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Black skin is thicker than white

MARTINE ROSTADMO

martine.rostadmo@tidsskriftet.no
Martine Rostadmo, doctor and editor of the Journal of the Norwegian Medical Association

Unequal outcomes are observed for different ethnicities in Norway's public health service. In order to address this, we need to confront our own prejudices first.

Photo: Sturlason

Stillbirth and neonatal death are harsh and tragic outcomes. We have long known that the probability of such an outcome is twice as high for some immigrant groups than for the majority population in Norway (1, 2). Explanations of such figures tend to claim that immigrant status is not really a factor. And certainly not skin colour. Maybe it is related to differences in education? The mother's age? Parity? But no. When controlled for demographic variables, the difference between the groups is greater, not less (1). Language and cultural differences, then? No. That doesn't apply to women who were born and raised in Norway. Women born and raised in Norway by Pakistani parents are more than twice as likely to experience a stillbirth than women with Norwegian parents (1). In the United States, the neonatal mortality risk is twice as high among black children than white children (3). However, the risk of a black neonate dying is halved if their doctor is also black (4). In Norway, it is also estimated that many stillbirths could have been prevented if the women had received better care. This particularly applies to immigrant women (5).

«Maybe the treatment inequality is greater than we imagine»

Maybe the treatment inequality is greater than we imagine. In Norway, the risk of ending up without an epidural during an instrumental delivery is higher for women of a Somali background than for ethnic Norwegians (6, 7). It is well-documented internationally that pain management varies with ethnicity, and that black people receive the poorest treatment (8).

Medical history has some dark chapters; chapters we would rather forget. One of these is its justification of slavery, founded on pseudo-scientific beliefs in innate racial differences between black people and white people. Black people were believed to have thicker skin and were considered not to feel pain in the same way as white people (9). Premised on these ideas, black people were used as guinea pigs. Dr Sims, the inventor of the vaginal speculum and regarded as the father of modern gynaecology, experimented on female slaves. He operated on their genitals, again and again, for no reason and without anaesthetic, because he wanted to perfect a surgical technique to correct genital fistulas (9).

«They also assessed fictitious black patients to have less pain than fictitious white patients»

Unfortunately, some of this murky thinking persists in medical discourse. In a study of 222 medical students in the United States, half had at least one misconception about physiological differences between black people and white people, for example that black people have thicker skin or less sensitive nerve endings (10). They also assessed fictitious black patients to have less pain than fictitious white patients. I myself had not been working for long as a nursing care assistant when I reported on a patient who was in great pain. The response I received was: 'Is she not the Somali one? You can assume it's only half as bad as she says in that case.' I had to go back to the patient and tell her she would not be getting painkillers. Unfortunately, this was not a one-off occurrence. In the end, I suppose I just started assuming that they were exaggerating their pain.

If we want things to change, acknowledgement is the first step. Assigning characteristics to an individual based purely on skin colour or ethnicity is surely nothing short of racism? Perhaps the next time we have a patient from a minority group we should endeavour to ensure that their treatment is twice as good as normal. Spend time. Arrange an extra check-up. And then we need to start the uncomfortable conversation about what may be influencing our medical assessments (11). Because medicine is not colour blind.

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