of 29% of white citizens, minority groups like Hispanic and Black people have contracted the disease at higher rates, 34% and 28% respectively (Renton, et al). The current coronavirus pandemic has emphasized the striking health disparities in and injustices against minority communities. In a previous essay, I discussed restricted interactions between physicians and patients, consisting of the physician’s jargon and unrelenting orders, contributing to the rift in physician-patient communication. This lack of communication may stem from a physician’s lack of interest, a patient’s inability in describing their symptoms, or an actual language barrier. Unable to share their history and symptoms properly, already minoritized voices are excluded from receiving proper, receptive care. This form of patient abuse only feeds further into their ostracization from society. This essay will focus on how minority groups are excluded from adequate healthcare and education systems, as well as proper resources. Consequently, they are more likely to seek assistance from institutions that neglected their needs in the first place.

News sources in America began to cover the disproportionate rate at which the coronavirus affects minority groups. The CDC released a report that “included race and ethnicity data from 580 patients hospitalized with lab-confirmed COVID-19 [and] found that [...] 33% of hospitalized patients were black compared to 18% in the community and 8% were Hispanic, compared to 14% in the community. These data suggest an overrepresentation of blacks among hospitalized patients” (“COVID-19 in Racial and Ethnic Minority Groups”). Compared to the white community, Black people are at higher risk of contracting the coronavirus and inevitably falling deathly ill. A CBS article tries to make sense of the stark racial differences between infections and mortalities; “Experts say African Americans are more likely to live in poverty than almost any other race. Disparities among socio economic statuses also impact access to quality healthcare, nutritional foods, education and job opportunities” (Barden). The institutionalized methods in which minority groups are excluded from proper academic, nutritional, or medical care all contribute to the contrast between white and Black mortality rates. The inability to purchase healthy, fresh foods make minority groups more at risk for certain underlying conditions, such as diabetes. With these people isolated from the privileges of the hegemony, their conditions often worsen as professional and adequate medical assistance is physically or financially not practicable. Vice president and chief equity officer at Massachusetts General Hospital Joseph Betancourt further notes,

You think about [...] individuals who live in housing with multiple family members, individuals who didn't have the luxury of working from home and had to take public transportation to work, individuals who are essential workers in places like ... supermarkets and other areas where they're exposed to a lot of people. What we know is those – what we call social determinants, socioeconomic status, the environment, housing, all those factors, absolutely contribute to disparities that we see already and absolutely are the perfect substrate for the spread of a respiratory infectious disease, and minorities are disproportionately represented among those individuals who live in those conditions. (Alston and Dearing)

Marginalized populations often live in conditions that fuel ill health, leaving them vulnerable to infections like COVID-19. If contracted, they face the trouble of accessing affordable medical care. The CDC
summarizes the primary factors that play a role in disproportionate rates among various rates: living conditions, work circumstances, and underlying health conditions. Marginalized groups often live in densely populated areas where work is abundant; however, with an airborne disease, city living can prove deadly. Moreover, they compose a significant amount of the ‘essential’ workforce; “Hispanic workers account for 17% of total employment but constitute 53% of agricultural workers; Black or African Americans make up 12% of all employed workers, but account for 30% of licensed practical and licensed vocational nurses” (“COVID-19 in Racial and Ethnic Minority Groups”). Often, these employees are not granted paid sick leave or healthcare; thus they are left to fend for themselves if they fall ill to the disease. Ultimately, these realities, coupled with systemic inequalities, contribute to conditions that further endanger these populations. Unfortunately, the disproportionate effects of COVID-19 stem from deeply rooted, historical abuses of minority groups.

One of the most notable cases of medical injustice is the story of Henrietta Lacks; Henrietta Lacks was an African American who suffered from cervical cancer. Without her knowledge, her cells were taken and immortalized to foster a plethora of medical research projects, most notably contributing to the polio vaccine and space missions. However, the monumental benefit her cells were to society was not felt by her impoverished family who, along with other African Americans in society, could not afford the medicine their mother’s cells were stolen to create. The full story of Lacks’ life is investigated in The Immortal Life of Henrietta Lacks by Rebecca Skloot, which draws on qualities from journalism, ethno-graphy, and other writing methods to craft her narrative.

As a Black woman in a segregated country, Lacks is viewed by the hegemony as an ‘other’ and excluded from professional medical care. When she first discovered the lump on her cervix, her husband had to drive, “nearly twenty miles to get [to Hopkins], not because they preferred it, but because it was the only major hospital for miles that treated black patients. This was the era of Jim Crow—when black people showed up at white-only hospitals, the staff was likely to send them away, even if it meant they might die in the parking lot” (Skloot 15). Lacks physical isolation from white patients mirrors her ostracization from proper care, enforced by institutionalized discrimination in society. Black families struggled to attain middle-class status as Jim Crow barred them from holding stable, well-paying jobs. In order to receive any care at all, they were subjected to trusting an institution established by people who viewed these minorities as inferior. Skloot admits,

There’s no way of knowing whether or how Henrietta's treatment would have differed if she'd been white. According to Howard Jones, Henrietta got the same care any white patient would have; the biopsy, the radium treatment, and radiation were all standard for the day. But several studies have shown that black patients were treated and hospitalized at later stages of their illnesses than white patients. And once hospitalized, they got fewer pain medications, and had higher mortality rates. (Skloot 64)

While white people had easier access to adequate medical facilities, poorer Black families had to endure their symptoms until they became unbearable. As a direct result, Lacks’s cancer had more time to invade her body, making her recovery almost impossible. Just like the current pandemic, Black patients received the same care as white patients but suffered from higher mortality rates. The underlying conditions responsible for these deaths stem from a systemic exclusion from proper nutritional options and medical care. Ironically, the immense contribution of a Black woman’s cells to medical discoveries, used primarily on richer white people, only further emphasizes the exclusion of Black people from medical care. As Lack’s son Zakariyya summarizes, “Them doctors say her cells is so important and did all this and that to help people. But it didn’t do no good for her, and it don’t do no good for us. If me and my sister need something, we can’t even go see a doctor because we can’t afford it. Only people that can get
any good from my mother cells is the people that got money, and whoever sellin them cells-they get rich off our mother and we got nothing” (Skloot 246-7). While Lacks’s cells are being used for the better and to help many people, the white people they are benefitting only shun Black people from society. Deborah reiterates, “Truth be told, I can’t get mad at science, because it helps people live, and I’d be a mess without it. I’m a walking drugstore! I can’t say nuthin bad about science, but I won’t lie, I would like some health insurance so I don’t got to pay all that money every month for drugs my mother cells probably helped make” (Skloot 256). The benefit of HeLa cells to society was immense, however if minorities cannot even benefit from the groundbreaking treatments and discoveries they are responsible for creating, then there is little value to the medical effectiveness.

As long as the hegemony neglects injustices against minority groups, they are leaving these groups vulnerable to disproportionate, deadly effects in pandemics like the current coronavirus crisis. Fluid and comprehensive healthcare programs are vital to provide the most efficient and responsive medical treatments.


