

Examining Healthcare Accessibility: A Qualitative Review of Health Disparity, Medical Inequity, and Discrimination

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ABSTRACT

Contrary to the advent and normalization of complex medical technologies, health disparities, medical inequities, and healthcare-related discriminations have endured. This is due, in part, to the persistently increasing costs of health care and health care related services. It is also partially due to the general lack of access to quality health care amongst poor and minoritized peoples. These issues are exacerbated by the intermingling of micro and macro level aggressions, stigmas, and medical discourses that reinforce a framework of thanatopolitics (politics of death) and infra humanization-the belief that one's own community is more human than someone else's or that the outgroup is not human at all-within science and medicine [1]. The broader sociomedical and medical effects of infra humanization are the development of an ecology that fosters institutionalized health disparity and medical inequity. Thus costs, access, and perceived social worth/humanity become the variables through which one moves closer to or farther away from negative health outcomes. This article analyzes those issues via an exploration of the ways that health care systems or mechanisms of thanatopolitics and infra humanization are experienced and articulated by patients-specifically relative to medical inequity, health disparity, and healthcare-related discrimination.

Keywords: Medical Inequity; Health Disparity; Patient Care; Healthcare Accessibility

Introduction

For the purpose of this study, participants were asked to describe some of their experiences accessing healthcare, healthcare related services, and/or pharmaceuticals specifically in the United States as a means of obtaining a phenomenography of how they experience aspects of the medical community [2]. Qualitative data was also anatomized following informed consent and respondents were given pseudonyms associated with the crux of their narratives.

Interviews

Interviews lasted one hour to one hour and fifteen minutes each and were digitally recorded. Respondent narratives were then transcribed verbatim, cross tabulated, and analyzed using atlas.ti qualitative data analysis software and a language tonal analyzer. Qualita-

tive data analysis software was used to examine themes present in respondent narratives. The qualitative tonal analyzer assessed the occurrence of anger, disgust, fear, joy, and sadness present in the participant responses. It also examined the analytical, tentative and confidence level of the data (based on its linguistic style). Note, however, that the tonal analyzer evaluated each emotion categorically as opposed to comparatively.

Respondents

Participants for this study were recruited from the Houston and Galveston metropolitan areas through convenience sampling and snowballing. The target population sample for this study were adults of any sex, gender, or race who wanted to discuss their experiences accessing care related services. Unfortunately, several people did not

feel that they qualified for participation in the study. They assumed, even after repeated conversations to the contrary, that senior citizens, people with chronic medical conditions, or individuals who had experienced a trauma (physical, psychological, physiological or otherwise) were the most valid respondents for research on one's medical experiences. As such, a few individuals referred me to someone they perceived as better fitting my criteria. More specifically, for the interested but self-perceived unqualified individual, they had only been to see a doctor a few times (and for "minor" reasons) in their lives and thus their experiences were not relevant. As such, several individuals referred me to people who had more frequent physician-patient interactions due to chronic or reoccurring diseases or illnesses. Thus, of the twenty people recruited for this study, four people were self-excluded. Sixteen people felt that their narratives were fitting and thus continued participation in the study [3].

Qualitative Data

In cognitive narratology, the significance of one's narrative chronology lies at the intersection between *fabula* (the chronological sequence of events in a narrative) and *sjuzet* (the re-presentation of events through narrative) which act as a gauge of one's perception of his or her quality of life and lived experience [4]. Understanding the significance of *fabula* and *sjuzet* within the qualitative data of this study provides insight into respondent's health care experiences, self-perceived quality of life, and how that phenomenology situates within health disparities, medical inequities, and various forms of discrimination.

As such, it is valid and interesting to note that all of the respondents' narratives had similar properties. Not only were they all self-reflective—a necessary component for most qualitative interviews—but they were also comparative appraisals of the study participant's perceived social expectations and personal agency. Specifically, the chronology of each respondent's narrative either compared their present situation with that of the past or vice versa. Their recollections also all began in a time when the individual experienced the least amount of direct agency or when he or she relied heavily on proxy agency or via one's parents and one's parents' applicable insurance. No one was prompted to do this, and it occurred contrary to the age of the research participant.

