Cruelty and Health Inequity

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Recent events, including hate crimes perpetrated against LGBTQ + Americans, racially motivated beatings of older Asian Americans, and President Trump's dining with anti-Semitic extremists, bring near-daily reminders that cruelty and animus directed at minoritized groups remain widely tolerated, and sometimes even celebrated, realities of American life.[1]

Wounds inflicted by this cruelty are inevitably carried into health care settings, too-often perpetuated by the inadequacies of our recognition and responses. To be sure, health inequities and structural racism often arise from institutional and systemic factors rather than any specific person's conscious malevolence. Recognizing these impersonal, structural forces remains a key insight of epidemiological and social-science research. Yet this valuable focus on systems and structures creates its own blind-spots. Abstract discussion may lead us to overlook lived human experiences of animus and cruelty, and the reality that such sentiments provide motivation and political backing for intentionally harmful interventions, practices, and policies.

Over 30 years ago, two of us (M.H.C., H.A.P.) took courses on modern political ideologies taught by distinguished political philosopher Judith Shklar. She posited that human cruelty, "the deliberate infliction of physical, and secondarily emotional, pain upon a weaker person or group by stronger ones in order to achieve some end," is the deepest sin of our common political life, and arguably the greatest danger facing billions of people worldwide.[2,3]

Shklar's life experience supported this proposition. Born Jewish in 1928 Latvia, she narrowly escaped cruelties of Nazism and Stalinism. Upon Shklar's passing in 1992, Harvard Professor Stanley Hoffmann described her resulting perspective: "She once wrote that there are two kinds of political scientists: those who study power because they like to exert it and those who study it because they fear it – those who would like to ride the horse of power and those who are scared of being trampled by it."[4]

Shklar understood that cruelty, especially its tolerance by others, is a powerful driver of coercive and oppressive mistreatment of marginalized persons. This understanding must inform today's discussions of health equity. Examples of such cruelty abound. One of us (M.H.C.) was a medical student in San Francisco during the late 1980s, when hospital wards were filled with stigmatized gay men and people who inject drugs dying of AIDS. Many Americans felt little empathy or urgency regarding the carnage. Prominent commentators declared that these dying patients deserved their fate, bringing this plague on themselves through immoral behaviors. Although such cruel political impulses are easily identified with social conservatives, the unsympathetic reaction of some liberals towards intentionally unvaccinated hospitalized COVID patients provide chastening reminder that cruelty crosses partisan lines.

Cruelty has long been deployed to enforce unjust practices and subordinate minoritized groups. The National Museum of African American History and Culture includes former-slave Henry Bibb's account of a slave auction: "… she refused to give up her little one and clung to it as long as she could, while the cruel lash was applied to her back for disobedience. She pleaded for mercy in the name of God. But the child was torn from the arms of its mother amid the most heart rending-shrieks from the mother and child on one hand, and the bitter oaths and cruel lashes from the tyrants on the other." Some cruelties we tolerate today bear greater resemblance than we care to admit, including the cruelties of border-patrol agents separating migrant children from their parents. Such cruel practices, alongside arduous conditions in immigration detention centers, are at least partly intentional, designed to deter unauthorized border entry.

Medicaid, our main health coverage program for low-income Americans, reflects its own de facto racist and cruel history. It was established as a joint federal-state program, allowing states to underfund Medicaid, and thus to underserve Black Americans and others.[5] Blatant disparities in staffing, equipment, and resulting health outcomes across hospitals caring for COVID patients expose continuing

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harms inflicted by inequitably resourced medical systems. Predictably avoidable excess COVID deaths in communities of color are cruel. These cannot be sanitized by saying the $4.3 trillion (2021) US health care sector has "limited resources."

As cruelties continue to seriously harm our patients, health professionals must actively oppose personal and institutional cruelty, structural racism, and other efforts to disparage or marginalize disfavored groups. In 1995, novelist Toni Morrison elucidated parallels between racism and fascism as tools to consolidate power.[6] Steps included: "construct an internal enemy," "isolate and demonize that enemy," "enlist and create sources and distributors of information who are willing to reinforce the demonizing process," "criminalize the enemy," and "maintain, at all costs, silence." These challenges are ever-present, expressed in Shklar's 1939 Europe, Morrison's 1995 America, and our America of today.

Social privilege, hierarchy, and animosity are present within every racial/ethnic group, exemplified by bias against indigenous peoples revealed in conversation of Hispanic Los Angeles City Council members, tensions within Japan with formerly colonized minoritized ethnic groups, colorism, anti-Islamic sentiment, anti-Semitism, ableism, and animus directed at sexual and gender minorities expressed within many communities, including communities of color. Shklar argued in *Ordinary Vices*: "By putting [cruelty] unconditionally first, with nothing above us to excuse or forgive acts of cruelty, one closes off any appeal to any order than that of actuality….To put cruelty first therefore is to be at odds … with normal politics…."[3] This perspective, centering prevention of cruelty, brings practical implications for training, communication, and policies to advance health equity.

First, in our individual practices and health systems, we must ensure that each person is always understood and treated as an individual, not as a member of an abstract monolithic group. State-of-the-art health equity training for medical, nursing, social work students, and others must facilitate greater tactile understanding of patients' and clients' lived experiences. Stigmatizing language in health records often reflects cruel stereotyping. Openly cruel language, but also sanitized language and euphemism (e.g., "relocation camps" incarcerating Japanese Americans during World War II), create dominant narratives that harm marginalized groups. Improved training in trauma-informed care should be part of the solution.

Second, we must publicly oppose and defeat efforts to "other" and make invisible faceless marginalized populations. Dehumanizing Asians and Jews with ethnic slurs, or even to express ostensibly admiring stereotypes, makes it easier to overlook discrimination or commit acts of cruelty against them. Nazis cut off inmates' hair in concentration camps in part to dehumanize them. Humanizing marginalized persons and populations is an important step for transforming bystanders into allies.

Third, we must all insist that government laws and regulations, and organizational policies and procedures of private sector organizations, ban practices involving cruelty, and ensure effective care for those wounded by cruelty, who are disproportionately members of under-served, socially and politically disfavored groups. This requires Medicaid to upgrade minimum standards across states, to more closely match reimbursement rates provided by Medicare and private payers.

Shklar understood that persistent cruelty more frequently results from the failure of bystanders to intervene, what Dr. King rightly called "the appalling silence of the good people," than it does from the outright evils committed by the few.[4,7] To be serious about eradicating cruelty, we must all use our personal agency to address structural racism and other systems of oppression. Medical, nursing, social work, and public health communities have special responsibilities to exercise such vigilance, given the severe health consequences of cruelty. So does everyone else.

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