According to Albert Bandura's agentic perspective of social cognitive theory, human agency is characterized by self-reflectiveness which distinguishes between one's ability to have and apply direct personal agency, rely on a kind of proxy agency (agency via the help of other people), or rely on collective agency which is actualized by socially coordinative and interdependent means [5]. Within the context of the qualitative data obtained for this study, an individual's ability to either obtain and use private insurance, obtain and use governmental insurance or that of a proxy's (such as a parent or guardian), or one's need to seek health care via a community health facility or clinic, for

example, was discussed in the respondent's narrative chronology by first articulating a period in time in which the individual seemed to lack direct personal agency. This chronological structure represented a time when they had what Bandura described as a reduced "capacity to exercise control over the nature and quality of their own lives"—hence the need to begin each narrative from a point in which he or she had (or has) the least amount of agency.

Thus, respondents were comparing their past and present experiences based on how they perceived their ability to take care of themselves relative to the standards, expectations and/or norms of American society. This could be better understood by asking oneself at what age or in what period of life you are responsible for yourself and your own well-being? The answers you may come up with are a part of a larger social and cognitive process. Such answers were communicated by respondents via the structure and content of the initial chronological structure (*fabula*), and the specific elements and re-presentation of their narratives (*sjuzet*). For example, respondent M.P. began her narrative by stating that: [6]

Well, recently it hasn't been so good with the (pauses) I am on government insurance. I am actually finding it really difficult to find a doctor to see me when they find out that I have the discounted or subsidized plan. So, currently, I do not have a Primary Care Provider. I have only recently found a gynecologist who would take my insurance after calling about seven or eight different offices. So, it's not going super well lately, and I have only recently become interested in (pauses) I have been keeping up with my health. I turned twenty-seven in September and so now I'm like I'm getting older, and I have to start taking care of myself because mommy and daddy aren't going to be like "go to the doctor" anymore. So, I have to take care of myself and find the resources myself and it is proving difficult.

M. P. began her narrative by articulating her contemporary inability to access health care using governmental assistance and related it to her perception of what she felt she should be capable of given her age and degree of autonomy. For example, she stated that she was twenty-seven years old, that she was getting older, and that she should be able to take care of herself. Her need to use a kind of proxy agency—previously through her parents but currently through the use of governmental insurance was not in tuned with the kind of agency she believed she should be able to exercise [7]. Given her health care situation, however, she lacked the agency to do that. Thus, as noted via a tonal analysis of her narrative, the retelling of her experiences indicated high levels of anger, sadness, fear, tentativeness, and conscientiousness at 63%, 43%, 26% as well as 10% and 23%, respectively [8].

Similarly, respondent V.A., began her narrative by stating the following: When my parents came over and I don't remember what earlier forms of health care were like, but I always went to the doctor every year. I always went to the dentist. I don't remember having an ID, but I am pretty sure that my dad had some form of health insurance

like maybe a gold card. Then one day he was like "Go to the doctor! Go to the dentist before it runs out. Go to the eye doctor!" because we had optometry care too. And I didn't I don't know why I guess I was busy with school and then things started going not downhill but going typical, I guess. Like I had teeth problems and then eye problems and then I think that the first time that it finally sunk in that we didn't have insurance was right before we got government healthcare, it was I think I had to get my eye examined and I had to pay out-of-pocket and it really hurt having to pay for like your own glasses and paying for the check-up and the eye drops or whatever. You realize that other people didn't have what you have or had and you didn't take advantage of it. So, for me at this point, I am just paying everything out of pocket, and I haven't been to the doctor in a while and like the dentist either. Like, I had a really bad fever two weeks ago and I think that maybe one of my teeth was falling out and I have to think about saving up money and not going out and doing all of this stuff that I have been so accustomed to. Like, I need to save up and go to the dentist. I might just have to pull the tooth out. So, yeah, that's where I am right now. I am just having to think long term about my health and just eating better and all of that.

V. A.'s narrative is also a comparative of her previous health and health acquisition status with her current experiences. According to a tonal analysis, the syntax and prosody of her narrative depict high levels of anger, fear, and tentativeness, at 74%, 43%, and 94%, respectively. Like M.P., the interaction between V. A.'s narratives' fabula and sjuhet with her linguistic structure and tone are indicative of her perceived quality of life and agency via self-reflection. More specifically, V.A. perceived herself as having a quality of life that negatively compared to her previous healthcare-related experiences. It was perhaps these elements of her narrative that facilitated the production anger, fear and tentativeness identified in her narrative retelling.

Another respondent, B.D., noted a similarly structured, comparative phenomenology as well as a transition from proxy agency to a reduction in her ability to take care of herself. She stated that:

I was living with my mom, and I was under her insurance and back in the day, I guess maybe I didn't know enough, but insurance was great. It was not a problem to go to the doctor and it was not a problem to get medication. But as I got older I would say that it all stayed that way through college when I left home and got my own job. I was fortunate enough to get a job that had insurance. So, I was actually able to go to the doctor when I needed it and I could go and get medication. Then I started a new job and I just noticed that maybe insurance was free before then and now they wanted to charge me for it. I am not really sure how that went. Then suddenly, you start to be more aware of everything. You are wondering like how much co-pays are and just wanting to know the cost of everything, my medications, and strips and everything just suddenly became this huge burden.

Like many of the other study participants, B.D.'s story was laced with fear (57%), sadness (45%), and tentativeness (86%). She also

acknowledged a generally decreased ability to take care of herself relative to the cost and accessibility of health care and health care related services. Narrative snippets such as M.P.'s, B.D., and V.A. not only speak to some of the economic and health related hardships faced by some impoverished peoples, but also how that positionality affects one's self-perception and well-being, and his or her intrapersonal and interpersonal engagement. These are socio-medical affects that have stemmed from one's difficulty accessing health care and/or health care related services and can instigate medical inequities downstream.

Generally, medical inequity is facilitated by the unequal accessibility and/or affordability of health care and health care related services. Disparity is normalized through thanatopolitical systems which favor the wealthy. Thus, the kinds of narrative descriptions noted by M.P., V.A., and B.D. are significant because they provide context for understanding and forecasting the interplay between medical inequity and disparity by describing some of the contemporary hindrance's individuals experience relative to health care accessibility. Furthermore, contemporary health care trends are not leaning towards greater accessibility and affordability for indigent families. So, the inequitable access of health care and health care related services facilitated by neoteric medical technologies that do not account for pre-existing disparities, healthcare biases, and racialized medicine, for example, may increase the disparate nature of the healthcare system. Thus, cost and access become significant indicators of actual or perceived health outcomes.

Cost and Access

Within respondent narratives, cost and access were discussed as dynamic concerns with specific issues being the price of pharmaceuticals and private insurance, the amount of time (relative to cost-benefit) one spends searching for a physician that will take government subsidized insurance, one's ability to directly and immediately access health care, and issues of care continuity [9]. Self-medicating was also a recurring theme within respondent narratives relative to cost-albeit with much less frequency. The plight of M.P. is an elaboration of such an issue. She stated in the following excerpt of her narrative that:

I think everyone should have access to health care. So, it's frustrating to kind of run into all of these roadblocks and it's interesting too because I have had doctors make the appointment and they take that kind of health insurance but then they'll call back about a day or so later like "Is this a government plan?" Then, they say that they can see me, but I would have to pay out of pocket. So, yeah. They can see you but it will be about four or five hundred dollars. I started calling around because my insurance sent me a list of approved providers. So this is actually going off of their website's list in my area that take that insurance but then, again, when you go down the list it's something different. I found (pauses) I think it was like the seventh or eighth person who would finally see me and I had to wait a month [emphasis

hers] I think before they had an available time slot. And they were actually very sympathetic and were saying that like “we’re very booked because a lot of people have this problem.” So, I self-medicate. It can get to a point where, you know, I am relatively healthy. So, I haven’t (pauses) it hasn’t gotten to a point where I needed to see a doctor in a short amount of time. So, luckily it hasn’t really gotten to the point where I have to really try to figure it out. But like, if you get the flu or a cold, I don’t go to the doctor I just self-treat it with some Theraflu or something [else] unfortunately. But it is scary knowing that you don’t really have that resource that you need if something did get bad. It’s like you have the illusion of having it because a part of actually having it is being able to access it. It is almost like it is kind of like a mask to avoid the tax penalty. So, it’s like you have insurance so you avoid the tax issue, but you don’t have any of the benefits from it.

Unfortunately, as noted by M.P., having insurance does not necessarily equate to being able to access healthcare-related services in any meaningful way or timely manner. In these instances, the individual tax mandate acts as a negative, biopolitical sanction applied to the American populace in the name of public health [10]. M.P.’s narrative is thereby a depiction of biopolitics and a reiteration of the ways in which poorer health outcomes are facilitated by persisting inaccessibility to health care or health care related services. Yes, she technically has health insurance but if one has to wait a month or more to be seen by a physician it is logical for them to feel that they do not actually have entrée to that benefit. Also, given that most viral and bacterial infections may only last about two weeks, by the time M.P. is likely able to get in to see her doctor her sickness may have already subsided. Such a situation is analogous to a fictive idea of someone who owns a car but can only drive it once every month or two. Eventually, that person may begin to feel that the car is not actually his or her property. Occasional access to the car would also have no major impact on his or her daily transportation needs, his or her ability to access locations beyond the vicinity of public transportation and could potentially compound costs relative to the need for vehicle maintenance and bus, Uber, or taxi services. Similarly, according to respondent M.P., having governmental health coverage provides a miniscule amount of assurance and does not account for the costs of self-medicating [11].

Respondent W.Y.’s health care phenomenology was also fraught with systemic health care accessibility issues, disparities, and discriminations. For her, however, the decreased ability to access regular doctor’s appointments for therapeutic treatment of her chronic illness and prophylactic treatment of other more acute sicknesses, caused her symptoms to worsen over time. W.Y.’s difficulty accessing healthcare also negatively affected her continuity of care. During our interview she stated that:

Unfortunately, I don’t have health care coverage (pauses) per se. So, I have been left, basically, to navigate the Harris County Health System (long pause). I had some health issues and ended up with pneumonia and was unable to get rid of it and ended up with a lung

mass. So, I was going to [name omitted] hospital and they basically (pauses) after I returned a few times (pauses) urged me to get care under the Harris Health System because I didn’t have private insurance. Eventually, I was fortunate enough to find out that I didn’t have lung cancer or breast cancer, because I was tested for both. and that my lung (pauses) the lung mass was granulated so it would just basically dissolve over time. Eventually though, I ended up with (pauses) my home had mold in it which I suspected but I ended up having some more serious health concerns from the mold. And so that [emphasis hers] issue dealing with that with the Harris County Health System was well (pauses) different because I was not an immediate concern and so care was, at that point, so-so at best. I would say it was average at best. One of the problems I had was that there was no continuity of care. So, when I would receive or rather go to my appointments, I would see one resident at this place on this day and I would see somebody different on the next visit. So, the continuity of care and with the health issues I was having (pauses) I was having lung problems (pauses) so the care just was not adequate.

I’m forty-six years old (pauses) almost forty-six years old so I feel like I know my body and I know when something’s not right and so, you know, being that I don’t have a long history of care with this certain provider, they pretty much don’t know you and know your body. It’s like when I go in and I have a complaint or a concern it really was sometimes kind of brushed off. I would go in there and I would tell them “This is what’s happening” and that it was the same way that I felt when I had pneumonia. I’d say, “My body feels exactly the same during that time that I had the lung mass.” But, you know, they still just kind of did what they wanted to do. At one point I feel like I am having, well, I know that I am having, some memory loss right now and I have had a terrible time trying to convince them that I need to see a neurologist and then right now, see, I am waiting since when (pauses) I want to say December but it may have been October to see a rheumatologist for a diagnosis. I have some positive Lupus tests and I have some arthritis that has started but all they do is basically give me pain meds and say well we think that it is possible that you may have this but it is also possible that you don’t and until you see a neurologist (pauses) I mean until to see the rheumatologist we won’t have a definite diagnosis. But, I won’t see (pauses) I can’t see a rheumatologist until July which is about six months out. So, I am still waiting to see a rheumatologist.

According to respondent W.Y., when she needed immediate, emergency care she was able to get it. She went to the emergency room. She received all applicable testing, medications, and follow-up appointments. However, when her lung condition went from acute to chronic the immediacy and continuity of her care shifted dramatically. At the time of our interview, she had already waited four months to see a rheumatologist and would need to wait another six months before being able to get in for an appointment. That is almost a year of waiting for a doctor’s appointment. Meanwhile, over the counter ibu-

profen and steroids have been suggested as a means of dealing with her pain. This matter further problematizes her plight in that some of the adverse effects of uncontrolled pain include the loss of physical strength, immune system impairment, and increased susceptibility to disease- issues which could potentially irritate her preexisting conditions while simultaneously increasing her susceptibility to other diseases and/or sicknesses [12]. Additionally, although she pays very little for her health insurance, the costs for her prescriptions were double that of retail pharmacies. To an individual who earns less than 150% of the federal poverty level of \$21,983 a year for two people, the differences in pharmaceutical costs could be astronomical [13].

Additionally, narratives such as W.Y.'s outline the relationship between one's socioeconomic status and the inability to access consistent care or otherwise afford health care related services. They also evidence the reality that access to care and care continuity are not mutually exclusive. Instead, they bleed into each other and reveal how one's poor health becomes a consequence of his or her level of poverty (or perhaps a lack of private insurance) [14]. More specifically, according to Becker and Newson's article on the interplay of one's socioeconomic status and dissatisfaction of care, "low socioeconomic status has potentially deadly consequences for several reasons: its associations with other determinants of health status, its relationship to health insurance or the absence thereof, and the constraints on care at sites serving people who have low incomes." Consequently, the burden of illness is defined by the tautological, inextricable link between poverty and poor health-an issue that Western society has known about for decades and that does not seem to be changing in the foreseeable future.

According to respondent C.C., one's inability or difficulty to pay for medications is a reoccurring plight witnessed by many people in the pharmaceutical industry. She stated in her interview that:

People would get prescriptions filled (pauses) they'd find out the price and then the prescriptions would get left behind. So, they wouldn't get their prescription. Sometimes it would be because of a high co-pay. Sometimes it would be something that was just a couple of dollars that they would need to pay for their mother's prescription, but they can't pay the couple of dollars for their mother's prescription. So, the item would get left behind. So, price is some issue. Price or paying for prescriptions was an issue for a number of people. They may just go without their medicine, or they may have to wait until their check comes in or put it off or wait until next month or whatever.

Depending on the pharmacy those prescriptions would be returned to stock within seven to fourteen days. But, the prescription is good for a year; unless it is a controlled substance and then it's only good for six months. So, it would be returned to stock, and they could just call back and have it refilled. It's not like they lose it or they [are] penalized by their insurance or something or rebilled or something. There are times like, for instance, there was a guy and his mother had

just been released from the hospital, I think, and she needed these medications and (pauses) a lot of times with Medicaid you have a zero-dollar co-pay. It's free. But with certain medications that may not be covered by Medicaid and they're over the counter they have to pay out of pocket for it. So, she had a pain medication that was zero dollars, but the pain medication caused constipation. The constipation medication was considered over the counter and wasn't covered, and it was just two dollars and he left it behind. And, I let him know what the purpose of that medication was and why it was important for his mother and he just said that he would have to come back and get it. Well, it was eventually returned to stock. The kinds of issues described by study participants W.Y. and C.C. are further compounded by institutionalized racism inherent in many of the ideologies, epistemologies, and praxis of medicine.

Access and Discrimination

According to Kelly H. Hoffman et al, "individuals with at least some medical training hold and may use false beliefs about biological differences between blacks and whites to inform medical judgments, which may contribute to racial disparities [15]." Such beliefs stem from normalized and legitimized ideologies of the molecularization and biologization of race and racialization that have persisted through history. Socialized ideas of the kind of Black/White dichotomies also inform medical students' perceptions—and thus their treatments—of African American and White people. For example, in a study published in the Proceeding of the National Academy of Sciences, some of the racially biologized ideas existing amongst medical professionals included beliefs that the nerve endings of African Americans were less sensitive than their White counterparts; the notion that the blood of African Americans coagulated more slowly than Whites; that White people had larger brains than African Americans (and thus greater intellect); that the skin of African Americans was thicker than their White counterparts; that African Americans were more fertile than White people; that African Americans had more efficient respiratory systems than Whites; and that African Americans had stronger immune systems than Whites [16]. These assumptions are culturally malignant in that they not only influence physician prescribing tendencies but also the general doctor-patient engagement as a whole.

As varied medical technologies such as AI or machine learning continue to be developed without healthcare biases or normalized structural violences in mind, the kinds of racially biologized concepts referenced in the preceding paragraph will be further mapped on to and into the epistemologies, interpretations, and process of the scientific and medical endeavor. As with many other such instances that have occurred through time, those ideologies will be legitimized, socialized, and heralded as objective within scientific and medical communities. According to Giorgio Agamben and Zygmunt Bauman "to the conscious understanding of agents, such as researchers, medical doctors, or lawyers, these [kind of] phenomena will appear more as blind zones and un-intended consequences than as intended action

[17].” Nonetheless, to those individuals who are directly and indirectly affected by racial and racialized molecular and biological supposition, the individual intentionality of the researcher or physician is surpassed by institutionalized thanatopolitical medical systems that facilitate and perpetuate inequity and disparity.

One of the most pervasive examples of this is the overrepresentation of minority peoples in the inadequate treatment for acute and chronic pain management. According to a recent study published in the *Journal of Clinical Orthopedics and Related Research*, for example, the undertreatment of pain for minority populations is largely due to physicians who are unaware of their own cultural beliefs, subjectivities, and/or stereotypes regarding minority peoples, pain management, and the use of narcotic analgesics [18]. Persisting stereotypes feed the kinds of medical inequities discussed by many of the respondents of this study. For example, according to respondent C.C., stereotypes regarding the African American threshold for pain and/or the abuse of controlled substances (such as pain medications) create disparities in pain management between racial groups. During her interview, she provided the following perspective:

I have actually had to correct one of my Techs who (pauses) ok, so there is an issue with people abusing pain medications, or narcotics or sedatives, oxycodone or whatever and an issue of people selling those things on the street. So, the Tech was just turning people away and wouldn't fill their prescriptions for those kinds of things. So, I was noticing that if it was a Black person that she would just turn them away, but she would fill those prescriptions for people of other races. She would just turn the Black people away. But when you can look at their profile you can see how often they get it filled in. Now there is this thing out here where you can log into it and (pauses) say if I pull up your name, I can see all of the controlled substances that you've gotten filled at different pharmacies. People would get away with filling out a prescription at one retail pharmacy and they don't know that the person also just got one filled at another retail pharmacy because they don't have access to each other's systems. The person may even have gotten them filled the same day—two different doctors with two different prescriptions. So with this new system, it will get rid of that issue. I can go in and see that someone just got one filled two days ago. Another way is to look for trends. Are they doctor shopping? Are they on all these different kinds of controls? So, there are a lot of different red flags.

So, I said “um, what's the problem with that?” She didn't really have a good reason. So, I said “before they leave let me see the prescription. Let me be the judge of what happens here.” So, she was the gatekeeper whereas I would be the person that needs to decide, and I needed to see if there was an issue or if there was something that made me think that there was a problem. So, I was just realizing that

if it was a Black person that she was more likely to treat them like they were a drug abuser or whatever and thus their prescription didn't need to be filled. It was her personal bias. This was a Hispanic young lady, and I already knew that she has certain biases toward people because she would outwardly say things that were very critical without knowing that she's saying things that were very critical or inappropriate. So, based on my observations I realized that she didn't even know that she was feeling those things necessarily. So, I just basically took away her ability to make that judgment—I took away her ability to make that decision.

Again, preconceived notions of race and racialized behaviors (such as stereotypes regarding the abuse of controlled substances) work as primary agents prohibiting an individual's access to medical goods and resources. Such issues, in addition to those of cost and access were repeatedly articulated in respondent narratives. Respondents' healthcare phenomenographies also depicted a lack of confidence in the health care system, decreased feelings of agency, decreased quality of care, decreased continuity of care, anger, and fear. These experiences and feelings are significant to understanding the broader medical and socio-medical effects of varied health care systems on poor and minoritized peoples. Aspects of these experiences were captured in the tonal analysis.

Tonal Analysis

An aggregate tonal analysis of the interviews showed that 72.5% of participants expressed anger within their narrative retelling. An additional 28% of respondents were fearful. Disgust and sadness were equally indicated in approximately 6.5% of the experiences articulated by participants, and 10% of participant narratives indicated feelings of joy. The most prevalent aspect of the interviews, however, was the feeling of tentativeness, at 92%. What is most telling, however, is that none of the participant narrative experiences indicated feelings of confidence (see table 4). Note that these percentages total more than 100% because they are analyzed by the software as independent variables (Figure 1). Creating a dialogue between respondent narrative fabula and sjuzet with the aforementioned aggregate tonal analysis allowed for the critical analysis and nuance of participants' phenomenology. Many of their subjective realities were underlined by a lack of confidence in their ability to access health care and/or pharmaceuticals. This sense was compounded by feelings of tentativeness and fear—the latter of which to a much lesser degree. A further analysis of respondent interviews indicated that their feelings were likely in response to the intersection of increasing or unstable health care costs with an inability (or decreased ability) to actually access care or applicable medications. Discrimination (based on race and/or insurance type held) was a peripheral issue that also affected the timorous sensibility of respondent narratives.

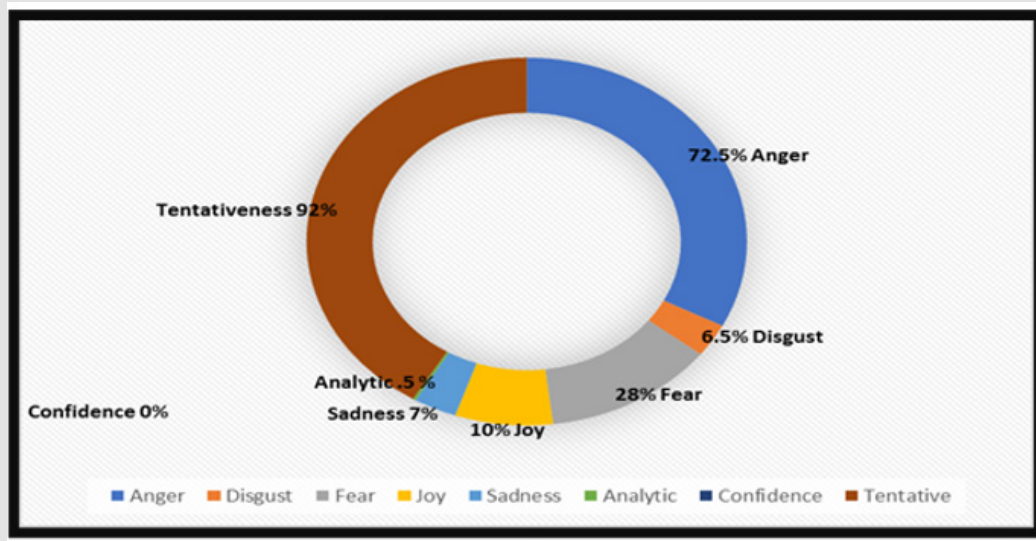


Figure 1: Aggregate Tonal Analysis of Participant Interviews.

Conclusion

And, while discourses on the medical, and social implications of race, racism, and discrimination in general continue to be intellectualized amongst a variety of medical and academic disciplines, their impacts have yet to effectively penetrate the epistemologies and praxis of the medical and biomedical industries [19]. This is perhaps due to the centuries of scientific racism that worked to legitimize health disparities, medical inequities, and discrimination. However, we cannot begin to discuss the prevalence and perpetuation of these issues if we are unable to first acknowledge that they exist. Instead, we (members of the academic, medical, and scientific community) have reified biological reductionism and genetic essentialism and used their bases as the most relevant and meaningful proxies for medical and social scientific research and practice. This further victimizes racialized and minoritized people within the framework of medical progress and continues to muddy the reality of how progress is experienced by all people-as noted by the narratives told in this article.

Conflict of Interest

The authors have no conflicts of interest associated with the material presented in this paper.

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- Note that times of respondent silence or sentence discontinuity during the recounting of his or her story is textually recorded as a "pause."
- Note that the percentages listed total more than 100% because they are thematically characterized (as referenced in the methods section of this paper) and analyzed relative to the prevalence of a specific them (such as anger, fear or sadness) within an overarching category such as "emotion."
- As previously noted, the three categories examined are emotion, language style and social tendency.
- In an attempt to maintain thematic integrity, the metaphorical use of the term "cost" was not reassigned under a different category. Instead, when and/or if a respondent used the term relative to a cost-benefit analysis, it remained as a part of the broader conceptualization of the term.
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